"There is instant change. Someone who could not see, once the glasses are given to them, now can see. There is instant satisfaction, which really increases job satisfaction for community health workers, motivates community members, and gets them excited for other services as well": Abraham Zerihun, of Last Mile Health, on integrating near-vision glasses into Ethiopia's government community health worker program.

Rollo Romig
January 11, 2026

Rollo Romig: If you could start off by introducing yourself and what your role is at Last Mile Health. Then, also tell me a bit about how Last Mile Health got involved with near-vision glasses.

Abraham Zerihun: My name is Abraham Zerihun. I work as a country director for Last Mile Health (LMH) in Ethiopia. LMH has been working in Ethiopia for the past six years. Starting last year, we started the work of near-vision glasses because we were involved in upskilling or training community health workers. We call them health extension workers in Ethiopia. One of the training areas was non-communicable diseases.

In that area, eye care is an important chapter of that training. Handling presbyopia is something we felt was important after our initial conversation with the Livelihood Impact Fund, and learning about the experience of other countries who have started distribution of near-vision glasses from a livelihood standpoint, improving people's livelihoods. We felt that we could also apply that in Ethiopia, but maybe a different approach we have done in Ethiopia is to integrate it with the non-communicable diseases approach, as some sort of an entry point, not only for eye care, for other non-communicable diseases as well, such as diabetes and hypertension.

Rollo Romig: It is an unusual intervention, right, in relation to the other things you do? What persuaded you that this would be a good thing to get involved with?

Abraham Zerihun: Initially, we could not really see the link between reading-- even the name reading glasses might look like helping people to read as opposed to helping people in their day-to-day tasks. But most tasks require near-vision. Without near-vision it's very difficult to accomplish most of our day-to-day tasks. This was very new for us, but after looking at the evidence and what it really does to someone's life, we started seeing it as a huge opportunity to increase the credibility of our community health workers and also to improve broader health services.

We felt that it could have a significant spillover effect in terms of increasing the credibility of community health workers and attracting more people to services. Not only that, during our pilot, we could really see how it could transform someone's life and someone's livelihood. Someone was operating a hair salon or a small photocopying business, or someone sifting through lentils, or someone who wanted to read their Bible. These small things definitely improve someone's quality of life, and not only quality of life, they can also have an impact on their income.

That meant that it would be hugely accepted by the community, valued by the community, [it would] improve the credibility of those community health workers who are providing it. That was really what convinced us eventually to have a pilot and also advocate to the Minister of Health that this might be a new intervention, a new approach that could transform the way we provide care for non-communicable diseases, especially considering that non-communicable diseases were not part of the package for many years, the community health package.

The Ministry was really pushing to improve non-communicable disease management, at least early identification and referral at the community level. This could be an entry point. We cannot think of any other example where we were providing a valuable commodity to community health workers, and we felt the pilot really demonstrated that this could have a huge impact in improving people's livelihoods and also improving overall health service utilization.

Rollo Romig: Can you talk more about giving a valuable commodity to people and how unusual that is?

Abraham Zerihun: Community health interventions usually do not involve provision of free valuable commodities to community members. This, I feel, is an exception because reading

glasses are expensive commodities, and providing that definitely motivates the community. Not only the community, but the community health workers. We call them health extension workers in Ethiopia, who are providing that to community members.

When you see the excitement of someone receiving glasses for the first time is when you really see how these commodities are valuable, and also how transformational they are to someone's life. One of the most important aspects of this work that we have seen is that there is instant change. Someone who could not see, who did not have near vision, once the glasses are given to them, now can see. There is instant satisfaction, which really increases job satisfaction for community health workers, motivates community members, and also gets them excited for other services as well.

We are providing that valuable commodity and, in return, basically changing someone's life. Someone who did not have good near-vision in their day-to-day life now has this valuable commodity, which has a huge impact.

Rollo Romig: Tell me about the credibility part of it. In what way does distributing these glasses improve the health extension workers' credibility?

