“The community cadre model is where the government can be a good partner– the best partner, actually”: Follow Up Conversation with Amit Gupta, COO of The/Nudge Institute, on government partnerships, securing funding, and managing community distribution models.

Rollo Romig

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Rollo Romig: Could you start by giving me some background on The/Nudge? How would you describe your organization in a nutshell? What is your general approach?

Amit Gupta: The/Nudge is an India-based nonprofit, and our geographic focus is India. The objective of the organization is to contribute to making India poverty-free, within our lifetime. We believe that to make any perceptible difference in the poverty level for a country of India's size, whatever we do has to be able to scale to millions of people. Otherwise, we won't make a dent. We can do that only if we work in programs that have that big a potential. We have two kinds of programs.

One is Direct Implementation. The idea of Direct Implementation programs is that we run action research in an Indian context wherein the solution is addressing a large enough population where poverty is prevalent. The solution can scale and is economically sustainable. We believe that we can do that only by partnering with others in the ecosystem. Anything we try to do all on our own will have inherent scale limits.

We have a phased approach to doing this. The first phase is what we call the 'prototype' phase. In this prototype phase, what we do– either through our own ideation process or by studying other scalable models that have worked in other parts of the world– is we run some experiments in an Indian context and see if the solution is relevant and if it checks the boxes I described earlier. This is a typical product tweaking-iterating phase.


Once we have done that, and we think we have a working prototype, we go to the next stage, which is called 'propagation'. In the propagation stage, the idea is that we want to implement it at a certain scale, so we provide evidence and figure out the right pathways to scale the program or intervention. Then comes the 'proliferate' stage, wherein we are largely reliant on government and market players to implement our solution at scale and we work with them as a knowledge partner to support them in their journey. That's one set of programs. An example of such a program is our Economic Inclusion Program, that aims to uplift the most excluded households, particularly women, out of poverty, in partnership with the government.

The second kind of program that we have is an Ecosystem Program, wherein we focus on four pillars. The first pillar is supporting a government by providing them input for the right welfare schemes, policies, and so on, so that the government can become both a doer and a payer at scale.

The second pillar is becoming a means for more funds to come into the sector. We provide that through our incubation programs, our acceleration programs, our grant challenges, and also by working with the government and supporting them in their different schemes for poverty alleviation and so on.

Then, the third pillar is bringing the right talent to the sector. There, we have a fellowship program with the government wherein CXO-level talent comes in and works for a government bureaucrat for 18 months. We also have a social entrepreneurship program, and sometimes we have an innovation fund kind of program (like The/Nudge Prize Challenge).

The last pillar is using technology as a growth lever. Technology is not just high technology. It can be basic information technology, or deep tech in terms of agriculture, or climate tech. This can have a paradigm shift in the way one solves the problem.

These are the four pillars of social-ecosystem building. We've got Direct Implementation programs and we've got Ecosystem-Building programs. We believe that all these come together and support each other.

Rollo Romig: Would you say that all four pillars apply to the approach that you're taking with the eyeglass project?

 **Amit Gupta:** The eyeglasses project is a Direct Implementation program. What happened is that we, along with a couple of leading global foundations, started studying programs that improve livelihood and alleviate poverty at a global scale. We couldn't come up with a list that reaches two digits, unfortunately. We saw programs like the 'graduation approach', direct cash transfers, and trail bridges. We also saw that reading glasses is a program that can scale and have an impact.

 When we observed potential there, we studied it in the Indian context. How big is the problem? What can the impact be? What are the hurdles to scale, and what should the scale approach be? Based on that information, we started working on it. Since it is our direct implementation program, there is the 'prototype, propagate, and proliferate' framework. The glasses themselves are not quite prototype as they have been around for seven centuries, so it's more of a propagate stage, but how one propagates is a bit of a prototyping.

 The first issue that needs to be solved is how we fix the distribution of reading glasses. That distribution can be fixed through a community cadre model or an entrepreneurship model. The community cadre model is where the government can be a good partner– the best partner, actually.

 We work with the government to identify the initial sources of funding using a community cadre, and then in parallel, we work on tracking the entrepreneurship model so that we are making a market, for repeat purchases, and ongoing sustenance of the initiative. That way, it is not continuously dependent on philanthropy or government subsidy.

Rollo Romig: What stage would you say you're at right now?

 **Amit Gupta:** Essentially, we work with different government organizations to ensure we have the right schemes and conducive policies for reading glasses. In India, glasses are not medicalized, so the community cadre is able to do that.

 The first thing we're focused on is working with central and state governments to see how a reading glasses program can fit into their existing priorities. From there, we support them in launching a government-funded program—covering everything from cost and scale budgeting to selecting the right distribution model, setting procurement processes and guidelines, and providing program management support within government systems. That's one key pillar of our work, and it's where a good chunk of my time goes right now.

