"It's a matter of culture": Nasser Diallo and Sage Ramadge of Clinic+O on building with community health workers, overcoming reading glasses skepticism and starting an NGO from scratch

Ambika Samarthya-Howard

March 6, 2024

Ambika Samarthya-Howard: Can you start by telling me about your organization and the specific model you've tried out to distribute readers?

Nasser Diallo: No problem. Sage [Ramadge] and I decided about three years ago to create a social enterprise, but we weren't able to get funding. So we started an NGO instead. We started raising funds. The reason I'm telling you this is because there are a lot of binary things, black or white.

 We are in Francophone Africa, Guinea, West Africa. We have our own currency. We have an unstable government. We are tiny. The level of attention that we get is very low in comparison to South Africa, Nigeria, Ghana and Senegal. We had to work with something. So we started a telehealth NGO. We hired doctors and nurses and then we started going to people. And people were looking at it like, are you out of your mind? This is not going to work because even if we go to hospitals, we talk to people, to doctors, and they ask how we can help them over the phone.

And we've had to readjust. We realized that we have one physician for 10,000 people, and four nurses for 10,000 people. So we decided to bring in community health workers. We approached the Ministry of Health. They were not interested then. But we kept going, we built a team of community workers. We found an area and we committed to offering primary care services using three ways. Mass consultation is the entry door. What is mass consultation? It's a consultation

whereby we come with a minivan, a tent, and at least three to six people, community health workers.

Ambika Samarthya-Howard: Are these community health workers that you've trained or that you've gotten through the ministry?

Nasser Diallo: At this point we have nothing from the Ministry of Health. We started reaching people through the mass consultations, and treating them. And then some who require treatment, we know a community health worker cannot screen someone for high blood pressure and diabetes and put them on medication. We dial in an endocrinologist or a cardiologist. That's where telehealth comes in.

But we seek the support of a community health worker who checks your blood glucose to see if it's high and then speaks to the endocrinologist. And then from there we do home care visits. That same community health worker would follow up with you at least at home to figure out whether you are doing well or not. And by design, I had nothing in my head when I was leaving my job at Facebook and going to Guinea doing this. Everything came together with the reality of the drought.

We branded ourselves as mass consultations. And then we just realized we need to map out the network of medical providers and partners within our region. Because if you tell me you want something, I know a community health worker will not be able to do it. I have to refer you either virtually or in person to someone who can help you.

 And then to do that, we realize you cannot refer someone without a medical record, be it in paper or digitally. We built our own spreadsheets using Google Docs and Google Drive, whereby we understood what needs to be logged in. And then from there we use a WordPress site to build our first digital medical record that is linked to a medical ID card.

And from there we went up to 5,000 people. And then we took that, we went to the Ministry of Health. We said, "Look what we are doing." They said, "Amazing, but you're too small." And from there we get into a hackathon that brings together 33 countries for type one diabetes organized by the University of Harvard, Novo Nordisk and Roche. And we presented our technology there. We won the first prize in front of Senegal, South Africa, and Nigeria.

 Then we went back to the Ministry of Health. The Ministry of Health says, "Amazing, you are a gem. We are giving you a license to do the work that you want to do." That's how we entered into a relationship with the ministry. From there, the Ministry of Health gave us some guidelines as to what matters to them.

 We started integrating those guidelines into our network, meaning primary care services with the hardest of hardest people to reach. We set our site in Mamu, an area that is 360

kilometers away from Conakry, the capital city of Guinea. And then we started offering primary care services in collaboration with the Ministry of Health.

 We built a workflow, a screening based workflow or a symptom based workflow to minimize the mistakes that community health workers might make if they are screening patients. For instance, instead of giving a community health worker a chance to screen you and say, "This is what you have," we screen you based on symptoms. They will just say, "Ambika, do you have a headache?" You say, "Yes." "Are you coughing?" And so on. Based on those symptoms, we give you a hypothesis of what you have.

And were you happy testing to confirm or not confirm that hypothesis before moving you to the next level of care? That's how we built a full medical record that collects demographic data, vital data and medical data.

Ambika Samarthya-Howard: Are you doing this all via paper records or somebody enters the data in their phone, or both?

 **Nasser Diallo:** Everything is done digitally on a phone. And everything is done by the community health workers. Everything. But before we get there to community health workers, we train them of course. We use our resources. Most of these community health workers have never used a tablet, have never seen any digital medical record, have never done any tele-consultations or any virtual consultation. We are the first who introduced that to them. And in a two-week frame, we are able to get them up to speed and make sure that they are able to access the services that they have.