 **Abraham Zerihun:** We actually want to study this. There's research going on at the moment, but anecdotally, from what we have observed, it's very clear that it definitely improves their image and their standing in the community because they are bringing a solution that otherwise would be very difficult to access for community members. There's no access to reading glasses in these rural communities, and even if there were access in maybe nearby towns and cities, it's an expensive commodity, which it's difficult for people to put their hands on.

Since those commodities provide a real solution to your day-to-day life, that definitely improves the standing of community health workers in the community.

Rollo Romig: What was the process like to convince the government to get on board with this? Was it difficult to convince them?

Abraham Zerihun: Initially, like I said, even for us, we had to learn about reading glasses. We did not have experience. I think maybe the same goes for the Minister of Health, where the focus was mainly on improving refractive error in children in schools. Reading glasses were not on the top of the agenda.

 We had to provide evidence and experience from other countries. But the pilot was quite powerful in providing that evidence from home, from Ethiopia. After seeing that evidence, and after seeing that community health workers could be a vehicle for reaching community members who are struggling with this, the Ministry was convinced.

 There were different stakeholders involved. Optometrists were also involved in making sure that this is not replacing or making their profession irrelevant, but adding more valuable tasks at the community level.

 We also had a referral process, where community members who had more complicated eye problems could be referred to health centers. Community members who had other conditions like diabetes or hypertension could be referred to the health center. This helped to address the concerns of the Minister of Health and other stakeholders, and that helped in convincing the Ministry to give us the go-ahead. Now, we are at the scale-up phase, going beyond the pilot, and planning to reach thousands more people with this.

Rollo Romig: Have you found that distributing reading glasses does improve people's uptake in other interventions?

Abraham Zerihun: Anecdotally, yes. We want to back it up with real evidence and numbers, so there's some research going on at the moment. One of the things we do is that before you receive reading glasses, you undergo a test, which is done by a community health worker. She does the vision test. Not only that, she does your hypertension and diabetes tests as well.

 As part of the package of interventions, we've made sure that community health workers have the skills to do their blood pressure measurement, their diabetes testing. That was a critical skill community health workers did not have before this program. What we have seen is that people are so motivated to get glasses, but as part of getting glasses, they get other services as well.

This is increasing the uptake, at least anecdotally, but we want to actually put numbers to this claim. We are actually doing some research on that, but our assumption is that it really does improve health service utilization, particularly in the context of non-communicable disease services because we are providing this as an integrated package, not as a standalone program.

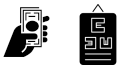
Rollo Romig: You were talking about eye-health professionals—optometrists and ophthalmologists. Has there been resistance from these groups to the program?

 **Abraham Zerihun:** There has been a push to know more, to understand more, and for us to address their concerns. Their concerns are whether health extension workers are qualified to do this. We were saying that this is an integrated service. For parts of the service which they are not qualified to do, we have designed a referral system where patients are referred to the health center level [to be seen by] more qualified professionals, such as optometrists. They have been part of the process. I think making sure that they are part of the process from the design phase to the implementation phase has been very helpful. Now we have optometrists who are championing this.

We engaged different stakeholders from the beginning, and one of the most important ones was the association of optometrists and professionals working in eye care. We made sure that we addressed any concerns they might have, and we addressed any potential resistance so that they are champions of this work now. They've been involved from the very beginning.

 We also tried to address any concerns they might have by establishing the referral system, where patients who might have complicated eye care needs, are referred to the health center level where a more qualified optometrist can attend to their needs. We have also included

them in the trainings and to oversee and observe the screening and distribution by community health workers as well. I think that way, we worked to address their concerns, and also to make them champions of this work.

 The main concern expressed by optometrists is related to the quality of service: if community health workers could be trained adequately, and are able to provide presbyopia screening and distribution of glasses with quality. There has not been any concerns raised on the sale of glasses, or if this would eat into profits, because the demand for service is still not that high. The demand has not been created. The concern we have tried to address mainly revolves around concern of quality, proper adequate training, supervision, and oversight.

Rollo Romig: Tell me a little bit about the form that the pilot took. What did you learn from it? What were maybe some things you tried in the pilot that you realized, "Well, this isn't working. We'll have to change this part of it."

