"We need a hundred points of sale": Jordan Kassalow and Ella Gudwin of VisionSpring on increasing uptake, government relationships, and supporting pharmacies and CHWs

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Ambika Samarthya-Howard: Could you talk about two examples of scaling your models that you've worked with that you felt, to date, have been the most effective way to solve the presbyopia problem?

Ella Gudwin: The *Reading Glasses for Improved Livelihoods* program is the longest running program. I think the thing to understand, and Jordan [Kassalow], you lived it so you can talk in more detail, but just to set it up. The estimate is that the world needs 400,000 points of sale and distribution of reading glasses to close the billion person gap in refractive errors broadly. So myopia is exploding and myopia is growing and that's what needs prescription glasses. But as populations age, we need more and more reading glasses for longer periods.

As populations become more literate, we need more [reading glasses]. We also need reading glasses for non-literate tasks, but the urgency around literacy increases the need. The research is so clear that reading glasses are not just for reading. Reading glasses are for tasks that are directly tied to income earning, [it is important for] people to understand that the need for reading glasses is much deeper than literacy.

So with that as context, while the need for prescription glasses is growing, you could say broadly half of the problem in the world can be solved with reading glasses, the problem being the billion person gap. In order to do that, we need a hundred points of sale and distribution of reading glasses to begin to get at that. So if we can buy glasses in a pharmacy or a bookshop or a train

station in higher income countries, why are they still locked up in the four walls of hospitals and clinics in lower income settings?

And so Jordan set out with the idea that community health workers and lay people, basically community agents of some fashion, should be able to sell reading glasses. And then Jordan, if you want to go into the origin story and how disruptive of an idea that was, it would be fair to say Jordan got very big threats. But it's now been mainstreamed as an idea, but there's an evolution. There are ways that it works and ways that it doesn't work.

Jordan Kassalow: Yeah, just the status quo, if you will, before we tried what we were doing at VisionSpring over 20 years ago, was that in order for people to get reading glasses, they needed to see an eye doctor. And we thought that was ridiculous because, A, it's not a medical requirement to prescribe reading glasses and, B, there just weren't enough eye doctors in the places where we were working to even come close to solving the problem.

 And so we just took a very practical approach and said, well, since there aren't enough eye doctors, and since this isn't a very technical thing, and in fact in most parts of the developed world, it's a consumer product, people could self prescribe them, why don't we try something similar to that? But it was hard to get people to self prescribe them because they didn't know anything about them.

We had this intermediary step between self prescribing and an eye doctor, which was [using] a minimally trained community health worker who understood a little bit about measuring for reading glasses in terms of who needed them and who didn't, and if one needed them, whether they needed a plus one, two or three prescription. At that point it was an innovative thing that got a lot of pushback, particularly from the ophthalmologic and optometric communities. How dare you prescribe something that's a medical product and you're going to blind people because they're not going to go get their glaucoma tests and all these kinds of rationales for why it shouldn't be done. But we didn't listen and we created a fact. And then over time, the public health world, the community health world, realized that it wasn't such an outlandish thing. In fact, it was the smart thing to do and a practical thing to do to solve a problem that was being unaddressed.

Ambika Samarthya-Howard: You went into a situation where people were not open to this idea and then you were able to scale that idea. How would you actually describe the model that you put in that worked?

 **Ella Gudwin:** I think the trick is what didn't work first. So the first way that we started was the idea of a business in a bag where you give a sales agent, mostly women, the ability to do the distance vision screenings, refer people for other eye conditions, and also be able to diagnose presbyopia and reading glasses. Then you learn things like, well, is that person going to be trusted

in their community because they were a community health worker and now they are an eye doctor, but since when? You have to build trust in the fact that they know what they're doing because people have been trained to think they have to go to an eye doctor.

 The other thing that is really important and what doesn't work is that reading glasses are a slow moving commodity. If the community health worker is only selling reading glasses or the health agent is only selling reading glasses, she can't make her full living on that product alone because once somebody has their glasses, unless they're losing them or unless they're growing out of their prescription, it might be a year or two before they go to buy a new one. And if her territory is relatively small, she will saturate her territory. Then you start having the loss of your sales force after 12 to 18 months and they drop out and look for other revenues.