Ambika Samarthya-Howard: When did you start doing the eye work?

Nasser Diallo: It's been a year now.

Ambika Samarthya-Howard: I'd be really curious to know how you've been applying that for the glasses and how that's gone.

Nasser Diallo: The eyeglasses project has been an extremely interesting project that I'm going to break down into three buckets. The first bucket is the perception of care. We had an internal problem with our own medical team that eyeglasses are not something that requires a physician. It took us close to three months to persuade our team that anyone can prescribe those eyeglasses because they don't need an ophthalmologist.

Ambika Samarthya-Howard: And was that battle harder for the community health workers and the people that they're speaking to or harder for both?

Nasser Diallo: We had not even reached the community health workers yet. This was between us and the doctors who supervise the community health workers. We have an internal team of physicians that vet everything that we are doing to make sure that it aligns with the guideline of the Ministry of Health. The guideline of the Ministry of Health in Guinea has medicalized reading glasses. Then here we are telling them, "... you can sell [reading glasses] in the market like peanuts. You don't need an ophthalmologist just to screen someone." They said, "No, this is not going to work. It's unethical."

We had to fight our own team to understand that we are not harming. To them we are harming the community by not going through a physician. I think there are two things. One, the perception of care and two, the fear that we need highly skilled people to do this. That's the first thing. Now the second thing that makes this project really interesting is the quality of the eyeglasses and the perception of the clients. Once the client comes to us and we say, "Here is a pair of eyeglasses, it's free."

Ambika Samarthya-Howard: When you say a client comes to us, I'm so curious how that happens. By client, do you mean a person, and by come to us, do you mean the community health worker?

Nasser Diallo: Let me back up. To distribute these eyeglasses, we went through mass consultations and home care visits. In the mass consultation we tell people, "If you need to be screened for presbyopia, come."

Ambika Samarthya-Howard: Where are they coming to? Everything you've been telling me so far is you going out. When you're saying they're coming, where are they coming to?

Nasser Diallo: What I mean by come is "come to our tent, we are out." Let's say we are outside in a market and we are saying to people, "Come to our tent, we'll screen you." Anytime we do a mass consultation, it's done with a tent.

Ambika Samarthya-Howard: Got it. And how often have you done that for this pilot?

Nasser Diallo: We have done over 20 mass consultations.

Ambika Samarthya-Howard: And do a lot of people come?

Nasser Diallo: Yes, a lot of people come. But this is not just for eyeglasses by the way. We're not just doing mass consultation for eyeglasses.

Ambika Samarthya-Howard: You bundle the care?

Nasser Diallo: We bundle the care.

Ambika Samarthya-Howard: What other stuff do you consult with?

Nasser Diallo: Yep. We do consultation form. I'm just going to share my screen and show you briefly some of these, maybe the visual may help clarify some of the things. This is our team of community health workers. This is the pilot that we are doing right now. And these are the steps that we try to follow.

 Step one, we screen people. We have all people, we screen them and then we do telehealth if it's needed. Here is what local and religious leaders that we work with that give us an opportunity to enter the community. And this is what we mean by a town hall or a mass consultation where we bring people together. Now if we ask someone, "Do you want to get screened for eyeglasses?" We just ask them to come to the tent and then they get screened for eyeglasses.

 And here is how we do the training for our community health workers. We train them theoretically and then we use the equipment to train them for high blood pressure, diabetes, gastritis, malnutrition and so on. And we do digital training as well to help them understand how our app functions. And then we go back to the community. This is the minivan I was talking about. And we have again the tent behind us. That's how we do our mass consultation, just for you to have an understanding.

 If you bring someone into that tent and then you tell them, "Hey, I have a pair of eyeglasses. It costs nothing. Take it." They say, "These are fake eyeglasses. The eyeglasses are fake. There is no way you [would] give me this pair of eyeglasses if it costs nothing because it costs $5 to $10 in the pharmacy." You have to go to the pharmacy and you have to have a prescription from an ophthalmologist. It's a minimum of $10.

We said, "Okay, let's charge $1." If you charge $1, people say, "You know what? The $1 that you are asking me for is too low." I mean, they're not telling us it's too low, but they are still saying it's fake. If you charge them $2 to $3, they say it's [too] expensive. This is just the mindset we have been battling with.