Abraham Zerihun: The pilot was a big learning process for us. None of us have implemented a reading glasses or near-vision glasses project before. It's also new to the Minister of Health in terms of health access workers, community health workers, actually being a major part of the distribution of reaching people who have these problems. There's a lot of learning, I think, from all sides—from us and from the Minister of Health, as well.

 We learned a lot from the fact that reaching rural communities with reading glasses is a huge logistics undertaking. That's something we learned quite quickly in the initial part of the pilot. It's costly as well. There's lots of different ways of reaching people that we have tried. We've tried air transport. We've tried ground transport. There's some innovative ways, such as using the postal service, which were very cost-effective as well as effective in terms of reaching community members. There's different logistics approaches that we have tried and learned from, which we are applying in the scale-up phase as well.

 In terms of our training approach, there's a lot that we have learned. We are using multimedia as a powerful tool for upskilling community health workers. We have developed a learning video that community health workers can go back to, because the way we train community health workers is we call it a blended approach, which has a digital component, then a face-to-face component.

They have their training content in their tablets, so they can always go back and see how to test for presbyopia. Even if the distribution is happening maybe six months after the training, there's a training video which is available on demand on their tablets, which they can always access. We have learned that training community health workers through multimedia, through something they can always go back to access, is a very powerful tool for improving knowledge and skills, and also improving retention.

Rollo Romig: Tell me more about this blended approach. You're doing both in-person and online training, right? How did you arrive at this blended approach?

Abraham Zerihun: The focus of Last Mile Health is really improving community health programs. Community health workers are central to that. Improving their skills is one of the most important programs that we've focused on in Ethiopia. We looked into different ways of continuously improving the skills of community health workers, because improving someone's skills is not a one-time affair. It's something that needs to be continuous throughout the program.

The Ministry was telling us that this is a resource-intensive activity, and we were tasked with finding solutions for that. Solutions that improve skills and knowledge but at a lower cost. Using technology was very effective in doing that. Instead of bringing people for training for a number of days, we could cut down on that and use technology to deliver part of the training, so that's something we have tried. We had an initial pilot where we proved that with a blended approach, where part of the training would be digital and more skill-focused training would be face-to-face, we were able to cut down the cost of training by 40%, which was quite significant for the Minister of Health as well.

The digital component involved a lot of multimedia—a lot of learning through videos, animated videos, stories—which are more effective than giving a big manual for community health workers to learn from. These multimedia-based trainings were very effective in improving knowledge and skills. The face-to-face training focused on more practical hands-on skills, where health extension workers were taken through skill labs and did a skills assessment. We tested how they did presbyopia screening. They had a skills assessment in front of them, where we could see health extension workers in real-life scenarios screening people for presbyopia. Combining multimedia-based digital learning with real life skill-based training really made sure that community health workers had the knowledge and skills to provide those services.

Rollo Romig: Which regions did you start with for the pilot?

Abraham Zerihun: With the pilot, we had five regions spread across the country. Of course, this decision is made together with the Minister of Health. Now with the scale up, we have a much broader reach with around 10 regions across the country. Ethiopia's quite diverse. The northern part is very different from the southern part, the western, and the eastern part as well. In the scale-up phase, we will have around 70 districts spread across the country within the 10 regions that we want to reach.

These are regions with different cultural and language backgrounds. There are some pastoralist regions as well as agrarian regions. We are reaching a very diverse set of locations within the country, which means that we have to customize our approach based on that. For example, our training content needs to be delivered in different languages in different areas, which means we need to translate content, customize content based on some of the cultural contexts across the different parts of the country.

Rollo Romig: Tell me more about this customization. Aside from language, how have you had to change your approach in different places?

 **Abraham Zerihun:** For example, like I mentioned, we use a lot of character stories and animated videos, which are situated in a model village that community health workers are working in. Stories are about solving problems in a specific context. Those stories may not be relevant in one area. The examples you give in an agrarian, more stable, environment is different from examples you give in a pastoralist area. The situation, the context, is different. When you are describing a village or a family context, even names that you use in those stories have to be different from one region to another so that it's more relatable to community health workers, and also community members as well.