 In parallel, we are doing our own pilots to figure out what the standard operating procedures for different kinds of community cadre-based models should be in different contexts. We are experimenting with different variants and incentive systems for a village entrepreneur model to understand the cost economics: how much will it cost, what will the volume be, what will the sales be, how will we generate demand, and can it be a sustainable model on its own.

Those are two parallel things we are focusing on right now. As we speak, we have pilots going on in three places. We are in discussion with the All India Institute of Medical Sciences [AIIMS]. We are exploring partnerships with the leading institutes in India as knowledge partners, again including AIIMS, as well as the likes of Aravind and Shroff Hospital.

 The third thing we are working on is in support of the other two. We are exploring different technology solutions for digital workflow, tracking, and such. We are having discussions with various players and evaluating various technology approaches, including existing solutions used in a few states.

Rollo Romig: Could you tell me a little more about those pilots and how they're going? What have you learned so far from those processes?

 **Amit Gupta:** The very first pilot we did was about nine months back, in the northern part of Karnataka. We did that in partnership with VisionSpring. VisionSpring was our knowledge partner, and they were very kind to send their optometrists. At that time, our focus was to understand the awareness around the issue and the adoption of solutions. In that pilot, we screened about 1,000 people for presbyopia. About 750 people, give or take, got reading glasses. One very interesting learning from that was that the people who were given those glasses saw an instant benefit. We went back to do a post-adoption survey and saw that close to 90% are still using glasses.

 The second thing we found was that, when we surveyed them, the majority showed an interest in paying for the glasses so long as they had access. The price they quoted was anywhere between Rs. 200 to Rs. 500, which is a large range, but the median came out to be about Rs. 350. The third thing, which was more interesting, and which we need to learn more about as we go, is that while eyeglasses enhance people's lives, there's an inhibition around taking those reading glasses to work. Perhaps it's a fear that they will destroy it or something like that. But of all the people who were using the glasses, only about 35% were using them for their work.

One needs to understand the factors impacting this, which include age distribution, occupation type, and the extent of visual impairment. I don't know if you need reading glasses. I do. And I do everything humanly possible to not wear them. I wear them only when I cannot live without it.

The same thing probably applies there. How does one educate others about the glasses' sturdiness and benefits? These are some of the things we learn from these pilots. We learn one thing, and we try a few more things. Next time, we might do some pilots without optometrists present to see if we are underprescribing or overprescribing. We also want to explore questions like: What is the distribution curve of the diopter strength?

 We got the initial results of the first batch, where we gave glasses to 200 plus people in Rajasthan, in Northern India, where one can argue that awareness might be lower and social stigma would be higher, but we didn't really find that. We used the community cadre, and there was no trust issue. People were lining up to get glasses. Of course, they were free glasses. But overall, we are finding that community cadre screening is working. People are very happy to use it. We will see what the adoption rate is, and so on.

We also see a prevalence of presbyopia below the age of 40. While the number is low, we do see that prevalence. The distribution of the diopter strength was normal value. We did not see any abnormality there. The age group that showed up was anywhere between 35 and, in one case, 98 years old. These are some of the initial learnings. We'll have to see how many people will continue using them, and how many of them will take their eyeglasses to work.

We are also experimenting with small, A/B product testing. When we give someone reading glasses, even if someone tells them that the glasses are not for looking ahead, they're only for near vision, what we are doing is giving them not-quite bifocals– only the lower half of the glasses is presbyopic lenses; the other half is normal lenses. That way, you can keep wearing them and you will not have any problem. We'll see if that increases the adoption rate and the number of people taking them to work. It increases the cost only by about Rs. 10, Rs. 15, not a whole lot, but if it increases the adoption, it's completely worth it.

Rollo Romig: You mentioned that there is sometimes a reluctance to wear the glasses. What do you think accounts for that? Do you think people worry the glasses are too fragile or something like that?

Amit Gupta: Yes. The glasses are a very precious possession for them. If someone has the comfort of knowing that if they break something, it's not very expensive and they will be able to find a replacement, they'll use it. Whereas if someone breaks something and they don't know when they'll next have access to replacing it, they're going to be very protective of that pair of glasses. That's one hypothesis we want to test to try and fix that problem.

The second thing is that both the people who are doing the screenings and the program participants need a bit of education. They need to understand it's not just about reading or household chores. This will help you in agriculture, in weaving, in everything.

The third thing that needs to be looked at is our need to be intellectually honest with ourselves. For instance, I wear 1.5 in my late 40s. Unless I'm reading something, I can live without it. If somebody is in an occupation where they are in that age group, which is the prime of their life, they can kind of live without it. There's no question that the glasses will improve people's socioeconomic and overall well-being, but whether the impact will be equally acute for everyone is something to be tested.