 We did learn in the early days that people will pay one to two days wages for eyeglasses. That's not often enough to cover the full maintenance of the delivery channel, but it does allow for a subsidized model. So it won't necessarily be a profitable model, but it can be an easily subsidized model. We learned that community health workers can be trained to be effective, and to Jordan's point, the bridge between self prescribing and having a doctor. It's basically an assisted sale. They can be trusted by the community and earn their trust to do that, and they can be an effective referral bridge.

Reading glasses are best understood as a margin positive item in a bundle of goods and services. When the community health worker or the agent has other means to their income, whether they're selling nutritional porridge, birth control or other things, glasses become a high margin item for them, even though they're slow moving in their bundle.

 Same thing in the pharmacy. Now in a pharmacy, if you just put eyeglasses on the pharmacy shelf, they will not move because people do not know how to pick them up. You have to train the pharmacist to be able to engage the community member to help them know what their power is. You're a power one, you're a power two. Once the community understands, oh, I'm a power two, then they know they can come to the pharmacy if they break their glasses. We've done experiments where you just put glasses in pharmacies and you just do straight and they will collect dust.

Ambika Samarthya-Howard: How do you break through other urgent health needs, like outbreaks, malaria and all of this stuff, and actually have somebody going to a pharmacy or going to a community health worker for eyeglasses versus something life-threatening?

Jordan Kassalow: There's a number of different things about that. Your observation is correct.

If you have a hundred health needs, the correction of presbyopia is going to be somewhere further down on that list compared to malaria and tuberculosis and AIDS and all those kinds of things. And as a result, we have skewed away from health as our primary industry or area that we focus on.

We don't think of ourselves as a health intervention as much as we think of ourselves as a livelihood and education and safety issue where we look at the outcomes of what glasses do for people rather than the health issue that is the cause of people needing glasses. So that's one thing. But when we do find ourselves in the health realm and we are competing, let's say, at the community health worker level and or the pharmacy level, one thing that is very powerful about what we do is that for every person in a community, a larger number of people need eyecare than almost anything else. And that's why in the United States it's hard to get vision and dental insurance because everyone needs dental care and everyone needs eyecare. So it's one of those very powerful interventions that can bring people into the health system.

Presbyopia is a very powerful thing that can bring people into the eyecare system because it's the base of the eyecare pyramid and vision is often the base of the health pyramid, and you can detect other kinds of health issues, whether it's diabetes or hypertension through the eye. So we can leverage that advantage.

And something else that's very powerful about vision is that the correction of vision is an immediate fix where other health issues people are dealing with have to be understood on an intellectual plane. You can't really feel hypertension, and by taking hypertension medicines, you're not necessarily feeling any better. And so it has to be understood intellectually, whereas vision is a very visceral thing. One moment you don't see and the next moment you do. And so it provides health workers with a very powerful sense of agency and the community health workers love it because their customers are like, "Wow, you really helped me. You really helped me see."

Ella Gudwin: You're magic.

Jordan Kassalow: Yeah, you're magic. Now I can work, now I can read my Bible, now I can do the things, now I can sew that item I couldn't before. So there's some huge advantages that we have even though we're not number one on the list in terms of urgency.

Ella Gudwin: There's two other things just to add to that. One is, for the community health workers and the pharmacists, a lot of them are middle-aged themselves. So when they're getting the training for their site tests, they're getting the glasses themselves the first time.


Second, we know that eyeglasses increase functioning productivity and income, and that's where we have really directed the randomized control trials, to understand that. But the thing that becomes very clear is even if we just did a survey, for example in Bangladesh, we're getting ready

to expand the reading glasses program into a whole network of microfinance, and people will tell you within a couple of weeks of getting their glasses, 83% of the people who got glasses for the first time reported ease of doing their work, ease of doing daily tests.

And so to Jordan's point, if people understand it as beneficial to their livelihoods, then they look at it not as a trade-off between malaria and diabetes, but as 'both and'.

 I think the only other thing to note is that if we understand glasses as delivered through health channels, but with an income outcome, the literature reviews show that it has the greatest boost in productivity in a RCT. [Other interventions,] whether it's deworming or bed nets or other things, has a 15% increase in productivity. Whereas the Lancet article that we did with PROSPER showed a 22% increase in productivity and all the way up to 32%.

Ambika Samarthya-Howard: A lot of the folks that we've been talking to have either done their pharmacy pilots or their community health worker pilots. You have spoken so far in this conversation about both. And I was wondering, do you integrate both into one model or do you work with community health workers and then they go to the pharmacies? What is the relationship between those?