That sort of cultural customization needs to be there. We need to also be mindful of religious diversity as well as cultural and language diversity. All of that customization needs to happen so that the stories we use for learning are more relatable and are more relevant to the context.

Rollo Romig: The community health worker system, or health extension worker system, in Ethiopia seems like a pretty well-developed system in comparison to a lot of other places. Tell me a little bit about the form it takes here and whether that's been a big advantage for you, having this already very robust system.

 **Abraham Zerihun:** Yes. Ethiopia is considered an exemplar in its community health program. It's a program, which was designed, I think, more than 15 years ago, has been instrumental in improving maternal and child mortality, which makes it a bit different from some other countries in that it's been fully integrated into the health system. Our community health workers have proper formal training before they join the program. Not only that, they're salaried full-time civil servants. They're not volunteers. They are salaried full-time civil servants, who are fully integrated with the primary healthcare system.

Not only that, it's a backbone of our primary healthcare system. 70% to 80% of people in Ethiopia live in rural areas, and these 40,000 female community health workers are the most effective way to deliver health services to our people. We have a huge opportunity in Ethiopia to use them to deliver this service. Not only that, it's already part of the package of services that they deliver. In many parts of Africa or Sub-Saharan Africa, countries which use community health programs, non-communicable diseases are not part of the package.

The Minister of Health in Ethiopia may be one of the first to integrate non-communicable diseases, because non-communicable diseases are becoming a huge disease burden in Ethiopia. They are the number one cause of mortality in Ethiopia. We cannot ignore non-communicable diseases as part of our community health intervention. It's a huge opportunity in Ethiopia to use them to integrate reading glasses, not only to solve people's near vision problems but to use them as a gateway or an entry point for other diseases such as hypertension, diabetes and others.

Ethiopia could be that blueprint to show that non-communicable diseases could be addressed or community programs could play a part particularly in early detection and referral. Some of the lessons we are documenting here, we feel could be used in other countries that may not have community programs that are as developed as Ethiopia's community health programs. Those lessons, and documenting those lessons, could be a powerful example for other countries.

Rollo Romig: If you were giving advice to someone from a different country who was trying to get a program like this started, and maybe in particular a country that doesn't have such a robust community health worker program, what's some of the key advice that you would give them? What are some of those lessons?

Abraham Zerihun: I think whenever you bring services down to the community level, there's definitely resistance and skepticism of whether it's feasible and could be done with quality. We have seen this during the HIV era, where there's task shifting and bringing services down to the community level, where there's better reach, but there's also some skepticism on quality of service.

 How you address that is by bringing the evidence that it works. I think some of the advice or the lessons we have seen from Ethiopia is that community health workers still remain one of the most relevant and effective ways of reaching a massive number of the population across all areas. With proper training, with effective training, that concern of whether it could be done with the right quality could be addressed. I think if the right stakeholders within the Minister of Health, the right stakeholders within professional associations, such as optometrists or other relevant stakeholders could be engaged early on, this could be a very powerful way of reaching those in the last mile, reaching those in the most rural parts of the country.

We have more than 1 billion people in Africa. It's estimated that around 700 million of them are in rural and remote areas. We cannot reach all of them with sophisticated hospital care, tertiary care. The most cost effective way to reach people is through community health programs. Community health workers have proved to be a very effective approach for reaching a massive population, which otherwise would not be reached with healthcare, including for near-vision programs.

With the increasing burden of non-communicable diseases, community health programs are still a very relevant way of reaching people. I think we have seen that near-vision programs could energize, motivate the community, and community health workers as well, to reach a broader goal of reducing the impact of non-communicable diseases in rural communities in Africa.

Rollo Romig: Who's supplying your glasses? Have you been able to get the supply that you need whenever you need it?

 **Abraham Zerihun:** Glasses are being supplied by RestoringVision with support from Livelihood Impact Fund. So far, we did not have a problem getting glasses. Of course, the glasses we have now are much smaller compared with the demand. In Ethiopia, the demand is estimated to surpass 10 million. We have secured 355,000 glasses, which is still very small compared with the demand, but is a massive leap compared with the pilot as well. During the pilot, we reached 26,000 people. We now have plans to reach 355,000 in the next year.

