“When are you coming to my neighborhood?”: Elizabeth Smith and Maggie Savage of EYElliance on building demand, ensuring supply and navigating a Ministry of Health

Ambika Samarthya-Howard

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Ambika Samarthya-Howard: To start, could you give me some background about your work with EYElliance?

Elizabeth Smith: Prior to EYElliance, I did a lot of international development work. I worked with the UNDP for around seven years or so. I joined VisionSpring in 2011 and worked closely with Jordan [Kassalow]. EYElliance grew out of conversations he and I had been having at VisionSpring about solving the problem at the population level, which no one entity is going to do, right? So we co-founded EYElliance in 2015 and I've been doing it ever since. So I came into this work with some institutional knowledge from when I was at VisionSpring, but things [in the space/sector] have changed significantly since then.

The first thing Jordan and I did was spend seven months learning about what's working with other eye care NGOs, because we really didn't know what other people were doing outside of VisionSpring. So we spent a long time getting really smart about what was working, other solutions. And we also spoke to a lot of actors outside of vision. So just to say, as we founded EYElliance, we came into it with this deep understanding that VisionSpring didn't have all the answers, a deep understanding that it would take more than one entity and more than one sector [to solve the problem], and that we had a lot to learn from cookstoves and off-grid solar and nutrition and all these other global alliances that have come before us.

Ambika Samarthya-Howard: In terms of both the work you're doing now and the work that you did with VisionSpring, what kind of models have you seen to be the most effective for distributing reading glasses for presbyopia at scale?

Elizabeth Smith: We're going to speak mostly to delivery through community health workers (CHWs) since that's what we primarily do. But when we founded EYElliance, we knew there was a proof point that VisionSpring had. I mean, listen, Jordan ideated that model over 20 years ago, right? This idea that a community level worker could deliver a pair of reading glasses. Much of that work has been done and is still being done in parallel systems, meaning outside of the government and many aspects of delivery being done by NGOs. When we started EYElliance, we knew from the beginning that we wanted to test whether we could enable governments, ministries of health, to become the implementers.

To us, it's national level delivery through community health workers. I mean, given the enormity of the problem we need to utilize channels that already exist and can reach large numbers. Those are pharmacies and CHW systems, but CHWs will reach significantly more numbers of people, millions more, and then are already built, whereas pharmacies still need to grow and expand to have the same reach.

Going back to the beginning of EYElliance, we have looked at the last mile delivery mechanisms and with pharmacies, but you're going to get more intel on pharmacies from VisionSpring. But it comes back to the fact that there's a real demand issue. And so for near term impact, getting glasses on faces, adding reading glasses delivery to existing CHW systems will reach the most people and will be the fastest way to do that

Ambika Samarthya-Howard: Maggie, can you share your background and the work you do with EYElliance?

Maggie Savage: Sure. I was with CHAI [Clinton Health Access Initiative] for six years before coming over to EYElliance. I helped start the Assistive Technologies program at CHAI. And my background is originally in the health financing space. I worked on health insurance reform in Ethiopia for quite a while, but then switched over to leading market shaping strategy development. And that parlayed into the work around assistive technologies, eyeglasses and the like.

I really went in depth into the assistive technologies markets and the solutions. And in that process, got to know Liz really well and made the switch over to EYElliance, to lead EYElliance's private sector strategy. Now I am EYElliance's COO overseeing both our public and private sector pieces of work. So I am kind of sitting in between both this piece of government delivery through CHWs, but then also what we're looking at in the private sector across the entire value chain of private sector business to really shape those markets for that end user delivery.

Ambika Samarthya-Howard: In terms of what you've seen with the work that you've done around motivation and barriers either for demand or supply chain, what are some of the things you feel are most effective for scale? What are the things that you've done that have worked?

 **Elizabeth Smith:** At EYElliance, the model we work with is that reading glasses are given for free through community health worker systems. So this is a bit different in the sense that what we've seen in Liberia is that over 75% of the people who were screened needed reading glasses and they're all wanting the reading glasses. I mean, there's not a demand issue because they find out they have a problem, they see clearly as part of the screening and they want the glasses. And so that's just to sort of share that we do things through the government, but it's a little different than maybe the conversations you've had with other folks.