 **Ella Gudwin:** We started off with community health workers and health agents, but then the reality is the training and how you equip a community health worker with how to do the screening is exactly how you equip a pharmacist. So it translates very easily.

  The way that you manage pharmacy sales though is a completely different distribution strategy, and pharmacists are much more margin and business oriented. And so being very clear about the value proposition to the pharmacy, pharmacists have a little less time on their hands for everybody who comes in their door. So how to make the vision screening process super lean is important. And not all pharmacies are the same. You've got chemical sellers or drug sellers who are not necessarily licensed in the same way as a pharmacist who is a licensed pharmacist. Within a pharmacy, you will have a pharmacist and a technician. You have to train both of them.

 And the other thing is whereas a community health worker is going door to door in their community, the pharmacist is in the four walls of their shop. Some of them will do a little bit of outreach, so how you mobilize people to a pharmacy is different from how you mobilize people around a community health worker. And then the other is just they can sit side by side. For example, in a district in Sherpur, in Bangladesh, the community health workers were there first, but then we started to put glasses in pharmacies in the marketplaces.

And here's the thing, the community health workers tend to be a principally female channel in that context in Bangladesh, 65% of the customers are women because they are rooted in maternal child health, whereas the pharmacies tend to be in the marketplace, and it's the reverse. 65% of the customers are male in the pharmacies because they tend to be moving about in the community a little bit wider and broader, and will go to the market town more often. And so you get this really lovely yin yang that was working. There's a lot of complementarity. You can do both. You can have one or the other.

Ambika Samarthya-Howard: What are the biggest challenges with each?

 **Ella Gudwin:** The biggest challenge on the community health worker side, well, for both of them, they've all got competing priorities. With community health workers we have found that selling door to door doesn't really work every day like an Avon lady. She's much more efficient if she does a micro camp once a month and brings people together for the purposes of a vision screening. And there are two reasons that works. One is because there's a lot of stigma associated with getting glasses, people don't like to be the only one getting them, and if you bring people together in a mini vision camp, then if my neighbor gets her glasses on the same day, I'm more likely to get glasses too. So you get this knock on effect and the normalization of vision screening and glasses. The micro vision camp is actually one of the most important things.

 The other is purchase priming. Not everybody, especially women, has purchasing authority in their household. And so you have to let people know the price in advance so that they come with money on the day because lots of people will show up and get the diagnosis, but if they are not prepared to buy, they won't have cash in their pocket or approval to buy.

Then the other is that for the pharmacies, they're entrepreneurs and they're chasing margin and they're looking at some of their faster moving things. Some of the pharmacies are service oriented and some of them are not. So there are some pharmacies that have a little consultation area. Some of the pharmacies do things like a blood draw or malaria testing. So choosing the right location is important. How trusted they are in their community and for what and whether they have a service orientation are key ingredients for success.

Ambika Samarthya-Howard: I know that you have started working with different pilots and with different pharmacies, and so I was wondering if you could talk specifically about what you feel needs to be prioritized in terms of partnerships, what you think is the highest priority for scale.

Ella Gudwin: Jordan, do you want to talk about government partnerships and the work that Alliance has done and where that's going? I think just in terms of where things can scale and the need for partnership. I'm thinking specifically about community health workers in Liberia and now the recent relationship with CHAI.

Jordan Kassalow: In terms of governments and community health workers, VisionSpring pioneered the whole area of taking nonmedical staff and turning them into vision agents to correct presbyopia. And we've done it really almost since the beginning. That really was our founding premise and what we've been doing for 20 years. We've done it with BRAC in Bangladesh, now we've done it with BRAC in Uganda. We've done it with some other NGOs, and it's something that we saw really work.

 One of the premises of EYElliance was to take interventions that worked and had been pioneered by social enterprises and try to bring those programs to governments to empower them and enable them to integrate those strategies into government systems. And as you know, the community health worker systems within governments have really exploded over the last decade plus and even now is more of their heyday than ever. So we wanted to test the idea of whether governments can take on this work. Can we get them to write it into their national policy for their community health workers? And the answer we've found is yes.