And also not everyone has presbyopia. A lot of people have problems with their eyes, but it's not presbyopia. The minute we are unable to help them, they say we are good for nothing. Even if we refer them to a doctor, because we even started talking about presbyopia. We just say, "Come and let's screen you for eyeglasses," because no one knows what presbyopia is. If you say presbyopia, they say, "I have a problem with my eyes."

This is the situation in which we are where we have tried to sell these eyeglasses for $1. It did not work properly. Giving it for free, it did not work. And now we are figuring out a way to distribute

these eyeglasses after a year. And what is that way? It's making sure that we blend them into the network of community health centers in which we are working. That's one.

 Now we have an integrated approach with the ministry of health whereby we integrate our community health workers into the community health centers. Our eyeglasses are available at the community health center. For anyone who comes to the community health center, you can get screened for eyeglasses. That's one.

And two, we decided we have to make sure that for each pair of eyeglasses, people pay $1. And we explain why it is important for people to pay $1. The way we are pitching it, this works. We are saying, "This pair of eyeglasses cost $10, but since you are a clinic member, we are subsidizing the $9." The minute we say that, they take the pair of eyeglasses.

 We are trying to launch a digital campaign because our focus was mainly on rural locations. And for someone who has presbyopia, they can still function. They don't consider that as a disease. The perception of disease in rural communities is, “I'm sick. I cannot move.” And at that, people are willing to pay 10 times the cost of healthcare. But the moment they are able to function, I cannot see 100% but I can see.

Ambika Samarthya-Howard: I'm curious, in the last year, what have you done differently or what other things have you tried that you feel worked? I see what you're saying about figuring out a really good price point. What other things have you tried?

 **Nasser Diallo:** We are trying to partner with schools on a project that we call J Zones to make sure that we can use the network of existing infrastructure.

Ambika Samarthya-Howard: And when you say partner again with schools, it's still the community health workers?

Nasser Diallo: It's still the community health workers. Right.

Ambika Samarthya-Howard: And then they would do the screening at the schools?

 **Nasser Diallo:** Yeah. But we want to do a knowledge transfer here. What we want to do is to find people at the school who can get the training from the community health worker, so they can do the screening because we don't need to be a community health worker to hold a piece of paper and ask someone whether they can see it or not. This is not medicalized. We don't need community health workers to do this.

 What we are doing is to increase the skills of people who can screen for eyeglasses by using students within the school. We call it J Zone. What we are realizing is using only community health workers is limiting our opportunity to distribute these eyeglasses. A community health worker has no specific skills that make them qualified to distribute these eyeglasses. Anyone who has the proper training can distribute these eyeglasses.

Ambika Samarthya-Howard: But the reason that you use community health workers isn't because of the skills, right? It's because of the perception of the people when they buy the glasses, I would think, because they want to make sure that the screening goes well, that the glasses are accurate, and community health workers have a much more trusted relationship with your clients.

Nasser Diallo: That is correct. But at the same time, community health workers have a limited set of clients that might take the eyeglasses. I think it's a matter of culture. What we want to do is to tackle the culture. What is tackling that culture? It's just being upfront and telling people, "If you don't see properly, okay, it could be presbyopia. And that has nothing to do with a medical condition that requires a physician."

 Own it, accept it. And from that perspective, I believe that I have a greater opportunity to screen my mom and tell her to take eyeglasses, than anyone else. Because she trusts me, she knows I'm not selling her and I can tell her that I have received the training. And that way these people can go on their own time in the community where they are known, where they are trusted.

 That's where we call them J Zone. In French, it's called Jeune Zone. We are trying that. We are trying to train these young people, meaning volunteers, who can help us distribute these eyeglasses. Because to communities, this is not a medical problem. Communities feel like you are making this a problem. “It's not a problem for me.”

Those who come to us with problems with eyeglasses are not the ones we can help. They are the ones who need to see an ophthalmologist because their problems are not presbyopia. This is really the dilemma. And when I met Abi, I thought I could distribute this like peanuts. I was completely wrong because the perception from the community, the medical perception of eyeglasses has been a challenge.

Sage Ramadge: When we say school students, these are high school age. These are students, the schooling happens at generally a slightly later age. These are young people aged 16 to 20. It's not children, it's young people who are going to school. They're trusted in their communities, they're trusted by their families to make medical decisions because they're literate, because they're educated.

And so this is Nasser's story as well. If he went to his mom and said, "Hey, mom, I'm concerned about this. Your vision is a challenge. I've learned this and I've been trained." He's the trusted party. And so we're looking at that as both an outreach opportunity for Clinic+O, but also a training opportunity for potential community health workers. For this is professional skill building for young people, whatever their role, they're learning digital skills using our phones and tablets.

