“Critical pathways to scale”: Mark Lorey of RestoringVision on government partnerships, social entrepreneurs, and utilizing trusted community voices

Ambika Samarthya-Howard
August 9, 2024

Ambika Samarthya-Howard: Can you start by sharing your name and a bit about your organization?

Mark Lorey: My name is Mark Lorey and I serve as vice president of global programs and impact at RestoringVision, based just outside of DC. I've been with RestoringVision for about 14 months. Prior to that, I worked with World Vision, an international humanitarian and development organization, for about 20 years, with roles in Africa and globally. Before that, I worked with Save the Children and other organizations in Africa, Asia, and the US.

What really drew me to RestoringVision, and to this space overall, is the impact this work makes in individual lives. It's such a far-reaching impact, and it’s immediate and sustained. There is also the potential scalability of that impact, as the difference we make in one person's life can be replicated millions of times over and can result in very concrete, meaningful changes in many lives. That's especially true for those who are most marginalized across the world and who have little to no access to this simple and amazing tool of reading glasses. It's a privilege to be a small part of that.

World Vision reaches over a hundred countries and half a billion people annually, with an annual budget of $3 to $4 billion per year, so I have a clear sense of how quickly we can scale and we

need to scale in this space. I also have a good sense of many different mechanisms through which we could work, which are not necessarily top of mind or even on the radar for a lot of traditional eye health organizations.

Many of the pathways [to scale] are through unusual suspects, those who are outside of the familiar, fairly small group of organizations that are currently working in the eye health space. That's one of our major emphases within RestoringVision. We've really sought to accelerate that in recent years.

Ambika Samarthya-Howard: Has that always been the case, or did you guys start off with community health workers and pharmacies? How has your trajectory changed over the past 20 years the organization has been in this space?

 **Mark Lorey:** RestoringVision started in 2003, and it was really the inspiration of our founder Mark Sachs, an optical company executive on the marketing side. He went on a mission trip in Mexico where he saw very long lines of people hoping for a pair of glasses, particularly reading glasses, and very limited capacity to respond to that need. They just didn't have enough glasses. Because he was in the optical space, he reached out to a few people and organizations he knew to see if they could donate some glasses. He linked them up with people who were going on mission trips to equip everyone accordingly. It was very humble beginnings. He started by just storing the glasses in his basement and trying to serve as a link between those who needed glasses and those who could provide them. Then it grew too big for his basement, so they transitioned to a warehouse over time.

Ambika Samarthya-Howard: Has it always been glasses for presbyopia, or did the glasses tackle a whole range of issues?

 **Mark Lorey:** It's always been primarily presbyopia, but from that time to the present day, we do some work with distance vision glasses: glasses to address myopia. We also do quite a bit of work with sunglasses as protective glasses, especially in high UV environments. All of the sunglasses and the distance vision glasses that we receive are donated glasses. They come to us, and then we link them with partners around the world who need them. That's less than 5% of our work.

 The vast majority, 95% plus, focuses on presbyopia. Most of these are new, high-quality reading glasses purchased through a production agreement that we have with the world's largest manufacturer of reading glasses. That's a key success factor for us as well, this ability to purchase glasses basically at cost, and then distribute them to partners we identify across the world.

Ambika Samarthya-Howard: They originally started distributing it through missions. What was their primary distribution model once they were at scale?

Mark Lorey: Our scaling began when our current CEO, Pelin Munis, came in about nine years ago. Pelin began to think beyond that initial model toward a new way of working, which was with large-scale humanitarian organizations. She began establishing partnerships with a number of partners we still work with quite closely, like Americares and Catholic Medical Mission Board.

The focus was on organizations that already have a model of sharing and sending items overseas, usually health products, but sometimes a wider array of other kinds of products as well, so it was natural to fit into their distribution plans. It was initially challenging to convince some of these partners, but once they saw the strong demand from communities and the impact in people's lives, they were very willing to scale pretty rapidly. One example is Americares, which has gone from reaching a few tens of thousands to now reaching over one million people a year in their work with us. We are continuing to grow that number as the demand continues to grow from their partners in multiple parts of the world.

Ambika Samarthya-Howard: Is this the only product that Americares distributes, or is it sent out in a bundle of products?