When we started this program, we conducted an extensive bottom-up analysis to estimate how many people would be significantly impacted. We began with 147 occupations, based on the Government of India's classification, and identified those that require near vision. That narrowed the list down to 47. From there, we further refined it to 21 occupations, focusing on those most likely to employ people from economically

marginalized communities. For example, while a software engineer might need reading glasses, they can typically afford them.

Our estimate was that roughly 66 million people in India would have this problem, which is more than 20% of presbyopes in the country. A significant income impact will likely only be apparent in that 20%. That same 20% will see significant productivity improvement and will have substantial ROI, in general. Of course, this is a hypothesis that we'll have to keep on testing.

 **Rollo Romig: You mentioned much earlier that reading glasses are not medicalized in India. Do you mean you don't need a prescription, and you don't need an optometrist?**

 **Amit Gupta:** Exactly. I can walk into any store in Bangalore and walk out with not only reading glasses, but any kind of glasses.

Rollo Romig: That's interesting because here in the US, reading glasses are not medicalized, but other glasses are.

 **Amit Gupta:** Yes, in the US and the UK, you can get reading glasses over the counter. Here, too, you can get those reading glasses, which are prix fixe. It's not only reading glasses; it's all kinds of eyeglasses. If I go to any store that's in urban India, there will be someone running eyeglass testing. Does that person have four years of optometric training? No. They will have some training, and they may be an ophthalmic assistant. They will test properly for myopia and other things, and they will have a machine. Technically, they're not violating any rules currently. It becomes even easier for presbyopia.

Rollo Romig: That's great because in some of the countries we're looking at, reading glasses are medicalized, which is a big hurdle for distribution. Speaking of, what are some of the structural hurdles that you're encountering? What kind of problems have you run into or challenges you've run into while running these pilots?

Amit Gupta: One challenge is that if we do this in a rural area, the economics need to work. Who pays is a different problem to solve, but fundamentally, that needs to work out. Every time, if you will have to have a bespoke channel for distribution then your economics will be topsy-turvy. it's not going to work out.

 Now, if somebody in the community is doing this, there are two variables that we look at. One is the volume of work. If the catchment area is limited, the number of things they do have to be more than just screening for presbyopia. Otherwise, they will not have enough work. That's one model to look at, and that's where we think that self-help groups and ASHA can be useful because they are doing many things in a limited catchment, and can add this one thing to what they're already doing.

 The second variable is the area of catchment in which they are operating. If you want to do only presbyopia, then the catchment area should be large. Catchment areas can be larger in general when you are mobile. You should be able to go to different people without having an expensive four-wheeler. It needs to be a very lean model. The cost economics need to work out. That's what we are experimenting with. If one has an established shop or something like that, the footfall in that is not going to win. There's the cost of running the establishment, and then one needs to look at how quickly and easily one can train people to screen, because if training is very complicated and takes too long, somebody is paying for it, and it will not be sustainable.

Then there's the economic contrast between Southern and Northern India. In the South, both affordability and income expectations for those conducting the screenings are higher—meaning they expect to be paid more, and the people receiving the service are generally willing to pay more. In the North, it's the opposite—those doing the work are okay with lower pay, and those receiving the service are less willing to pay. These dynamics vary across different parts of the country, and that's what we're working to understand better.

 Maybe the entrepreneurship model will catch on in the southern part of India sooner than the northern part of India. Maybe the community cadre model in the highly populous regions of Northern India will get more traction than in Southern India.

Rollo Romig: You can't have a uniform price point because it's completely different economics.

Amit Gupta: Exactly.

Rollo Romig: You mentioned pilot programs in Northern Karnataka and in Rajasthan. Was there another one too?

 **Amit Gupta:** Yes, in Uttar Pradesh [UP]. There, we are trying the entrepreneurship model. Shroff Charitable Hospital has its vision centers there, and they have trained a few people, so we have two or three people acting as village entrepreneurs, in different contexts. They each have a catchment area with a population of say 25,000 to 50,000 people. Right now, we are experimenting with paying them salaries because we don't want them to be hesitant about any potential risks.

 We are trying to figure out what the volume generated in a month would be, and based on that volume, what variants of the incentive structure, in addition to salary, will drive the right behavior. It might be you screen more, you get paid more. Then, we want to figure out how much it really costs to do these things on the ground, all things considered. If you are a mobile entrepreneur doing screening, we want to figure out how you win people's trust so they have that screening. How do you get people to buy things from you? What are the mechanisms to generate demand and trust, and what are the hurdles? This is what we are experimenting with. It has been a week or so since we started doing this in UP, and we will probably roll something out somewhere in Southern India next because of the differences in the economics I explained earlier.

Rollo Romig: You mentioned the importance of collaborators in getting this work done. Can you tell me about your collaborators in this?

