“If you're not seeing clearly, how can you do daily tasks?”: Mohit Chelani of The/Nudge Institute on framing near-vision glasses as a livelihood intervention

Rollo Romig

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Rollo Romig: Could you start by telling me about what you do for The/Nudge?

Mohit Chelani: I’ve been almost five years at the organization, and I've served in multiple roles. I started as almost the first team member for one of the fellowships we run. The idea of it was to bring in senior professionals, people with 20+ years of work experience, and have them work with the senior government officials. In our world, they're called additional chief secretaries and principal secretaries, basically heads of departments who are managing a particular departmental mandate.

The idea was that these two people would come together to work on strategic projects and bring about technological innovation. We were able to bring in some interesting folks from industry and the corporate world, and have a crossover so that best practices can flow, with more innovation shared across the portfolio. People who have seen a certain level of scale within their corporate world can use those first principles and design large-scale programs for government, more or less. The two-fold objective was that somewhere down the line, we also nudged them to consider transitioning into the social sector. That is what I did for three years.

After that, I was feeling an itch to change roles. At the same time, Atul, our CEO, was looking for a head of strategy and chief of staff, so I took that role for almost eight months. In my current role, I’m head of product for the Insight program. This is the same reading glasses program that LIF funded. Within the product scope, my larger mandate is designing the product, SOPs [standard operating procedures], and guidelines. How does policy look when we are thinking about large-scale implementation of community cadre-led screening and distribution? How do we look at advocacy? How does government look at small pilots like the one we’re doing in Meghalaya?

When we pick a block, how do the operations look? Whom are we coordinating with? Within the overall operational logistics aspect, how does procurement get figured out? How do you look at training? How do you look at screening and distribution? The ultimate north star is adoption of near-vision glasses, because only then people will start realizing the advantage for what it brings in terms of productivity and income potential. That's largely what I'm looking at. At this point in time, because we are fairly new as a team within the org, I'm also looking at operations, speaking to stakeholders on the ground, and rolling things out. I'm wearing my operational hat, running around Shillong, in Meghalaya, and speaking with block stakeholders to fix the date for the training, making food and venue arrangements.

Rollo Romig: Do you have to take into account safety concerns while traveling around in the rainy season, in terms of landslides and this sort of thing?

 **Mohit Chelani:** That keeps running in your head, but it hasn't been any point of bother when it comes to Meghalaya per se. What I was hearing from a couple of colleagues is that certain areas within Meghalaya need a 4X4 to access them. We're wondering how to reach out to these blocks.

Rollo Romig: Let me ask you about The/Nudge's nationwide strategy with the eyeglasses. You've had pilots in five states, is that right?

Mohit Chelani: Yes. We're speaking to many of them, up to 20, as I last remember. Actively, it would be closer to five. These are conversations we've initiated. Some would be in the active portfolio, some in the passive portfolio, some have been snoozed.

Rollo Romig: You seem to be taking very different approaches in these five places where you've got active pilots. How would you characterize these?

Mohit Chelani: When we think about a large-scale implementation for near-vision glasses, there are two broad approaches. One is a community cadre-led screening and distribution, which is largely within the health scope. ASHAs [Accredited Social Health Activists] are health professionals who go door to door delivering health services to lactating women, to children, to different individuals within the households they cover. Every single ASHA is responsible for close to 1,000 or so people. Every a month or two, or a quarter, they visit these individuals to track their nutritional and healthcare needs.

 Beyond that, there are also Anganwadis, centers where an Anganwadi worker takes care of early child education while also looking at nutritional needs for children. Within this health ecosystem, we try to develop a health community cadre or a non-health community cadre. In India, there is a huge social network of self-help groups. These women come together to form a community which can take care of the needs of a certain number of households connected to the self-help group, to create livelihoods and financial inclusion for themselves.

There are multiple cadres for mobilizing these self-help groups. There are community resource persons, CRPs is what we generally call them. These are very particular Hindi terms. There'll also be Samuh Sakhis, Krishi Sakhis who evangelize best practices for agriculture or agricultural

produce, and Poshan Sakhis who have a mandate to ensure the right kind of nutritional best practices.

A very popular nutritional best practice that the government preaches in India is a Tiranga meal. A Tiranga meal is basically a tricolor meal where there is richness and diversity so that more nutritional depth and diversity is reached. It's not only consuming rice or wheat because this may not be able to capture your holistic nutritional needs.

All these self-help groups are largely targeting communities who are either extremely poor, that is, people with an annual income lower than ₹25,000 per annum [approximately $300 USD], or poor families and households, who are a little better off but still only able to have two meals a day and may not have a sustained livelihood for themselves. Whenever a health calamity occurs, they're again thrown into vicious circles of poverty. There are quite a lot of these community cadres in the non-health regime who can also be mobilized and trained for screening and distribution of near-vision glasses. Then there is the non-health community cadre, which is the CRPs, Samuh Sakhis.