Mark Lorey: We work with Americares using two approaches. The first approach is working with their partners on large-scale shipments of specific items. So the partners ask for, say, a container full of health product X, or a specific medicine—a half container of medicine Y and a half container of medicine Z. In that case, they work with us because they have partners in let's say about five countries per year that really want 100,000 or 150,000 pairs of reading glasses. We'll send a container specifically to that Americares partner, in that country, and they take it on. The other approach they have is on-demand distribution. Americares has a catalog of products and people can say I need this much of X, this much of Y, and this much of Z, and reading glasses are included in that. Then, they can pack a container accordingly, with all the different items the client needs.

Americares works with partners in all the countries where they're present, so it's the partners placing the orders to Americares because they know that in their clinics, for example, or in their community development programs, there's real value in having reading glasses as a part of that program. So they say something like, please send us 30,000 glasses along with 50,000 aspirin doses or 20,000 emergency shelter kits, or whatever is needed in their context.

Ambika Samarthya-Howard: How, then does it get to RestoringVision? Does Americares put this order in with RestoringVision?

Mark Lorey: We have an annual planning cycle because we have to give quite a bit of lead time to the manufacturer when we're talking about so many millions of glasses per year. They know how much is needed in advance, and then we phase that production over the course of a year. Currently the majority of our glasses are shipped in the last quarter of any given year for the next year. We usually start working with our partners in July and August on plans for the following year.


Americares will say something like, “We've heard from these six country offices, and they want these shipments directly.” It might be 100,000 to one country and 150,000 to another. In addition, they ship, say, 350,000 pairs of glasses to the Americares distribution center in Connecticut, which they use throughout the year to fulfill the small-batch orders that are given to them by partners. Based on our experience over past years and what we've heard from partners this year, we’ll say the amount we think is going to be necessary. Then we can send more through the course of the year if they end up receiving orders for more glasses than they expected.

Ambika Samarthya-Howard: How many partners like Americares do you have currently?

Mark Lorey: A good number actually. I would say in terms of large international NGOs, there are probably four primary partners: Americares, Catholic Medical Mission Board, Food for the Poor, and MAP International [Medicine for All People International]. This year, we’re also exploring several others that have reached out to us and that we’ve contacted. That's been a key mechanism, and it has evolved from there.


We have the largest scale of any organization focusing on presbyopia and the lowest cost, and there are two critical success factors for that. One is our strong production and operations capacity. We’ve got an at-cost model and our operations team is really solid and can facilitate the shipping of those glasses to anywhere in the world.

Ambika Samarthya-Howard: You guys don't produce the glasses yourselves, though, right? You have a commercial partner?

Mark Lorey: Correct. Our commercial partner is called FGX, and it's part of EssilorLuxottica. They provide good quality glasses, which they see as part of their social responsibility. That also helps seed markets for the future. They're partners we very much appreciate.


The second critical success factor I would suggest is our deep commitment to partnering and our capacity to partner. We love to partner. I especially love to work with organizations that

have never done anything on vision before and can integrate it into their existing efforts. From my perspective, that's one of the critical pathways to scale.

Ambika Samarthya-Howard: Can you talk a little bit more about how you decide on partners? And how do you work with the fairly massive organizations you just mentioned? I know they have the most amount of reach, but they also have the most amount of complexity and bureaucracy.

 **Mark Lorey:** It is a combination of relationship building that is rooted in humility and a sense of the value and the impact of this particular intervention and its ability to make a difference. Being able to make a compelling case for how this work makes a difference, having evidence of its impact, and being able to discuss how it can be readily integrated into existing efforts is also key.

 In terms of how we choose organizations to work with, we first look at organizations that have existing in-kind distribution mechanisms and infrastructure. That's a key consideration. Do they have an operation in place already that is able to distribute goods, or effective partners in-country that are able to receive them? In a lot of cases, we send it directly to their partners in-country, but they facilitate that.

Then, we look at the target group. Does their work reach people who are likely to have presbyopia? It doesn't need to be fully focused on people of that age, but they do have to have substantial programs that have a reach beyond just child and maternal health, for example. Programs that have a livelihood component are even better fits for our work. There are many more organizations that we could partner with, and we're on that journey.

Ambika Samarthya-Howard: Do you reach out to them, or do they reach out to you?