We have reached 72,000 so far. By the end of July, we hope to reach 355,000, which is a massive improvement compared with where we were, but compared with the demand, there's still a huge gap that we need to fill. In terms of supply of glasses so far, with the target group that we have identified, we've been able to secure those glasses.

Rollo Romig: What have been some of the logistical challenges getting those glasses into the country?

 **Abraham Zerihun:** Yes. Logistical challenges start from importation. With support from the Minister of Health, we've been able to address those challenges. Whenever you import goods, there are several procedures that you have to pass through. We are now trying to find champions within the Customs Authority. We did a glasses day within the customs authority. We screen customs officials, customs employees, so that they're able to appreciate what these goods are for, which has been a very powerful advocacy tool.

Now, we have people within the Customs Authority, starting from the leadership to those customs officials who facilitate the importation process, who have been screened for near vision issues. We ask customs officials who review people's documents, so near vision capabilities are important to their day-to-day work as well. Our advocacy has not been only within the Minister of Health, or within the health sector, but also with very important entities such as the Customs Authority, who help us clear our imported glasses.

Rollo Romig: That's so smart. Your primary government partner is the Ministry of Health. Who else are you working with or relying on in government?

 **Abraham Zerihun:** Within the government, as I mentioned, the Customs Authority is one. We also have to work with various regional governments and regional health bureaus. We have to sign MOUs with finance bureaus in different regions as well. I think we sometimes have to work with the police because we are transporting glasses across different regional lines.

Rollo Romig: Oh, so do the police have to give you clearance?

 **Abraham Zerihun:** We always have to make sure that we have permission from the Minister of Health, [and get] letters that accompany those glasses being transported, so that in case customs officials or police officials stop our trucks, the purpose of the goods that we are carrying is clear. And the communities we're reaching are also clearly mentioned in those letters. We have to work with different government offices when we do this. This also includes local governments such as district officials, district health offices, of course, community health workers, health extension workers, health centers as well. Even within the Ministry there's different hierarchies of offices and subnational authorities that we have to work with.

Rollo Romig: You also get permits through the Food and Drug Administration, right?

Abraham Zerihun: Yes. When we initially import glasses, we have to do pre-import permits, and get approvals, make sure that the glasses are of good quality, and provide documentation of where the glasses were manufactured. All of that process needs to go through the Food and Drug Administration as well.

Rollo Romig: Do you feel that glasses are too highly regulated? If you could, are there changes that you would make in policy around regulation of eyeglasses?

Abraham Zerihun: Yes. In the Western world, when you travel outside of Ethiopia, you see that reading glasses are non medicalized. You can purchase them in supermarkets. You can purchase them at the airport. You don't need any screening. You just check which power suits you based on your near vision status, and purchase glasses in a very non-medicalized way. That's not the case in Ethiopia. I think there is a need for more advocacy to make near-vision glasses less medicalized and more freely available because it's been proven that more access is possible when they're less medicalized.

Rollo Romig: You mentioned so many different government stakeholders who you need to work with from the national level down to the most local level. It's a lot of relationships to manage. What have you learned about how best to manage all those relationships? How do you approach that?

Abraham Zerihun: Well, we work closely with the government. We accompany the Minister of Health in reaching its goals. We don't have separate goals and ways of working outside of government. We are here to support the government. The fact that the way we work already incorporates working closely with the government and building those relationships, that was very helpful when we brought this near-vision glasses project to Ethiopia. I think the nature of our work demands that we build strong relationships with the government.

That's the Last Mile Health way, and that means that our staff, the way we work, is oriented towards that. Working closely with the government, and relationship building. It was not that difficult for us, because the way we work is already oriented that way.

Rollo Romig: It sounds like you're on target for 100,000 of glasses distributed by next month, by February, which is huge, but then it's still just 1% of the total need, which is daunting. What are the biggest challenges that you still need to find solutions for?