 When EYElliance began, we were really clear that NGOs historically have done demand creation work around their access points. Like catchment specific demand. We learned that to really be effective, you need to create demand at a much larger scale. So consumer campaigns are what we've looked at, right? Some behavior change work. But you need something on a much larger scale.

 And we learned from the mistakes of others who had shared, this is off-grid solar, that they had done a big consumer campaign and then people were showing up looking for the off-grid lights at places where they were not yet available. And then the problem was those lights weren't in enough distribution outlets, right? And so then you've sort of lost a little trust with the customer base. So someone's gone to seek out the product, it's not there.

And so what we heard early on from those who've done large scale work was to make sure that when you do those large scale consumer campaigns, behavior change campaigns, that there's enough penetration. When people get those messages, they need to have a place to go [to get the product]. So frankly, we've not done the large scale campaigns yet. It's something we're still really interested in doing, but because we haven't felt like there's been the penetration to do what we hope it would do.

Ambika Samarthya-Howard: When you were saying that in Liberia you've had no issues with demand, is there something that you're doing that has made that so easy? Because in a lot of other places it sounds like the demand is one of the hardest things that people are fighting against in terms of actually getting enough interest for people to actually wear the glasses, whether it's cultural barriers, stigma, or other things.

 **Maggie Savage:** I think because we're going through a well-established community health worker system, those community health workers have strong relationships with the

communities that they're serving. And so when they're bringing a new product offering to the community, there's already a trust there that this is something positive.

We're doing some evaluation work around that question right now. But what's really interesting is that because they're trusted community health workers and they've been trusted by specific communities, such as women and children on delivery of a variety of packages of services, we are now adding and integrating in eyeglasses delivery for a population that hasn't been served by community health workers. So it's also an opportunity for the community health workers to expand their presence and expand how others in the community are seeing them because they are bringing something needed to them and seeking them out.

 So with the community health workers doing the work, either door by door or holding small scale neighborhood screenings and then delivery of the reading glasses, initially people come to that because they already have this trusted relationship. And then there's the second piece of, as others in the community hear about the new product offering or the new service offering, we've heard stories about them seeking out their community health worker and saying, "When are you coming to my neighborhood or my cluster of homes?" And so I think that's been a really important part of this work in terms of these aren't mass campaigns, there's some light social mobilization within it, but it's really relying on those trusted relationships and the respect that community health workers have within the system.

Ambika Samarthya-Howard: I'm curious, when you're talking about outbreaks and other life and death situations, how have you been able to prioritize community health workers in terms of giving out eye care versus the other things in their service bundles?

Maggie Savage: I think that started from the early days of the Liberia program in terms of those initial conversations of integrating this into the service package reform that was ongoing in the country. Making sure that there is that understanding of what is this going to take, what is that balance between the time trade off of them delivering reading glasses, which it's not an everyday acute need and so they can space out and head to populations that they wouldn't necessarily always reach on their timetable.

 I think the second part of that piece of it is thinking about how we're seeing that we're reaching a slightly different population than those CHW's normally see. For example, a 50-year-old male in the village is now getting services from a community health worker. And so he's seeing that value. And so that has long-term effects in the system for an overall benefit aspect of this as well.

 **Elizabeth Smith:** I would just add to what Maggie was saying that, so this work is in Liberia, it's about integrating reading glasses into both policy and broader CHW training package. It's the

services not coming and going. It's in there. So as long as those community health workers are delivering this package, [reading glasses are] a part of it.

Ambika Samarthya-Howard: How did you guys advocate for this to be a part of it within all the other priorities that the country has? Was that something that you worked with the government to do or how did you push that forward?

Elizabeth Smith: Yeah, we did it. I mean, we just made a successful case. And as you know, Liberia has a really comparatively highly functioning community health worker system. So like Maggie said, there was this window of reform where it made sense to start talking about this potentiality. We brought the evidence base.

EYElliance also was behind WHO coming up with that e-learning training module. So when we were sharing training information, that also came in handy. It's a time-intensive process. But that's what we do. We made the case that we thought this would be a worthwhile addition. We did a pilot and the outcomes of that pilot also really helped. We were already in an early version of the policy, but having the pilot did really help further solidify that into the policy and package.