Mark Lorey: A combination. In some cases, especially in the early days, it was RestoringVision reaching out. Now it's a mix. We're constantly exploring new networks, new modalities for adding this quite simple intervention in a way that adds value for everybody. A lot of those partners have found that it brings people in and keeps people in for their other interventions as well because it's again, such a clear, easy win for them.

 One of our partners has a separate program related to hypertension, so they have the same target group of older folks who are further on in life and more susceptible to hypertension, but for them, it's just screening. There's nothing they can actually offer in terms of medication or actual assistance; they simply refer people to a clinic. But if they're able to offer reading glasses, that's a great concrete thing that makes a difference in folks' lives and can bring more people in for screening as well. That's a win-win from their perspective.

Ambika Samarthya-Howard: Can you tell me a bit more about your other models and how they evolved?

Mark Lorey: We think about four main models according to the four main types of partners that we have. We've talked about the international NGOs already, and the next one I would highlight would be governments. I have three great examples of integration with huge potential for scaling.


One government partnership that we currently have is with the Ministry of Health in Ukraine, and that's fairly straightforward because it works through the existing health system. Of course, it's in a very challenging context. We began there soon after the war started, as part of the overall humanitarian response to so many people losing everything. Their homes were destroyed or they had to flee quickly. We're also exploring working with other displaced populations, both internally displaced and refugees. That's an example within the Ministry of Health context, which is a natural place to partner, and we can certainly do that in many other contexts.


The second program is in Mexico. Just last month I visited with the National Social Assistance Agency, SNDIF, which is the agency that focuses on those considered most vulnerable in Mexico—children, youth, the elderly, and people with disabilities. It has national level, state level, and municipal level offices, and they have a range of different ways of engaging with people via community events, homes and day care facilities for elderly people, and other approaches to outreach. We started with a few tens of thousands of glasses several years ago, and we're up to 350,000 pairs of glasses per year through this system. They receive the glasses, they send them to the state level agencies and municipalities, and they're distributed through those mechanisms. Because so many different countries have versions of a social assistance system, or a social protection system as it's often called, it's a very natural way of reaching many people.

The third example of a government system I'll mention is in Peru, where we work with the National Pensions Agency, *Pensión Sesenta y Cinco*, or Pension 65. It's part of the National Ministry of Development and Social Inclusion, and it is a social safety net pension system, so it's non-contributory. Anybody who's above age 65 and below the poverty line is eligible to receive it. People generally come into the office to get their monthly payments, so it's a perfect place to do basic vision screening and the provision of reading glasses. It's reached hundreds of thousands of people so far, and it's continuing to grow. We think it has strong potential for replication elsewhere in Latin America and beyond.

Ambika Samarthya-Howard: Could you talk about why that works so well in Mexico and Peru rather than other places? What factors have enabled you to go into these countries rather than others? What do you think are the factors preventing it in other places?

Mark Lorey: The first criterion would just be to ask: Do these systems exist in a country? If so, is there openness to working with partners? That level of openness varies from country to country, for various reasons. That's the key consideration. We're actually just about to conclude a study that's being funded partially by Livelihood Impact Fund [LIF] and partially by the Vision Catalyst Fund, that's looking at opportunities for replicating the pensions model across Latin America and parts of Asia and Africa, as well. We're looking at exactly the question you're raising. What are the most promising candidate countries based on the criteria that we feel enable success and effective facilitation? The criteria themselves are being defined through the study, but in many ways, the limitation is just having the bandwidth to reach out and approach them.

I think if we get a bit more support, we can bring on more folks that we'd like to work with, particularly regional directors who would be able to proactively engage. Right now, we're quite a small team at the global level, so that could really move us forward pretty rapidly on this because it is such an easy win. It adds values for the agencies, for the people they're serving, and certainly for the whole sector that's working in this direction.

Ambika Samarthya-Howard: Do you know how Mexico and Peru became two of the countries you started with?

Mark Lorey: I know how we started in Peru. We had contact with an organization called Management Sciences for Health Peru [MSH Peru]. It's a satellite of the US-based MSH. Our contact was Dr. Edgar Medina, a really visionary leader who thought this innovation could be incorporated into the national pensions program. He was able to lead the negotiations with the National Pensions Agency to make that happen. He presented it at the International Association for the Prevention of Blindness meeting, the annual global eye health conference, two months ago.