Ambika Samarthya-Howard: But you must have to work in partnership with the schools and with the government in order to do that. How has that been?

 **Sage Ramadge:** It's a direct partnership with the schools. We're not going to a higher authority. It's directly with the schools.

Ambika Samarthya-Howard: And how has that been received?

 **Nasser Diallo:** Extremely well. A little bit of context. In the absence of government, government is mainly absent in rural Guinea at every level. Most of the work that we do is done in rural locations. If the government is absent, the local communities take over. We are striking these partnerships with the schools, but the aim is to show that the model works so we can partner with the Department of Education to go to scale. We can have that partnership with the Department of Education the same way we have the partnership with the Ministry of Health. We can integrate a lot of schools provided the pilot works.

Ambika Samarthya-Howard: That makes sense. Can you talk to me a little bit about numbers? How many youths are you working with and how is it in terms of penetration of glasses and things like that?

 **Nasser Diallo:** We just started this program. We have partnered with two to three schools right now. I do not have the numbers right in front of me, but I'm happy to email you some of these numbers. We are training at one school in Simibosa. We have sealed the partnership. We are in the process of sealing the partnership with the school in Oricaba where we are operating.

 We are approaching this training through digitization. We are starting after school digitization, after school programs where we can give students an opportunity to have digital skills, but also be useful to their communities. And then we slide in the distribution of eyeglasses because you have to log that into our digital app. If you don't have the skills to enroll someone on our app, you won't be able to distribute the eyeglasses.

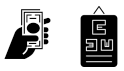
Ambika Samarthya-Howard: How many glasses have you sold through those people?

Nasser Diallo: I know how many people we have. On average, on a tent, we have minimum 50 maximum 100 people come to a tent a day. I know it's a big range, but that's the average of people

that come to a tent. And again, I can provide you the number of eyeglasses that we have been distributing through the tent via email. I don't have it on top of my head here.

Ambika Samarthya-Howard: What is your perception of the people who come to the tent and need eyeglasses and then go home with them? I'm curious about the ratio of people who come get screened for glasses and then how many of those people actually get them?

Nasser Diallo: First of all, nobody comes to get screened for eyeglasses. When they come they get screened for high blood pressure, diabetes, malaria. It's just a package that we screen them [for glasses]. We tell anyone who is over a certain age, based on the guideline that we have received from VisionSpring, we can offer you the screening of eyeglasses. And then you get screened for the eyeglasses.

 Now your question is really interesting. We have had two options. Option one, we have had people who came and who got screened and who got the pair of eyeglasses and they left. We do have some. But we have a lot of people who came and got screened and said, "Your pair of eyeglasses is too cheap. It's fake." Or, "You know what? I don't have a dollar to give you today. I will come back tomorrow."

This is to say, "This is not my priority. I got screened for what is my priority and I will see you tomorrow." That tomorrow will never come. Unless they are unable to see completely then they are willing to buy the pair of glasses.

Ambika Samarthya-Howard: What are you trying next? Is the school model what you're trying next to circumvent this cultural sensitivity issue?

 **Nasser Diallo:** Yes. The school model is what we are trying. And then blending into the existing infrastructure of the Ministry of Health through the community health centers and saying that we are subsidizing the cost of the eyeglasses because that's what the truth is. This pair of eyeglasses is heavily subsidized. It's actually the Livelihood Impact Fund that is subsidizing it for us to give it to them. In a sense they are not wrong.

It's just our communication. We are saying get this for $1. That pair of eyeglasses does not cost $1. For 50 years they have been told this pair of eyeglasses is at least $10. And we also do have a lot of scammers here who come and sell fake eyeglasses in the market so people are aware of it.

We are trying to adjust from three perspectives, one is to blend into the existing infrastructure of the Ministry of Health through our community health workers who can distribute these eyeglasses through community health centers. That's one.

Ambika Samarthya-Howard: And you have to work with the Ministry of Health to do that. How's that partnership been going?

 **Nasser Diallo:** Extremely well. The reception of it's extremely good. At this point we are able to distribute our eyeglasses within the community health centers.

Ambika Samarthya-Howard: Oh, great.

Nasser Diallo: Not only the eyeglasses, but all our services within the community.

Ambika Samarthya-Howard: How long has that been going on for?

Nasser Diallo: It's been two months now. Actually, less. From January.