Within the Ministry of Health, we were always targeting community health assistants (CHWs), which they're about 4,000 in Liberia. And there's another cadre that is community health promoters. And because of the pilot, as they were finalizing the policy around community health assistants, this wasn't even on our radar, but the Ministry said, "Let's extend this same service to the community health promoters as they start rolling out." And so I think that just speaks to the power of this institutionalization and having the Ministry behind it.

Ambika Samarthya-Howard: I'd love to hear about the pilot. I'd also love to hear about this e-course, because some things that we're investigating are tools and training and technology, and how to engage people to use them.

Elizabeth Smith: I think in terms of what was useful for us in Liberia was just the WHO having come out and sort of giving the endorsement that community level workers can do this. And so the WHO does have a lot of sway at ministries of health. I don't know if somebody talked to you about SPECS 2030, but the WHO has a new initiative that's specifically on eyeglasses that has launched and have already come out with a really great, I don't know if I'd call it a toolkit, but guidance on screening at different ages. Working with the WHO, both the early e-learning work that we had done with them and this newer bit of work will, I think, really expedited the case making to ministries of health.

Maggie Savage: WHO provided gravitas for when there is concern that whether or not community-level workers can do this work. And so having that learning platform was key. And

then that second piece around the pilot was really taking that and then showing that it is viable within the Liberia context.

What happened in the pilot in the one county is exactly what's rolling into the national level program. And so I think that's what's really important and unique about how EYElliance approaches this work in partnership with governments is the ability to think about integration from the beginning. This wasn't a parallel pilot. There was much more upfront work done on getting things integrated into the systems that were already operating for community level workers to where now it's not a huge lift to go from pilot to national scaling because all of the tools and resources were already developed and tested.

There's small tweaks and learnings from the pilot that are informing the new curriculum, and data collection forms will be fully integrated into the final national level package of services.

 But I think one of the critical things is building that integration from the beginning and understanding each of those integration points, such as having national ownership over the supply chain for the pilot, rather than just dropping the glasses at a health center, and really seeing how they flow from that national level. Each of those things take longer in terms of planning for a pilot, but the long-term dividends look so much different than your traditional pilot where you say, "We're going to test one piece of it." We really looked at that overarching systems perspective of how the community health worker or community health assistant program works in Liberia to ensure that it can scale.

Ambika Samarthya-Howard: Have you scaled past Liberia?

Elizabeth Smith: That's the idea. I guess maybe the part of the story that's important is that there was the global symposium on community health workers in Liberia, and we were approached by, I think, five countries to come and replicate what we did in Liberia. We still have to raise resources to do the work. Maggie can speak to any programmatic challenges, but we're not that far down the road in terms of that specific rollout. I think we can share some more specifics on how it looks different from country to country, but we have to raise resources to do that initial systems work that Maggie's talking about.

 The ministries will be paying for this work over the long term. So we're working ourselves out of a job, but that initial upfront capacity building and understanding the system and all that case making, the tools, everything, that requires some investment upfront to establish those systems. And so it's a difficult thing to raise funding for. Maggie, I don't know if you want to talk about the different countries and how they have wanted different things from us, because I think it's relevant to your work.

Maggie Savage: That's exactly what I was thinking about, Liz, that question of what rollout looks like for different countries. And I think a lot of it comes back to where those policy windows are. In some countries, we're able to really think about the alignment with a policy window in terms of them looking at that package or starting a new community health worker program and designing their package from the get-go. And so I think that's also been the number one challenge, thinking about those resources. But then number two is really trying to align that timeline with a ministry.

A while back, in Côte d'Ivoire, their head of community health approached us, but they've had significant delays on the rollout of the design of the program within the country for their community health workers. And so we are getting ready to launch a pilot with them around that same question of what do we need to design for integration into a new system and be able to answer that question really concretely. And we have really great learnings. I think that we'll be able to do some of that a lot faster with the Côte d'Ivoire government in answering some of those questions.

And then, there's other countries where some of these things are kind of organically happening or they're looking at if the country is more decentralized, what is the state by state approach going to look like? The packages are defined at a state rather than national level, but there can be national level guidance. So there's all of these kinds of interesting questions.