Ambika Samarthya-Howard: The scale that you are working in is a much higher-level, country-wide scale than other methods, particularly those involving community health workers and pharmacies. Do you have any insights around how your delivery channels differ from more on-the-ground delivery methods?

Mark Lorey: Good question. I'll start by mentioning the other two types of models that we have in place to work with our other two types of partners. Our third type of model is social enterprises, an example of which is our collaboration with an organization called Healthy Entrepreneurs. And the fourth is faith-based health systems, which corresponds to the community health workers piece quite well.

 Healthy Entrepreneurs is a Uganda-based social enterprise organization that currently works in about seven African countries. We have a really compelling impact assessment that's come out of our collaboration with them in Uganda. Our pilot was to incorporate reading glasses into the portfolio of products that their Community Health Entrepreneurs sell in rural Ugandan communities. Overall, we were very encouraged by the uptake and the response from customers. Basically the pilot showed that A) the people were willing to pay the cost, which was about $2.50 (the equivalent of about 10,000 Ugandan shillings, B) they otherwise had little to no access to reading glasses in their context, and C) it had a really remarkable impact on their lives. For instance, of the 273 people who were surveyed out of a wider sample of about 600: 96% said their confidence had increased, 80% said their dependence on others has reduced and their independence has increased, 87% said their ability to work has improved, and 94% reported significant overall improvements in their quality of life because of the reading glasses. It's great to have that kind of clear evidence.

Ambika Samarthya-Howard: That's great. Can you tell me more about the fourth model?

 **Mark Lorey:** The last model is a faith-based health system. You may well know from other work you've done, but in Africa especially, at least 30% but, often as much as 40% or 50% of total healthcare in most countries is provided by faith-based health systems versus the public sector or the private sector. This is because many of those were around before independence, and they are often very well-trusted and very well-known. In remote, rural areas, they may make up 60%, 70%, or even 80% of total healthcare. They're a great system to work with, and they have various strong linkages with faith leaders, primarily Christian and Muslim, at the national level and at the local level. We found those folks are great at the national level in terms of advocacy and at the local level in terms of what we call demand generation and building awareness because they're amongst the most trusted and respected people within the communities.

 That's why we have chosen to establish something called the Africa Clear Sight Partnership with a group called the African Christian Health Associations Platform [ACHAP]. ACHA is the umbrella body for Christian health associations as well as some Muslim associations across 32 countries on the continent, and it's well-respected. It's based in Kenya and funded by the United States Agency for International Development [USAID] and various other funders, including corporates and multilaterals. We co-created this partnership with them, and it started off at the beginning of this year in three countries. It's already expanded to six. We're very encouraged by the results in the first six months since this got up and running, and we think it has the potential to expand to well over 20 countries in the near future, really as rapidly as resourcing allows.

This is supported by LIF, and is part of their generous partnership with us. They're helping cover the core costs of this Africa Clear Sight partnership: a percentage of people's time on the ACHAP

team at regional level and percentages of people's time at the national level, plus the basic transport costs and necessary training costs. In each of these countries, they really leverage the existing systems that are there, so they typically have hundreds of member institutions, including hospitals, clinics, dispensaries, and community outreach organizations. They also have linkages to churches and mosques across the country. It's a great system overall to be able to leverage, and thus far the response has been very strong, and the uptake really positive. We think there's huge potential for expansion moving forward.

Ambika Samarthya-Howard: Who is training the community health workers?

 **Mark Lorey:** It depends on the country context and also on the regulatory framework within that country, such as the policy for who can be trained to do the screening and dispensing of glasses. What we advocate is that anybody can be trained to screen for presbyopia and dispense glasses. We've seen that work in so many countries. It's based on the principle that LIF and others strongly advocate, which is that in most places in the world, reading glasses are available through self-screening.

We look at a similar approach, but we take it a step beyond and are able to provide training to partners. Usually, this training of trainers takes about three hours, give or take, including practice. These trainers can then train almost anybody at a community level in basic screening and dispensing. That can include community health workers certainly, but it can also include pastors and imams, leaders of women's groups and youth groups, and volunteers from the community.