 Within Meghalaya, we are looking at a non-health community cadre called CGHA, Community Gender and Health Activists. It was pioneered during COVID when there was quite a lot of urgent demand. They had to create a cadre to do advocacy, spread awareness, ensure that the right kind of health-seeking behavior is adopted, ensure that everyone is getting vaccinated and follows the right kind of protocol.

At the same time, it's not a health cadre, so they aren't going around and providing nutritional-level interventions. They still do advocacy, more or less, or awareness evangelization. We are leveraging that cadre to be trained for primary vision screening, and they will be going door to door. There's also a very amazing institution within Meghalaya which is called VHC, Village Health Councils. If a village has 100 households, for every 10 households, there's a representation at the VHC level. It's a very community-driven, holistic institution, which takes care of healthcare needs within the village. If more sanitation measures need to be made aware of, or if there is an intervention that needs to be planned, or more women are being detected for anemia deficiency, for example, they'll talk to the nearest primary health center to find out how to ensure that more fortification tablets are available for these households.

 There are close to 2,700 VHCs within the state that host monthly meetings. Almost every village has a VHC. The idea is to talk about critical aspects within the state or village, and how to start working towards that. We're trying to integrate our program into these VHC meetings. The rationale is twofold. One is to ensure more households participate in this VHC, to ensure that institutional capacity is strengthened. When more households participate in VHC meetings, we don't have to mobilize them separately. We have to be very careful, because every day that an individual comes for an intervention, there is a huge opportunity cost because they're letting go of their livelihood for that day, which is critical. Certain households may be extremely poor, and unfortunately live hand to mouth. It's critical to plan the interventions in a way that isn't burdening the household to come to seek services every now and then. That's what we're doing in Meghalaya.

Within the community cadre there are two approaches. One is largely government-led, because most community cadre are anchored in government institutions. This program is at scale. Government is the payer and doer at scale, through the community cadre. The other approach is creating entrepreneurs. When you think about near-vision glasses, an average near-vision pair of eyeglasses would cost $2 to $3; in India parallels, it's, say, ₹150 to ₹200. Global research shows that an individual is very happy and willing to pay almost three times their daily wages to procure a pair of glasses, even if we assume minimum wages. MGNREGA [the Mahatma Gandhi National Rural Employment Guarantee Act] is one of the programs. MGNREGA basically ensures 100 days of minimum work for people who are unemployed. Within that also, let's assume ₹200 or ₹220 is paid daily, and three times that is ₹600 [$7 USD]. Even then, the near-vision glasses are almost one-third of that. Affordability is not that big of a challenge.

From an entrepreneur's standpoint, if we enable the procurement of near-vision glasses at $1 and $1.20, and they sell it for $3, they can earn a very good margin, and through that, they're able to sell more. If they're able to sell 10 glasses a day, they'll easily be able to make something close to ₹15,000-20,000 [approximately $200 USD] a month, which is a decent earning. That can create more livelihood opportunities for these entrepreneurs. At the same time, this is still a market-driven solution to drive screening and adoption of near-vision glasses. Those are the larger two approaches. One is a market-driven approach, which is the entrepreneur approach. The other is the government-driven approach, which is the community cadre approach.

Rollo Romig: With the community cadre, are they giving out the glasses for free, or is it at a subsidized cost?

Mohit Chelani: Mostly it's free, because a lot of these will be covered under different social welfare schemes. If we are speaking to the Ministry of Social Justice and Empowerment, it may get covered in India's Pradhan Mantri Jan Arogya Yojana [the world's largest health insurance/assurance scheme fully financed by government], or here in Meghalaya, we're looking at a state-level scheme where the budget will be incurred by the government itself. This is what we want to do after the Umsning Block pilot. There may be a scheme here or there where they may take a certain amount for screening or distribution, but largely when we are thinking of the community cadre implementation, it will be free of cost.

Rollo Romig: Where is the entrepreneurial approach taken?

Mohit Chelani: With the community cadre approach, we are looking at Meghalaya and Haryana, where we have a project with All India Institute of Medical Sciences, one of India's most premium medical institutes. We're also doing a pilot in Jhajjar, another district in Haryana. Besides that, there's a community cadre-led program in Wardha, Maharashtra, and one in Rajasthan. These are the five interventions I mentioned.

Regarding entrepreneurship, it is largely in Uttar Pradesh where we are working with Shroff [Eye Centre], and independently as well. Down south in Tamil Nadu, we are doing a project with Aravind Eye Hospitals.

Rollo Romig: In what states are you taking the community cadre approach?