 We have 45,000 people on our platform right now. And the Ministry of Health has asked us to digitize healthcare at the community level, the full healthcare at the community level they want us to digitize.

Ambika Samarthya-Howard: Congratulations.

 **Nasser Diallo:** Thank you so much. We have a strong partnership with the Ministry of Health. This is to say it's extremely difficult for someone to sit down in Paris or London or New York and think that something is going to work on the ground that they have never been to, they have never tried. And that's why I just wanted to paint that point from my perspective.

Ambika Samarthya-Howard: Have you seen anything that's going to shift the cultural change? You are working within the schools and working within the clinics, which is a great idea to integrate services where they are. Are you hoping that that also tackles that cultural problem?

Nasser Diallo: It will. What is this cultural problem, Ambika? It's preventative care versus security of care. This is not about eyeglasses.

Ambika Samarthya-Howard: Totally. It could be anything. It could be about dental stuff. It could be about absolutely anything.

Nasser Diallo: Exactly. It's just telling people, "You cannot just have a car and drive it until it breaks down in the middle of the highway. You have to think about maintenance." And we are approaching it from the preventative care perspective.

Ambika Samarthya-Howard: But if your house is leaking and your kids don't have pencils for school, then you're going to keep driving that car until it's broken down. How does your work change the cultural sensitization issue?

Nasser Diallo: To me, the value of your dollar today in comparison to the value of your eyes tomorrow, this is the battle. The value of your blood glucose today in comparison to the value of getting diabetes tomorrow. To me it's all about outreach and changing the culture.

This is not invasive, it's just going to the community, talking to them and approaching this from the perspective of wellbeing. Not from the perspective of healthcare. If you want to see your children graduate, if you want to see your grandchildren, you have to have eyes. And if you want to keep having eyes, you have to think about investing in your health. If not, you won't be around.

We are a Muslim country. If you want to go to Mecca and come back, you have to be healthy. If not, you won't go on a plane and go to Mecca. If you want to see your daughter getting married... That's how we are approaching this. We are approaching it from the perception of preventative care.

 One final thing. We have had one person who came, they could not see very well. And they had presbyopia. We screened them. We realized that they had presbyopia, but we did not have the right number with us on the tent. They started freaking out. They started saying, "You know what? Not only am I willing to pay for the transportation to go get that pair of eyeglasses, I'm willing to pay more." What are they telling us? It's at the stage of their eyes, since the stage is advanced, they cannot see properly, our eyeglasses are worth it for them. They are willing to pay. And we said, "No, you don't need to pay more than a dollar. We are going to bring the eyeglasses." "No, no, no. I want it now."

This is to say presbyopia is a condition that many people in Guinea do not know. They don't know you don't need to see an ophthalmologist. They don't know what the implications of having presbyopia are. As long as they can see at 80%, a pair of eyeglasses means nothing to them. But the minute they see 20% or 30%, the desire to get the pair of eyeglasses increases.

And that's where the battle is. We want to reverse that. We are able to reverse it with high blood pressure and diabetes today. Right now we screen anyone with high blood pressure and diabetes within the communities. But it took us about two years of screening, of sensitization, to get to that point. I think it's a matter of time until we will get there with the eyeglasses as well.

Ambika Samarthya-Howard: When you're talking about sensitization, you're just talking about habit and routine? Not necessarily a marketing campaign or uniforms and things like that?

Nasser Diallo: It's a marketing campaign from the perspective of having interactive radio shows where you have people come and talk to them in their language with their testimony.

It's more talking to the community, talking to the religious leaders. An Imam in the mosque is like a health god. When he says, "Go get the eyeglasses," people believe in him. And we have been

going through these channels. And from the marketing perspective, we think a dollar is the right amount not to be called scammers, because our community health workers are not supposed to be called that.

Keep in mind we are in a country where people were told that someone is spreading Ebola on people on a helicopter and it worked. The fake news and misinformation is really high. It was definitely the most challenging project we have had so far. Definitely.

Ambika Samarthya-Howard: The people who got screened and needed glasses, but could still see at that 80% level, do you know why they went on to get glasses when it wasn't so urgent?

Nasser Diallo: I think this is a tiny minority. But it could be those who have been sensitized before we come. There are many variables, but if I had met you a year ago or six months ago, we would have tracked that data. But what I'm trying to say here, we are going to think about tracking that data because that's important data to track. Why are you getting the eyeglasses? Why are you paying? Why are you paying for the eyeglasses?