That's what we encourage wherever the context allows because that's really what enables the scale to happen effectively, and at very low cost. In some contexts it's more regulated, like in Kenya, where there's currently a process underway to change that policy and make it more inclusive. It's those people who are authorized to dispense reading glasses, so folks in clinics who have some background in vision care already. In most cases, there are vision care services available, so it's a matter of bringing glasses into that space so they can reach many more people. A lot of them do outreach camps as well where they go into communities for a day or two or three, especially in outlying areas where people may not have any access to clinics or dispensaries.

Ambika Samarthya-Howard: I'm curious, what have you tried that hasn't worked? Or what are you finding to be the biggest blockers in terms of scale? And I ask that across all four models.

 **Mark Lorey:** I would come back first to the social enterprise model. For us, I think the scaling continues to be a question. The pilot worked really well, but is it possible to reach a large number of people through that? That's an open question for us. We see it can make a great

difference for those who are reached, but it doesn't yet seem to have as much potential for scaling as each of the other models that I've shared with you.

Ambika Samarthya-Howard: Because people have varying levels of motivation?

 **Mark Lorey:** Exactly. And different levels of income as well. This model doesn't reach the very poorest, the people living in extreme poverty. It's probably folks a level above that who benefit. That's one of the reasons why we think there's such value in providing that first pair free of charge when possible. We want to be attuned to not undermining the efforts of those who are selling glasses because we wholeheartedly believe that there needs to be a market with many different players. But we also think it's very valuable to seed the market by giving people free access to their first pair of reading glasses and having what's often a really transformative experience that then leads them to purchase a second or third or fourth pair.

The feedback we receive generally is, "This makes such a difference. I want to do what it takes to get another pair of reading glasses when I need them." We see our work as very complementary to the work of social enterprises, private sector players and others, and we want to be attuned to harmonizing with that work over time.

 The other area of advocacy is encouraging governments to include glasses within national health insurance programs. Whether it's payment for private providers or going through public providers or faith-based providers, that will make a difference in the long term to equip people. We also encourage inclusion of reading glasses as part of a pensions program or other programs that seek to reach vulnerable populations in different countries.

Ambika Samarthya-Howard: How as an organization have you managed to do all four of those models at the same time? I understand it's not at the same time everywhere, but are you trying to test what's working and then going to go deeper into one or the other? How are these related to each other? Are there a lot of differences among those four buckets?

 **Mark Lorey:** I actually see a lot of connections between the first, the second and the fourth models: the NGOs, the government, and the faith-based health systems. I think the social enterprise model is more of an outlier for us, just given that most of our work is free of charge to partners and free of charge to beneficiaries.

We see all three of those models having very strong potential for further scaling. The major limiting factor is resourcing. The other limitation for us is just the bandwidth and the capacity to more proactively pursue replication of these into multiple other contexts. But we don't see major barriers in any of these models.

Ambika Samarthya-Howard: Do these models work together?

Mark Lorey: Right now the need is so great. There are so many people who have uncorrected presbyopia across so many countries in the world, that even expanding ten-fold or fifty-fold from where we are, there would still be ample work for just about everybody. But it is something we look at on a country-by-country basis, because we work in about a hundred countries every year through our various partners. We want to make sure that we're not oversaturating a given area of the country because two partners are working there. We haven't really found that risk so far because, while we are growing rapidly and have more than doubled over the last couple of years from [reaching] about 2 million people with glasses in 2022 to more than 5 million this year, there's still a lot of space to grow. We'd like to reach 10 million per year within the next couple of years, hopefully 50 million per year pretty soon thereafter. As we are on that growth trajectory, we definitely need to be very careful to ensure that, in any given geographical context, it's the right kind of configuration of partners and that they're working with each other.

 We have a very active example now in Nigeria, where we're working to do this. There are two streams of work in that project. It's funded primarily by Founders Pledge, but LIF is supporting one stream of the project, along with Clinton Health Access Initiative [CHAI] Nigeria and the government. We're providing the glasses and the technical assistance, as CHAI has a more limited background in reading glasses and vision specifically. But they have a great background in working with governments as well as working on other kinds of assistive technology. That's the government stream.

The other stream is working with the Christian Health Association of Nigeria [CHAN], as part of the wider Africa Clear Sight partnership that I mentioned earlier. We're facilitating coordination between these two different streams. In fact, just yesterday, we had a good call to discuss that and to look at coordination at different levels, including at the national, state, and sub-state levels. We're quite encouraged so far by how that's progressing.