 **Amit Gupta:** In UP, we are working with Shroff. We are in discussion to develop a one-day training program through different partners like VisionSpring, RestoringVision, and Aravind Eye. Aravind Eye has agreed to do a one-day training, VisionSpring already has a one-day training, and RestoringVision has a super simple model. We are collaborating with Essilor in parts of Karnataka, as well.

 Then we are working with AIIMS and the R. P. Centre of Ophthalmology to do a pilot in a place that's about 100 kilometers from Delhi to see how well the community cadre model works. We are talking to different players in the industry about procurement of the glasses. Although we don't intend to do a huge implementation where we do screening and distribution ourselves, we want to understand the competitive price point at a certain quality. That's where we are talking to all the usual big players. Essilor is one of those. Then, again, VisionSpring, RestoringVision, and we

are even exploring options with the likes leading Indian market players. We're also looking at many contract manufacturers.

Rollo Romig: You're not trying to become the glasses distributor. You're trying to find the roadmap for how it can best be done in different parts of the country, right?

Amit Gupta: Yes. We are working on roughly 20 such discussions in different parts of the country, with different government entities.

 We are in discussion with one federal ministry, which is at a pretty encouraging stage, with a scale of 14 to 15 million pairs of glasses over two to three years. We are also trying to work with different state governments, and there are certain district-level discussions going on.

Rollo Romig: Is there anything else that you want to tell me that we didn't touch on?

 **Amit Gupta:** One of the fundamental hypotheses we have about our approach is that dealing with this as a livelihood and socioeconomic problem, as opposed to a public health problem, changes everything. Public health spending has limitations in developing countries. We spend close to 2% of our GDP on public health while the Organization for Economic Cooperation and Development [OECD] average is about 8% to 10% and the US spends probably around 17%. The reality is, there's already a paucity of money in public health in this part of the world.

On top of that, India is a highly populous country, so the per capita spending is even less. Where India is $74, the US is about $12,500. That's the contrast. With that limitation, the government will have to determine the best use of that limited money from a public health standpoint. There's an $11 billion budget, there are many serious problems to address, and they prioritize accordingly. With that lens, vision care is probably not at the top of the list, and rightly so. Vision care, give or take, get about $85 to $100 million in total. There are special schemes here and there, but that’s the general year-after-year allocation.

Even within that vision care model, the focus needs to be on cataracts, glaucoma, and blindness prevention, as well as myopia in school children. Presbyopia is not a public health problem, so what it comes down to is that very little money is allocated to it. Even asking to change that is not right because there are public health costs related to such a shift. However, if you change the positioning of the problem, and you begin to see it as a livelihood problem, then health is not the only option.

 India’s annual budget falls between about $550 billion to $600 billion. One-quarter of that goes into welfare schemes. Livelihood and poverty alleviation schemes alone account for about $20 billion a year. All of a sudden, your pool of the pie is not $100 million; it’s $20 billion. Then, with that $20 billion, you can say, "A little part of that can be allocated to vision care because it also alleviates poverty and improves livelihood." The constraint has been taken away. One can go to more than one ministry to seek support.

 Once they see the value, they are more than willing to do that. That's the number one thing. Number two is that it also unlocks who will manage distribution. These ministries and livelihood-related departments have a huge community cadre. That community cadre can be our distribution channel. This is a fundamental kind of shift in the approach that we are suggesting and trying to see how far it goes.

Rollo Romig: Thanks so much for talking today. These lessons clearly apply very specifically to eyeglasses, but I think a lot of the insights are quite far-reaching and could be applied to a number of different social entrepreneur projects. This was very valuable.

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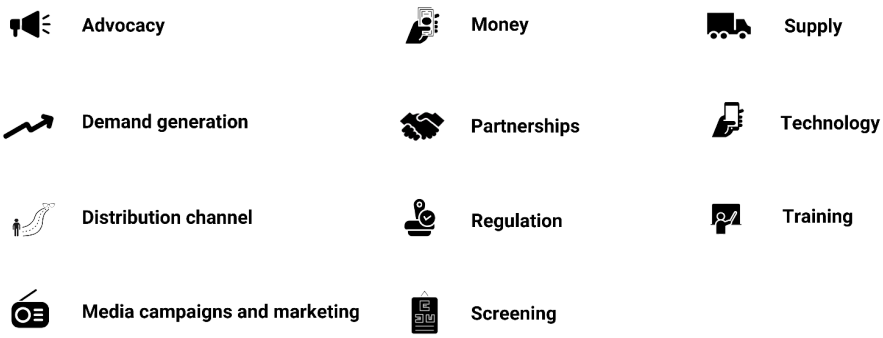

Rollo Romig (he/him) is the author of I Am on the Hit List: A Journalist's Murder and the Rise of Autocracy in India.

** This interview has been edited and condensed.*