 **Sage Ramadge:** I think that's in all that we've done in Guinea, so much of it relies on Nasser's superpower in understanding the stakeholders on the community side, identifying Imams and community leaders who are trusted authorities on understanding how to work with the Ministry of Health.

 I think it saves us a lot of time. We've gone from zero in early 2021 to now having a partnership with the Ministry of Health, having 45,000 people on our platform because of his ability to understand what the motivations are, where the incentives are. And to his point, it's not like we've figured it out. And we've made lots of mistakes along the way, but our ability to understand that and pivot, I think, is where this path to success happens.

I think when we had our initial conversations with Abi, it was like, "Great, we're going to go and get these glasses out. 7,000, let's do 70,000." And it's like, okay, let's get the first 2,000 out the door and then we'll see how we learn from each of those pieces before we can say, "This is what it's going to look like."

Our vision is being a social enterprise, not to be an NGO to solve healthcare, because the government has to take that on ultimately. NGOs in Africa can do a lot, but they're not solving the healthcare problem anytime soon.

 What we saw in Guinea was there was no partner for us to work with, so we had to create a partner. And now we're moving into that next level where our technology and then infrastructure, we launch a digital health hub in Oricaba. Oricaba is a rural community. Simibosa is a peri-urban community. It's within an hour of Conakry, but it is very low income. Even with that proximity, there's no access to services.

 In Oricaba and the rural community, we've established a digital health hub saying, "Okay, from the community health center, if somebody goes there, they can't actually get a lot of services. They're under-equipped. There's no medication. You can't get screened for lots of things." Instead of going to the capital city, Conakry, come to our hub where you can do a virtual consultation, which you cannot do at the community health center." And if you come to our hub and we say, "Okay, this is clear what you have, and it can actually be treated at the community health center. And we know that because we've digitized it and so we know what medication they have."

 The digital health hub is another point of contact and point of sale for eyeglasses. And that costs a lot less to operationalize and to build than a community health center. And so, we are saying, "Okay, this model, we're going to replicate this model in these countries where it's filling in these gaps that exist." And then somebody else can build that hub. We don't have to build all of these hubs. Somebody else can say, "Hey, this community wants to do it. Great."

We're trying now to move into these more replicable models that achieve this hope and dream of scale that we have for rural communities in Africa. This is one way that we think that we can do it. And the eyeglasses fall into that menu of services that we could provide. And then it starts to change some of those ideas where people are saying, "Okay, this is where I go to get these things. If my vision isn't good, I know a place where I can get that."

Ambika Samarthya-Howard: It's really about touch points. For the people who do end up buying the glasses, I wonder how many of them do it because they have a friend, a family member, somebody that they go to mosque with who actually has a pair of glasses? Because I also think that word of mouth is really powerful in terms of penetration.

 **Nasser Diallo:** That is so correct. And it's like you were in Guinea. That's our go-to-market strategy, word of mouth. The level of trust, your neighbor is not going to lie to you. Your neighbor has no incentive to say it works or it did not work. This is what Sage was referring to as a digital hub. Right now we are selling eyeglasses here where people come here and get screened. And this is a modular hub that is solar-powered.

These are touch points that did not exist before that give people an opportunity to understand that the culture is changing. Now they don't need to travel 65 kilometers to see an ophthalmologist.

And again, that perception of care that you pointed out earlier, meaning seeing equipment that can give you the trust that these guys know what they are doing before giving them my eyes. It's just the perception of care in hospitals. Period. It has nothing to do with healthcare. I don't waste my time. And that's really devastating for communities who make less than $2 a day. The cost of

transportation alone to go to this hospital one way is $3. And that's the culture we are trying to change.

Of all the 45,000 people that we have on our platform, none of them is coming from the hospital. All of them are coming from the community. That's extremely important. You want to be the middleman between the community and these medical institutions. And I'm going to spare you from seeing what the hospital looks like again. I'm not going to share that with you.

To me, I really underestimated the work that comes with [this project]. I just thought the absence of the product justified the needs. I thought if there are no eyeglasses, bringing in eyeglasses is the solution. I did not factor in anything that comes with the perception of eyeglasses, the perception of people who are distributing these eyeglasses. The perception of my medical providers. The perception of the culture of healthcare. None of that. I just wrote a proposal and said, "In six months we will send you deliverables whereby we distribute 7,000 pairs of eyeglasses."

Ambika Samarthya-Howard: This has been great. It's been really insightful.

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.*