Ambika Samarthya-Howard: Can you speak a little bit about the CHAN channel?

 **Mark Lorey:** CHAN has more than 600 member institutions across the country, including hospitals, clinics, dispensaries, and outreach organizations. They're choosing five states initially as starting points for this work, leveraging their existing capacity and structures in order to reach large numbers of people rapidly. That will be done through a combination of working with the clinics and the outreach organizations, many of whom have community health workers. They will work directly with faith leaders and faith community volunteers who will be trained in presbyopia screening and in glasses dispensing. They'll be doing that ideally as part of Friday prayers at mosques and on Sundays, when people have already gathered. So instead of

having to organize a separate event for people to come together, they'll be where people come together on a regular basis.

Ambika Samarthya-Howard: Even though they're a Christian organization, they still work with Muslims?

 **Mark Lorey:** Yes, very closely. First, they serve all people at the local level, regardless of faith. Second,they work proactively with both Christian and Muslim leaders at the national level. There are two umbrella bodies for people of faith in Nigeria. One is called the Christian Association of Nigeria [CAN], accounting for about one hundred million Nigerians. The other is the National Supreme Council of Islamic Affairs [NSCIA], and they have a social outreach arm called Mission for Education, Social, and Health [MESH], that accounts for about another hundred million or so Nigerians.

 A team of us from RestoringVision had the chance to meet with leaders from both of these bodies in Abuja, along with colleagues from CHAN and our regional partner ACHAP back in February. They were really enthusiastic about this work. We even did some distribution on site in Abuja together with them. They are ready and raring to go. The head of the Christian Association of Nigeria said that they have a communications network through which they can send messages to pretty much all one hundred million or so people in the Christian community in Nigeria within 48 hours. So when the glasses are available, they'll be ready to activate that and get the word out to people about where they can be accessed. We're happy to work with them as well.

MESH does this at mosques, and then there's CHAN serving as the umbrella group for faith-based health systems in Nigeria. CHAN has had good experiences doing grant-funded work with both umbrella bodies in the past, particularly in overcoming stigma discrimination related to HIV, which is tough. They managed to do that quite well in a very interfaith way.

Ambika Samarthya-Howard: How is this stream working with the CHAI stream?

Mark Lorey: In part it's through geographical coordination, as CHAI and the government's National Eye Health Programme are working in a number of areas where CHAN is not, and CHAN is working in some areas where CHAI is not.

Ambika Samarthya-Howard: Is that intentional or is that just to test out what's better?

 **Mark Lorey:** The government set the 10 states where CHAI and the government are working based on their sense of state governments' willingness and capacity. Then CHAN selected their states in consultation with the government, based on areas where CHAN has especially strong capacity and presence, and where they know they could have early wins. There are two states

where both are present and overlapping.In the meeting we convened yesterday with CHAI and CHAN, We discussed how best to coordinate in these states, knowing that there's way more need in both than either organization could cover. It's a lot of geographic coordination, working in different areas within the states, but also seeking to maximize state-level launch events and other things that are happening.

Ambika Samarthya-Howard: In terms of the work happening within RestoringVision, what does the coordination across different models look like? Do you have different people from your organization working on different models, or does everybody work on a different country? How does it work operationally?

Mark Lorey: It's a small group of us, about 40 people, of whom more than half are working in our distribution center: the warehouse in Ohio. They are great people, doing vital work because we do distribute a sizable number of glasses that come into the distribution center. But the majority ships directly from China to elsewhere.

In terms of our programs and impact team, we have myself, a director of Monitoring, Evaluation, Evidence, and Learning., and two colleagues who handle our program portfolios. One handles Latin America and is based in Mexico, and then one basically handles the rest of the world, and she's based here in the US. We also have teams focused on operations, philanthropy, finance, people, and communications and marketing.

We really like to put the vast majority of resources into the glasses and into our partners, but we are quite lean right now. We're finalizing recruitment for an Africa regional director, and that will be a major help to move things forward more rapidly there. We'd like to bring on an Asia and Latin America regional director, one in each, hopefully in the next six months or so. We are ready to bring other key positions on board as soon as resources become available to enable the exponential scaling that we are working toward..

Ambika Samarthya-Howard: Thank you so much for your time and insights.

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.*