As Ella mentioned, Liberia was the first country to do that, and they're rolling it out across the country. We saw that there was a huge potential, but because EYElliance is not a direct delivery organization, nor is it a large organization, we wanted to partner with other organizations that had the capacity to scale that idea. And so we are partnering with…

Ambika Samarthya-Howard: What a cliffhanger! We lost Jordan. Ella, do you know who you're partnering with?

Ella Gudwin: CHAI! The Clinton Health Access Initiative has been so successful with product introductions for the government, whether it's deworming or malaria, bed nets, or all manner of vaccines, et cetera. There's a specific skill set that is, how do you get a new product into the supply chain? How do you help reorganize the health information management system so that the data can move from the primary care level all the way back up to the middle center and back again. And so the work from Liberia has been codified and is ready to travel for other governments. VisionSpring has just secured a grant from the Vision Catalyst Fund to do the same work in Uganda. CHAI's a partner to that, so is BRAC, and so is Light for the World and a local eye hospital called the Dr. Arunga Eye Hospital. But it will be the very first time that the government of Uganda is preparing to bring eyeglasses down to the community health worker level.

Ambika Samarthya-Howard: You just named five or six partners, CHAI, BRAC, Light for the World, and a few others. What are each of their roles in this partnership?

 **Jordan Kassalow:** CHAI was a key component to the scaling. But the thing to understand around the community health worker models is that there are different ones. Many of the community health workers now are still unpaid volunteers. And so the big effort in that world is to try to professionalize them and get them to be on the payroll of the governments. Most of them do not charge for their services or do not collect fees. And so we're also looking for ways to work with governments to test the ability for them to collect fees so that they can sell the glasses. There's a whole bunch of different things that need to be tested around those models.

Ella Gudwin: And I think that when everyone assumes, to Jordan's point, that community health workers are all the same and they're not. Some of them are on a platform that an NGO has in terms of providing management and support with tablets and things. Some of them are backed by the government with NGOs providing technical assistance. Some of them are volunteers that get activated for an awareness campaign, for example, getting kids vaccinated or something, or if there's an outbreak. Not all community health worker channels are primed to start reading glasses on day one. There needs to be an assessment about which community health worker platforms are ready for it.

 One of the ones we're excited about is in Uganda, we have taken the *Reading Glasses* program with BRAC and we put it on the community health platform that they manage, so it's technically government community health workers where BRAC manages them and supports them and gives them the products and things. But also, there's a group called PACE that has community health workers. The Council of Churches has a health agent. In Zambia, CARE has something called Healthy Entrepreneurs, which are not community health workers, but they sell health oriented products. So it's finding the versions of this semi-skilled community-based individual who is health oriented, but also entrepreneurial and not just an educator.

Ambika Samarthya-Howard: How does CHAI and BRAC work together?

 **Ella Gudwin:** If you imagine VisionSpring, CHAI, BRAC and the Uganda government are all going to work together in one district. BRAC's role is that they are managing the community health workers information, the product delivery and the training. So what they're going to do is support the government and transition those responsibilities more to the district level government.

 CHAI is going to be looking at how to modify the health information management system to capture the right information and also how to introduce eyeglasses into the supply chain so it moves from the central store down to the community.

 BRAC has branch offices in every district and more, so in the short term, BRAC can substitute for a supply chain just to get a pilot started. But CHAI is doing the long-term work of getting the supply chain to work from the government. And then VisionSpring is a technical partner. We coordinate functions. We get the eyeglasses supplied to begin with, et cetera.

Ambika Samarthya-Howard: This seems like a really robust model where every single part has been thought out specifically from a partnerships perspective and getting the most impact that each partner can have. What's the biggest issue for scaling?

 **Ella Gudwin:** Money. Because if it works, then we're doing it in one district basically to build the muscle, get the costing, start to adapt the system, and then the question is: how does it become a national program? Same thing I think EYElliance would say, there are a lot of countries that are primed to be having this conversation. Nigeria is primed to have the conversation. Ethiopia is having the conversation, Kenya's having the conversation.

 **Jordan Kassalow:** I think money for sure is probably the largest issue. And then I think historically more so than now is just political will. This was not an issue area that was on any government's radar screen. It's starting to become so. There was a big meeting last March in Liberia where ministries of health from around the world came and spent four days looking at community health worker systems, and a lot of governments learned about reading glasses for the first time because EYElliance, CHAI had a booth there and talked it up.