Abraham Zerihun: We are very happy. We are getting closer to the 100,000 mark. It's a milestone that we have developed for ourselves that we want to celebrate together with the Ministry of Health. That 100,000, like you said, is still very small compared with the need of 10 million. That 100,000, we feel is a very important stepping stone, where there's going to be a lot of learnings in terms of logistics, in terms of, overall, how do you integrate this with the Ministry of Health system?

That's one of the things we feel scale would be attained, if we are able to fully integrate our logistics and distribution systems, our training systems fully with the Ministry of Health. That's why when we train community health workers about presbyopia, we're not doing it in standalone. We are integrating it with the Ministry system of training community health workers as part of training them for non-communicable diseases.

Other things we are trying are different ways of logistics and distribution. We hope reading glasses will be integrated in the national supply chain system, so that it's easier, cheaper, and more effective in terms of reaching the 10 million that we hope for. We hope this 100,000 mark would motivate the Ministry of Health by demonstrating that, even at large scale, this could be achieved: Demonstrate that community health workers are the most effective and the most

efficient way to reach people in the last mile in rural and remote areas. Armed with this evidence from 100,000, we feel we would have the tools for advocacy, for energizing people with the leadership within the Ministry, as well as our funding partners, to fill the gap of 10 million.

It might look daunting, but 100,000 looked daunting a few months ago, so it means that the 10 million mark is definitely within reach with more funding, and with more commitment from the Ministry of Health. We feel like every day that passes, we are learning valuable lessons. How this could be done in a more effective and efficient way. We feel like we have, at least, the tools to reach that 10 million with more commitment of resources.

Rollo Romig: Right now, you're distributing all the glasses for free. Do you plan to continue with a free distribution model going forward?

 **Abraham Zerihun:** I think there should be multiple models that should be considered, considering the setting, what's more appropriate for urban areas, rural, or remote areas, depending on the ability to pay for our community members, as well as, could it be linked with job creation? Can there be a local market for that as well?

I know the Ethiopian Ministry of Health is very much interested in local manufacturing of health commodities. The fact that you have your first pair of glasses, doesn't mean that you won't need others. In fact, you need to be continuously assessed to see if you need an upgrade of your glasses. This means that the fact that someone has glasses, does not mean that their demand is fully met. There might be different powers in a years' time, two years' time.

 I think, now, the focus is creating demand and figuring out how that demand is going to be met. There should be multiple solutions which create the local market for these commodities. We feel like once the demand is created, there are other opportunities that will be created to meet that demand. Those opportunities need to have a variety of solutions driven by the private sector.

There might be opportunities for integrating reading glasses into community-based health insurance, or social-based social health insurance schemes, so that there are different ways we are considering to pay for them. Having the private sector in mind, and what role they can play in the future, is also another important consideration.

Rollo Romig: You mentioned that you're continuously learning lessons that'll help you get to that 10 million point. Tell me more about some of those lessons. Even if you have just tiny examples of things you've learned recently.

Abraham Zerihun: One thing that we've learned recently is logistics planning. These glasses come in different powers. You can be a plus 1, or you can be a 3, you can be 1.5, or you can be a 2. This is based on the stage of your near vision capability, and what kind of appropriate glasses that you need. We have seen it can be different in different places. When you do logistics planning, you need to be aware of that. In the initial pilot, for example, we could not find many people who needed power three diopters, which is one of the highest.

 We needed to readjust our supply of glasses based on that demand. Sometimes that causes delays. The whole idea of this intervention at the community level, is you're providing the glasses right away, and there's instant satisfaction of the patient, or the client. When your logistics planning does not align with that, sometimes, there might be delays.

We're gathering more evidence in terms of the proportion of the different power diopters that we need to plan for. That helps in providing glasses to clients timely. There's these small lessons that are very much relevant for patient satisfaction that we have learned.

 We also have learned that we need to prioritize community health workers themselves, before we even look into the community. Because community health workers themselves, we have learned that a lot of them have near vision issues. Making sure that they are screened and given glasses before they distribute to community members is huge.

Because now they will be testaments to the value of reading glasses. When a community health worker is screening a community member wearing glasses herself, and describing her own journey, and her own experience, I think that's a powerful testimonial for community health workers. That's a lesson we've learned early on because, usually, you're focusing on community members to reach, without really focusing on community health workers. That has been a very powerful lesson. Whenever glass distribution happens now, our first clients, our first target groups are our community health workers themselves because their day-to-day job also requires near vision as well.