Mohit Chelani: Meghalaya, Odisha, Jhajjar in Haryana, Wardha in Maharashtra, and Rajasthan. We still don't have a district or a block at the state level in Rajasthan. We have some active projects and others which are maturing at this point in time.

Rollo Romig: For those community cadre regions, is the approach pretty similar across those five places? Any differences there?

Mohit Chelani: The differences would be that within the community cadre, there is a health cadre and a non-health cadre. In Meghalaya, it's the non-health cadre, the CGHS, which is the community, gender, and health activists. In Jhajjar in Haryana, we're trying to do both. There our objective is to distribute close to 50,000 near-vision glasses. 25,000 will be distributed by ASHAs, a health cadre, and 50,000 will be distributed by Panchayati Raj institutions or the self-help groups, a non-health cadre.

In Odisha, there's a similar approach, blending both health and non-health cadre. The difference is largely within the community cadre, whether it is a health or non-health community cadre. The other nuances are more around logistics, such as where the warehousing happens, and also within screening and distribution.

There are two approaches to follow. One is a camp-based approach. You mobilize the entire village, ask them to come to a certain place, a Panchayati office, a block office, or a convention center, and you screen them and give them glasses. Another is a door-to-door approach. The community cadre goes around the village, covers every household door-to-door, and looks at the saturation of all individuals within the village. In Meghalaya it's more a camp-based approach. The screening and distribution happen at VHC meetings. The Jhajjar in Haryana, along with AIIMS, is a door-to-door approach.

Rollo Romig: How are you making decisions about different approaches in different places? Is it based on local structures or government interests?

Mohit Chelani: A mix of both. In Meghalaya, there is a very strong village-level institution called the VHC. It makes sense to anchor the intervention in the VHC meeting so that it gets bolstered, and at the same time, there is more uptake. The objective is to cover more households within a particular village. If recommendations from the government and our understanding through field visits suggest that a camp model is better, we would switch to a camp model.

Here's why we did not choose a door-to-door model in Meghalaya. It's a hilly state. Going from one door to the other takes a lot of effort for the community cadre. At the same time, there are places which are extremely remote, so saturation becomes a problem. Since there is already an institution where more households are participating, why don't we leverage that?

Most decisions are made on the basis of how it is delivered effectively at scale. In Jhajjar, Haryana, along with AIIMS, it's a door-to-door implementation because we felt that the ASHAs will be much better if they cover the households door-to-door. It's more on the basis of our field assessment.

Rollo Romig: In these five states where you're primarily taking a community cadre approach, are the glasses always free, for now at least?

Mohit Chelani: Yes. We are also trying to establish evidence that the community cadre can deliver it effectively. The challenge at this point is that we haven't seen an uptake of a program which implements screening and distribution of near-vision glasses at scale by the community cadre.

Whenever we speak to different state governments, all of them ask two things. One, can a community cadre deliver screening and distribution effectively, and second, can it be done efficiently at scale? We are doing two things to substantiate that.

One is the project with AIIMS, the All India Institute of Medical Sciences, where both health and non-health community cadre are screening and distributing. AIIMS will publish a report to be used by all stakeholders across the state to make a case that the community cadre can effectively deliver screening and intervention at scale.

For the second goal, the efficiency of the intervention at scale, we're trying to contextualize it and pilot it in every state. In Meghalaya, we are piloting the Umsning Block with the Ri Bhoi District. It is very geographically relevant in Meghalaya from a political and development standpoint. We will distribute close to 14,000 glasses in Ri Bhoi to prove that this intervention can be delivered efficiently at scale on a state-level scheme to make Meghalaya presbyopia-free. We are taking this approach across all the five states we work in.

Rollo Romig: Are these pilots just to learn how to operate in these geographies and to show that it can be done, to give you enough information to pitch and launch a statewide program?

Mohit Chelani: There's also alignment with the state administration. It's not teaching per se, it's more advocating. It's an initial level alignment in that if you're able to do it within Umsning in Ri Bhoi, we will make this into a state-level scheme.

Rollo Romig: In the long term, do you plan to switch to a more entrepreneurial model in these states and sell the glasses with a subsidy, or do you expect to stick to a free model in these places?

Mohit Chelani: Not really. The idea is to have both of them work in harmony, because the objective is to make India presbyopia-free. One of the approaches is the community cadre approach, and the other is the entrepreneurial approach. The idea is to ensure that there is saturation and not duplicity. The objective will always be to operate these in tandem, and understand how they can be delivered at scale.

Rollo Romig: There's a certain tension between these two approaches, because if people are able to pay, it's better, but then if they're unable to pay, you want to make sure that they still get the glasses.