 So political will from governments is something that we have to work on. And also I think political will from the big organizations that are in the community health worker space, to see this as an area that legitimately should be layered on as they start to build up these health systems. So the Living Goods, the Last Mile Health, and the Musos of the world, continuing to work on getting them on board and advocating for this work would be super helpful.

 **Ella Gudwin:** To build on what Jordan said, there's one sensitivity, which is how much can one community health worker really take on in terms of, can you do diabetes and hypertension and vision and all the things? At what point is the bundle of services saturated? And that's a super fair question. There is a dialogue between the eye health divisions of the ministry, the optometrists versus the community health advocate. They are often at odds. But the most important message is that the more people get screened, the more people have a basic eye test, the more people will be pushed into the secondary and tertiary system.

And so this fear of like, "Oh, we're going to miss cataracts." You're like, "No, no, we're going to find more cataracts." So that sensitization of the optometry and ophthalmology community, and I think

the thing that has helped the most in the last three years is we have a resolution at the United Nations on eye health that recognizes eye health as a driver of multiple sustainable development goals, not just health, but livelihoods, education, road safety, economic inclusion, gender, et cetera.

 And then the other big one is that the WHO came out with the TAP training, which is part of the technology training for assistive products. And there is a specific module on reading glasses, and the module is designed for community health workers, nurses, and other lower level people to be able to implement the training. Jordan was on the technical committee for that, and so were some other organizations who have been doing this kind of work, including EssilorLuxottica.

What's happened now is that the WHO has taken the VisionSpring knowhow and turned it into a WHO sanctioned product and training and has made it ready for governments to use. People don't like to use the word demedicalized. The way that other people like to talk about this 'task sharing' approach is in fact the way of the future. And so that's a really important context for why now.

Ambika Samarthya-Howard: Looking back on everything you've done, you have been working on this for about two decades, what's your biggest learning? What do you wish you had done differently?

 **Jordan Kassalow:** Well, I'm glad we did all the things we did, and you only can learn at the pace that you can learn. But in retrospect, I think what we probably could have done better is that we could have earlier on in our history focused as much on the demand side of the equation as the supply side. So for most of our first 20 years, we were really taking a much more supply side approach to solving the problem. I felt that if there were glasses delivered by these different professionals that we talked about and people just had more access to the glasses, that it would unlock the demand. We've found that that's true to some extent, but there are other strong factors that are still keeping the demand much below what we had anticipated.

Ambika Samarthya-Howard: Yes, when you talked about partnerships, especially the one that you just talked about with CHAI and the government, it sounds like most of it's still supply side in terms of the partnership model. Do you feel like you're trying to also do partnerships on the demand side?

Ella Gudwin: Specifically with that partnership, there's actually a line item in the budget that's not funded right now, for a demand generation campaign. We are doing really important investigative work with Appleseed because it's very easy to blame demand on price. We believe that it's not just price. There's stigma and other intrinsic motivators.

 In Bangladesh, for example, over the last several years we put glasses into a hundred pharmacies with all these other partners, opened 12 optical shops, stabilized five vision centers, supported the three hospitals in the area that do eye health, and got community health workers. We did all the supply side stuff. We have gotten a hundred thousand people into glasses that way. But to Jordan's point, it's not enough if we don't do the demand. Everybody in public health will tell you, don't you dare go stimulating demand without having a place for people to satisfy it, meaning it's irresponsible to go stoke up all of this need and not be there with the solution. I do think that in the public health space, we can get too far down the supply lane before focusing on demand. But right now, for example, in Sherpur, we're rolling out this campaign specifically to now Ignite demand underneath those points of sale.

Ambika Samarthya-Howard: Who was the partner for this campaign in Sherpur?

 **Ella Gudwin:** There's several of us. It's the Ministry of Health, VisionSpring, Orbis, BNSB Hospital, Islamia Hospital, EssilorLuxottica, RestoringVision.

It's started now, and there's going to be community-based plays. I think for a long time, we were the only ones really focusing on the issue even from within the vision world. The vision world was very focused on cataracts, tertiary care and neglected tropical diseases. And I think in the last five to seven years, most of the big vision organizations have also brought refractive error into the middle. And there are reasons for that.

The International Association for the Prevention of Blindness has also just brought refractive error into the center of its strategy in the last five years. And WHO has just adopted it. So there's a lot of big shifts in the health and eye care space. But then the other one is in terms of what VisionSpring did, we did a quasi experimental study back in 2012, which was to understand income and productivity, but we didn't do our RCT until 2018, and I think we had the benefit of being funded by venture philanthropists who just thought it was obvious and they were like, "Quasi experimental design is perfectly good enough evidence for us."