And then in some countries you face challenges when the person who was your main cheerleader or the stakeholder who had pure ownership over it is no longer in their role. For each of those countries, I can kind of tell a different story of where we are and why.

But the one thing that feels really strong is, [one], that there is kind of this one continued interest. Two, we have proof points to point to in Liberia that we are starting to see in some other countries. And there's real interest as well on that kind of peer-to-peer or ministry-to-ministry learning of how this is working. And so I think when we have that ability to have them speak to each other as well, it really creates champions and moves things forward. So kind of like the WHO push, the ministry push, all of those things really combined to build that momentum internally within ministries.

Ambika Samarthya-Howard: What did you feel like were the main challenges that you had to face in scaling this in Liberia?

Elizabeth Smith: Government delays are my challenge, but I'm on a different side of things. I think what went well was integrating reading glasses into the supply chain. That was a big win for us. But from my perspective, the delay of the rollout by the ministry [was a challenge].

Maggie Savage: I think that's primarily the one and it's the one you see across this work no matter where you're doing. And I think that's where this early integration is so important in terms of getting that buy-in and getting some of those systems set up where you can always just point back and be like, "Guys, we've already done the work. We can move this pretty quickly."

So as we've seen some of these delays on the curriculum development or the rollout for the new national package of services, it's been really easy to say, "Hey, we already have this. We don't have to necessarily do another workshop on the curriculum for this aspect of the new package. You might have to go do that for some of the other things, but we're good and ready to go." And so I think that's probably the primary challenge.

 I think in terms of things like integrating into the supply chain and inventory management, what's been really great, but then also a challenge, is figuring out at what level of product characteristics the ministry wanted to track product within the inventory management system. For example, [tracking] material type or male and female [styles]. And so we've been integrating because there's been data coming back giving a good understanding of what felt like too many different product stock keeping units (SKUs) being integrated.

The government has been able to rationalize down the number of SKUs, while still having the right mix of powers with a variety of choices, for national scale out. [We needed to collaborate closely with the Ministry of Health so that inventory management didn't complicate things too much for CHWs]. And so while that felt like a challenge, it was because we integrated and had the right data flow that we were able to answer that challenge pretty quickly.

 **Elizabeth Smith:** I think we should just be clear that part of the reason we had too many SKUs was a donation issue. This was never the plan to have too many options for glasses. I mean, that's a learning coming out of VisionSpring. The reason we were in that situation was that there was a challenge with the donated product that we got because the idea was to never have that many SKUs. That's not a way to move forward with this. I will say, the ministry wanted to have more than we thought was advisable in the early days.

Ambika Samarthya-Howard: I've heard that you have to keep it low, but then I've also heard to keep a lot of variety and range. So I'd love to hear more about that.

 **Maggie Savage:** There wasn't much change in terms of the actual product. It was how the product was categorized. So while there's still that variety of choice, the SKUs of what they have is now +1.5s are being categorized under the same SKU, even though there might be a mix of colors or shapes. But that really helps for the management much further down the supply chain. You can manage that many SKUs up at the top of the supply chain. But really seeing where some of those bottlenecks started to happen and things as simple as it was labeled female. And so then a community health worker, if they only had that product left, then they felt like they couldn't serve a

male because it had a female SKU. But really it's the same general pair of glasses. So it was more issues around the classification rather than what will be ordered longer term.

Ambika Samarthya-Howard: That makes a lot of sense. I would never have thought about that. In terms of partnerships, are there any other partnerships that you feel were really crucial in terms of scaling? Who else is working with community health workers in Liberia in an innovative way, even outside of eyeglasses, that you could learn from?

 **Elizabeth Smith:** Our main partner is CHAI. We've been partnered with them for a while on the work that we do in schools. And this has been expanded now to partner and collaborate on this scale out of delivery of reading glasses via CHW systems. So aside from Côte d'Ivoire, every country right now that we're looking to replicate this in is arm-in-arm, in partnership with CHAI.

Ambika Samarthya-Howard: What do you feel has been valuable in that relationship or in that partnership?