Mohit Chelani: Correct. At the same time, we also have to look at whether these are also neighboring villages. Let's say in Village A, someone has to buy these glasses, and in a very close-by village, let's say 5 to 10 kilometers away, they will be giving these glasses for free, so there also will be a conflict. We also have to look at these kinds of logistical and administrative challenges.

Rollo Romig: That gets really complicated, trying to make sure that no one feels that they're treated unfairly in this. How do you manage that? How do you end up making those decisions about where it's going to be free and where it's going to be the entrepreneurial model?

Mohit Chelani: At this point, the models are still evolving. At scale, one aspect is very clear. The first pair of government-led interventions can be delivered at scale as part of a social program, which is free of cost, but somewhere down the line there needs to be an inflection point where the individual starts realizing that this is a very critical commodity for their livelihood and they should invest in procuring them.

Near-vision glasses are not very expensive from an affordability standpoint, even for the poorest of the poor households, within which an individual is earning ₹25,000 annually [approximately $300 UDS]. Global research shows that a pair of quality near-vision glasses lasts over two years. Even if they invest ₹100 or ₹150 [a dollar or two] over two years, that's not a major investment. After the first or second pair of near-vision glasses, some appetite and appreciation for near-vision glasses should grow, and they should procure it on their own.

At scale over the next decade and a half, there should be enough people who have become first-time wearers from an entrepreneurship intervention or a government-led free distribution, and they start realizing that this commodity is very helpful. Let's say you do nimble work on sarees. After wearing near-vision glasses, you can see much better, your stitches on the saree are much more beautiful, and it increases the value of the saree so you can earn more. As soon as someone makes that connection, they start appreciating that this pair is very valuable, and it becomes a commodity they'll pay for. That's largely how we are looking at scale. At this point, how we want to solve it is still an evolving decision.

Rollo Romig: Would you say that you are promoting the glasses primarily as a livelihood intervention more than a health intervention?

Mohit Chelani: Yes. We strongly believe that glasses, near or distance, have a huge impact on livelihood, because if you're not seeing clearly, how can you do daily tasks? I understand it's seen globally as a healthcare intervention, but we need to accommodate it more as a livelihood intervention, because it has implications for enhanced productivity and income potential, the markers for a strong livelihood intervention.

Rollo Romig: You also had pilots in Delhi, Tamil Nadu, Karnataka. Any others?

Mohit Chelani: Uttar Pradesh. For the entrepreneurial model, it's Uttar Pradesh, Tamil Nadu, and Karnataka.

Rollo Romig: Has Delhi been another approach entirely?

Mohit Chelani: Delhi is more of an administrative center. We are collaborating with All India Institute of Medical Sciences, which is based in Delhi. While the administrative anchor is Delhi, the intervention anchor is Jhajjar, Haryana. It's very close to Delhi, almost an hour away, and approachable. It is within the NCR, the Delhi National Capital Region. Other than that, we're planning another intervention with the Ministry of Social Justice and Empowerment, a central ministry based in Delhi, but it will be cross-country.

Rollo Romig: What makes that approach distinct?

Mohit Chelani: It will be a similar approach, leveraging community cadre, but the geography will change. Part of this scheme is still evolving. There are aspirational districts which are a little behind on the development of educational, healthcare, and livelihood markers.

The government has pioneered a very good initiative to bring the districts front and center, to focus on them and ensure that more incentives are delivered in these districts, so that somewhere down the line they can come in at par with the other districts. The objective for part of the Ministry of Social Justice and Empowerment program is how to look at certain marginalized or vulnerable target groups, such as castes, tribes, or individuals from these communities. How can we look at screening and distribution of near-vision glasses in these districts for these marginalized households? We will look for a committee cadre to do the screening and distribution.

Rollo Romig: Do you expect to take both the community cadre approach and the entrepreneurial approach in every state?

Mohit Chelani: Correct. At this point in time, until we realize that a particular approach can't scale, we will keep piloting both of these approaches, and bring them to a certain effectiveness and efficiency so that more community cadre can be leveraged for distribution. At the same time, more entrepreneurs can be created who can sell near-vision glasses.

Rollo Romig: Would I be able to see screening and distribution events on the ground in Meghalaya during the last 10 days of July?

Mohit Chelani: I hope so. I'll tell you how the progress goes. We're looking at training for the community cadre somewhere in the next week or two. All the VHCs we anchor, and the CGHS to screen and distribute, will start hosting screening and distribution pilots. I hope by the time you come, we can take you to some of the VHCs, and the rains will have settled. If not Meghalaya, then definitely Odisha.

Rollo Romig: I really appreciate your time, and look forward to talking more.

ICON LEGEND

Rollo Romig (he/him) is the author of I Am on the Hit List: A Journalist's Murder and the Rise of Autocracy in India.

** This interview has been edited and condensed.*