And so it wasn't until later that we started really doing these gold standard studies. And what we've found is that, because we're in a competitive environment for funds and mind share, at a certain point the RCTs really are needed. And maybe if we had to do it all over again, we would've built that evidence earlier.

Ambika Samarthya-Howard: What are you hoping from the Bangladesh campaign? And can I ask you why you chose Sherpur?

Ella Gudwin: Sherpur is a great middle district. It's got slightly lower than the average poverty level. It's got just slightly higher, interestingly, literacy, if I remember. It's a medium-sized district.

We chose it as a coalition. We went through a whole district selection process. VisionSpring did not choose it.

Ambika Samarthya-Howard: I'm just curious how people choose between rural and urban. Would rolling out in villages entail a bigger margin of growth for every villager? It seems like their lives would change so much more dramatically.

Ella Gudwin: We chose a district that has a really good mix between rural, peri-urban, and urban. They also have ethnic tribal hill tracks as well. They're called hill track communities. They're communities that are ethnically differentiated.

Ambika Samarthya-Howard: My last questions are, what are the questions we should be asking? Where do you see the gaps in your information? Where do you think we should be asking the pilots?

 **Ella Gudwin:** Well, there's a difference between asking the pilot and asking in general. So there's three big challenges. One is, and I say this all the time, people need glasses everywhere, so where do we focus to ignite a market? Because half of the problem is going to be solved with market-based solutions, and half of it needs to be solved with government and mission. And so where do we choose the area that is most right to be able to normalize eyeglasses wearing? And that takes us into the lens of looking at vision correction with glasses as a new product introduction strategy for a 700-year-old technology, which means you have to go to the early adopters.

 So to your point, in choosing where to work, we want to choose areas where you have a lot of near vision intensive occupations, tea, coffee, cocoa, vanilla, artisans, weavers, garment workers, get into those districts first because that's where the early adopters are. The pilots will fail if they're in an area where there's not enough footfall, there's not enough purchasing power, and there's not enough early adopters. And so choosing where to start matters. I think the other thing that matters a lot is pricing. These are highly price sensitive. [And style.] No more black glasses for the masses. People want choice. We need the dignity of choice. So every pilot should learn the preferences of their customer base and not just assume that it's going to be [the same basic style for everyone].

Everyone's thinking about what's the path to scale, what's the minimum replicable business unit? So what is the modality for adding?

Ambika Samarthya-Howard: Are there any other gaps that you feel like you have in terms of what you'd like to know?

Ella Gudwin: We don't know the tipping point. We're actually starting research on the tipping point. We know for contraceptives, if 40% of women get contraception and you can't see contraception, that women will start asking for it. The tipping point changes country to country, but roughly 40%. The question is where's the tipping point for glasses? We actually don't know, but right now, most of the communities that we're working with maybe 20 to 25% max.

 **Jordan Kassalow:** We've spoken more about the public sector than the private sector. I think the other thing that we don't know, which I think would be important to know, is that EssilorLuxottica is the largest optical company in the world. They also own the largest ready-made reading glass company in the world called Foster Grant. And to me, the question on the private sector side that we don't know is, what is the tipping point that we need to establish in order for Foster Grant to become interested in these frontier markets?

 Right now, you can't go into a pharmacy in the United States or Europe without seeing a Foster Grant pair of reading glasses. So what can we do to stimulate enough of a market [in lower income contexts] that they see it as a place where they can enter and scale? And then, are there either philanthropic and or development finance, international finance institution resources that can de-risk their going into those markets? Because they might not put the money in themselves since the profit possibilities are too far out in the future in their mind. If we can subsidize their entry into those markets through philanthropy and investments by international finance institutions, then there might be an acceleration of getting the biggest private sector players into these pharmacies and really help us scale it.

 **Ella Gudwin:** And to that point, the World Health Organization has set a target of increasing eyeglasses coverage rates by 40% broadly, which means that if the baseline in the community is 20% on day one, you're trying to get a raw increase to 60% coverage. And then to Jordan's point, because most of the private sector has been focused on prescription glasses because the margins are higher. Reading glasses are a high volume, low margin item so you've got to have volume. And in order to have volume, you've got to have customer demand.