 **Elizabeth Smith:** So much. I mean, their secret sauce is really enabling governments to add more services. We had no interest in going country to country and starting with no relationships, right? We would have to get really smart about that. I mean, we did it in Liberia, and it took a lot of work, but we also had some existing relationships there. This is a key point. It all started with the president of Liberia who we met. And so we came in at the presidential level, which despite administration changes, obviously had a real big influence in our ability to roll everything out and to make that case.

But I mean, there's so many benefits with CHAI. They are in so many countries, they're often co-located in ministries of health, we think working with them is the most efficient path to scale. And if we were able to get all the work funded, I mean, this is hundreds of millions of people that could be reached just through EYElliance and CHAI.

 **Maggie Savage:** I think you hit the nail on the head. It is really those localized relationships that can't be replicated by small organizations that haven't been in the country for 20 plus years. In a lot of these countries, CHAI is trusted and Ministries look to them, but then they also have their ear to the ground when they're starting to hear that pull or starting to hear conversations around, "We're going to look at rehabilitation or eye health or whatever it may be."

And then they now know that they have kind of an expert behind them, that there is a partner [in EYElliance] to really provide some of that technical expertise and where we can go build those relationships with CHAI teams and the government as kind of one team to serve that scale up and support the conversations around where eyeglasses could be integrated into different programming within the country at the ministry level.

Elizabeth Smith: And CHAI feeds into these policies. CHAI is one of these trusted partners that, a lot of times, not in every country, when ministers are developing a new policy or reform, CHAI is requested to be at the table, instead of having a glasses person at the table. I mean, this is a really efficient way to work. They have all that, not just the relationships, but they are already giving inputs into so many things.

And the other thing I would just add is their experience working with health insurance, right? So as a long-term potential for sustainability, CHAI are the people that could understand how viable it is to add reading glasses into health insurance, not us. So again, another value proposition.

Ambika Samarthya-Howard: Could you talk a little bit about how you selected the location for the pilot in Liberia and what are some of the learnings from the pilot?

Elizabeth Smith: Well, we didn't decide. The Ministry of Health did. So there's that short answer. There's a longer answer where the first county they had identified, there was some issue with. I don't know if you are familiar with the system in Liberia, but there are multiple NGO partners that sort of coordinate in different counties. And so at the time, the county they'd originally selected, there were some challenges with UNICEF and, our understanding was that, the community health workers weren't getting paid as quickly as they needed to be. So the Ministry shifted gears and put forward another county. This is really their decision. I wouldn't even necessarily say we were advisors on this. We were really just following their lead.

Ambika Samarthya-Howard: Do you know why they chose it or what the characteristics were of that first place?

Maggie Savage: Proximity to the capital was one aspect, as they were able to monitor and evaluate from a national level to understand what was happening in a more real time, cost-effective way. But then that county is more comparative at a national level in terms of peri-urban and rural mix of populations as well. So it wasn't just doing it in Montserrado [where the capital is], where you have a primarily urban population. You still had really remote areas, along with population clusters. It has characteristics that you would see in other parts of the country as well.

Ambika Samarthya-Howard: When you started the pilot, was the goal to make the county into early adopters?

Elizabeth Smith: Well, we started the pilot back in 2020. I'm not sure the early adopters are necessarily relevant, but I mean, again, it was the Ministry saying they wanted to do this work. And by the way, they don't like to use the word pilot. They don't really believe in pilots, because they have had many experiences where NGOs do pilots, the pilots end, and where are they? So they prefer to work on a phased national plan.

Going back to the earlier points, the reform process or the process of doing the next policy and package in Liberia took a lot longer than anybody anticipated. And so as this was sort of spread out over time, and, of course, the pandemic was a huge factor in the delays because the CHWs were delivering PPP, they came forward and said, "We really want to start the work in one county and we think this will help strengthen the case for inclusion. So again, I think they chose that county because of the reasons Maggie said. But like Maggie said, this is part of a national effort.

Ambika Samarthya-Howard: And in Liberia, with the work that you're doing both with CHAI and with the government, did you feel like you used the phrase tipping point a lot? Is that a goal or is that something that you think is valuable?

 **Elizabeth Smith:** The community health workers, and it's different in every country, but in Liberia, they live and work 5 km from a health center. So in terms of the tipping point, these are oftentimes very rural communities. So the odds of them reaching a tipping point where people are just going to go buy them at a pharmacy, again, every country's different, but I don't see an option where there's going to be widespread local access in these real end of the line communities anytime soon.