 We create vision camps. For example, in Ghana we're doing the vision camps in the cocoa communities to get people into their first glasses. And then in those same communities, we're introducing glasses into the pharmacies so that the pharmacies can sustain what charity has established. So I think one of the open questions is, what is the role of social enterprises like ours? There are roles for charitable organizations in stimulating market-based solutions. And this is why we're so interested in this tipping point question because we don't know.

We are designing ways to find out [about the tipping point] with Appleseed. When we started in Sherpur, we did a baseline study looking at knowledge, attitudes, and practices, in addition to a

population coverage baseline. And it showed that 19% of the people who need glasses have them. And there's a RAB, which is a rapid assessment of blindness that PEEK is working on with a bunch of other partners – we're a secondary partner to that in Kenya. I'm going to get the numbers wrong, but it's a really small percentage of a population in any given district that is accessing the eyecare services that they need.

And so when we start asking people about knowledge, attitudes and practices, the answer that we got on barriers is that 50% of the people are self-conscious about wearing glasses. They don't want divots on their nose. They don't want to stand out, they don't want to be seen above their "station". They're somehow self-conscious about wearing glasses. 30% of the people think eyeglasses make your eyes weaker for some reason, whether they are actually shrinking their eye, that their eyes are getting worse over time.

People don't know the price. Nobody knows the difference between prescription glasses and reading glasses. No one. Not even people with their master's degree. And so these are all things that we can measure and change when it comes to tipping points. So not only can you understand the effective coverage of refractive error at what point, but then at what point does footfall increase? What point do people start seeking out glasses and when do these knowledge, attitudes and practices shift?

Ambika Samarthya-Howard And then if you have that information, are you saying that that will be your in-country goal?

 **Ella Gudwin:** Yeah, because what happens if the tipping point is 35%, then you're saying every dollar after 35% gets faster and cheaper. So the trick is to get up to 35% and then maybe it goes faster and cheaper, or maybe the tipping point's 55% and then it gets faster and cheaper. For technology, for smartphones, I think the tipping point's like 17% or 15%.

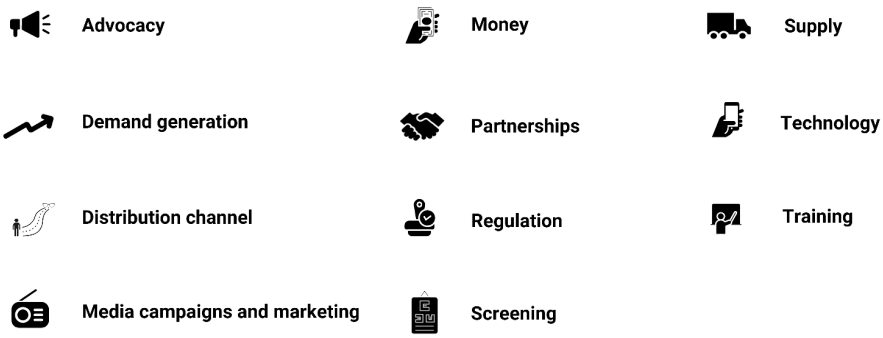
Jordan Kassalow: And then at what saturation point does EssilorLuxottica come flooding in?

Ella Gudwin: Where do the big ones come in? At what point does the private sector say, "There's enough customers here, move over charities? Here we are."

 **Jordan Kassalow:** And if we say the tipping point's 35% and we can show EssilorLuxottica that Country X has gone from 15% to 22% to 32%, get ready because that market in the next year or two is going to be ready for you and start revving up your engines, we can have a nice long-term scaling solutions.

Ambika Samarthya-Howard: That's really interesting. Okay. Well, this was great. Thank you both so much.

ICON LEGEND



Ambika Samarthya-Howard (she/her) is Solutions Journalism Network's Chief Innovation Officer. She strategizes on communications, metrics, impact, product and technology, leveraging platforms for the network and creating cool content. She also leads the Solutions Insights Lab, an initiative of SJN that uses targeted research and analysis to identify and interrogate what's working and what's not in a particular sector or field. She has an MFA from Columbia's film program and has been creating, teaching and writing at the intersection of storytelling and social good for two decades. She has produced content for Current TV, UNICEF, Havas, United Nations Population Fund (UNFPA) and Prism.

** This interview has been edited and condensed.*