  **Maggie Savage:** I think it is a really important point of exactly what you just said, Liz. These community health workers are often those serving more rural areas where you don't have access to pharmacies and things, and the definition of sustainability in this is really about the government seeing the value for their population, and that they are continuing to prioritize this and include it and put budget against it. And that is a sustainable path forward, if the government is allocating resources to this service through their public health systems. And I think that's a really important thing to remember and consider.

 There are different ways we can think about the financing systems of public health delivery in these countries, whether that's through social health insurance, community-based health insurance or just the provision of free services or even revolving drug funds via government budget for things at the community or primary healthcare level. And oftentimes those are still free services as we work towards universal health coverage in these countries. To me, there's a huge success and value in saying that the governments are prioritizing this and this is staying in a government-funded and supported package of services.

Ambika Samarthya-Howard: That's a very different way of looking at it. I appreciate that. Is there anything you both want to add?

Elizabeth Smith: Answering your question about things that I think would be interesting to learn, and it may already be part of the pilots. I'm not aware of everything LIF is doing. But a few years ago, [we were] looking at last mile distribution and we had a potential partner or a relationship with a last mile distribution collective. We were trying to get smart about what that would look like, we had a few interviews with a distributor who had been carrying reading glasses and then decided to stop carrying them. And I was able to call them and just sort of find out, "Why did you stop carrying reading glasses?" And I'm sure you've learned this in your calls, but the margin you make on selling a pair of reading glasses is the same as a bar of soap, right? But obviously, you replace a bar of soap every few weeks or months, and reading glasses can last two to three years, right? And so that was some information we learned.

I think you should talk to OneSight EssilorLuxottica Foundation because they've had some interesting learnings that I think might get missed in this if you're just focusing on LIF pilots.

Having the most efficient glasses displays where you're taking up the least space because that's the problem in these last mile shops. Space is at a premium, right? So how can you go beyond the traditional display settings? They've had some interesting learnings from pharmacies. But I think there is more learning to be done around what makes it worthwhile for these last mile distributors to sell reading glasses.

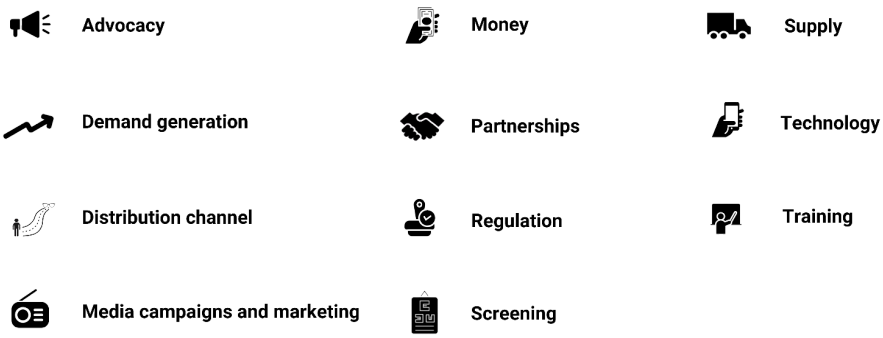
In terms of the partners that you asked about in countries, we were in close conversation with Last Mile Health and we started in Liberia. We are learning from Muso in Côte d'Ivoire. I think it's good to have conversations with both NGOs that have been working with the Ministry on the community health platforms in general, and then obviously our relationships directly with the ministry. I think that's been valuable to us when those partners are in those countries.

Ambika Samarthya-Howard: And that's more related to pharmacies than it is to community health workers, correct?

Elizabeth Smith: They weren't exactly pharmacies. They were sales agents and some dukas [last mile shops or kiosks]. And so we were looking into that because there's an alliance of those that have several thousand members. So we were looking at working with them, and I think there's still potential there. But it was a very clear response from the actual people selling the reading glasses that they weren't making enough margin for it to make sense for them to use up that space for reading glasses. Because of capacity constraints of a small team, we haven't spent as much time looking at this since then.

Ambika Samarthya-Howard: This has been wonderful. Thank you so much.

ICON LEGEND



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** This interview has been edited and condensed.*