Rollo Romig: Tell me a bit about how you think about demand. Do people know about near-vision glasses, and are there things that you do to spread the word, or generate demand?

 **Abraham Zerihun:** Yes. Demand generation is necessary, but demand is also high. That's what we have learned. But demand generation is necessary because people do not know that these services exist. Usually, before we do screening using community health workers, we do demand generation campaigns spreading the word that, if you're struggling with near-vision glasses, you can be screened.

With near vision, you can be screened for glasses, and we have glasses available for you for free. You have to spread the word before people start coming for screening. Once you do that, we have seen that the demand is very, very high. Sometimes during the pilot, we saw that when you get the word out for people to come and get screened, so many people show up at the health post level, you actually run out of glasses.

During the pilot, we saw that we were not able to meet the demand. Because initially, from experience of other countries, we were not very sure if people were going to show up. We saw during the pilot that the demand is there. Even in younger clients where you may not expect presbyopia, there's demand for that service.

 I think the most important thing is to be sure that after you have created the demand, there is reliable supply. That is the most important problem that we have to solve for.

We have to not only give glasses in campaign mode, but in routine services. When people show up, they are available, because sometimes in these rural communities, it takes time to spread the word, and by the time the message reaches the most rural pocket of a rural community, they might walk for hours to get to the health post. If they're out of glasses, then we'll have lost the opportunity for creating that patient satisfaction we feel will drive demand for overall health services. That has been the most important lesson that we have learned in this process.

Rollo Romig: How are you spreading the word? Are you using advertisements at all? Are you using community mobilizers? Or is it a combination of things?

Abraham Zerihun: Yes, it's a combination of things. In rural areas, there are market days where people come together. We use market days a lot for mobilization. There are community health workers who do house-to-house visits. They do campaigns for immunization and for other things. We're trying to use these as opportunities for spreading the word through other diseases such as immunization campaigns, or others as well. Or market days, trying to use religious leaders, trying to use the traditional ways of influencing community members, which we have been using for other services as well.

Rollo Romig: One thing we've noticed everywhere is that word of mouth is really powerful. That if you're informing the right people, then it's just going to spread like that. Have you found that too?

Abraham Zerihun: Yes. Absolutely. There are traditional mechanisms which people use for spreading news, be it when there's a funeral, or when there might be traditional religious gatherings where people come. There are important days that the community commemorates. There are traditional leaders, religious leaders within the community who have a lot of influence. Using all that means for spreading the word has been effective. The more challenging part has been, after you spread the word, are you able to meet all the demand? That's been, I think, the most important lesson for us.

Rollo Romig: Have you encountered any kind of skepticism among community members, or even any kind of stigma around near-vision glasses that you've had to overcome?

Abraham Zerihun: No. It's not been an issue. Skepticism is more, possibly, from policymakers, or from associations. There's no skepticism we have seen from community members, or stigma related to glasses. These glasses across the country have been received really, really well.

If you see some of the interviews we had with community members, you get really powerful testimonials. There's one common question that we ask about how much they would be willing to sell their glasses for. The answer consistently is, "I'm not selling my glasses for any amount of money." It shows you how much community members value their near-vision glasses.

Rollo Romig: Wow, that's a great question. Who covers the cost of the training? Is that government, because it is part of the Health Extension Program?

 **Abraham Zerihun:** Yes. We've been trying to mobilize resources to cover the cost of the training. Like I said, the training is not only presbyopia, it's a broader integrated training with major communicable diseases and non-communicable diseases integrated, bundled together. Different funders and the Ministry of Health cover the costs of these trainings. One thing we have done successfully, for example, is have the Global Fund cover the cost of the trainings. The Global Fund focused on HIV, TB, malaria, but because we bundled HIV, TB, malaria trainings with non-communicable diseases, these funds are being used to cover.

One of the things we want to demonstrate is, if you bundle and integrate services, you can use resources committed for HIV, TB, malaria, for eye care as well. This is, we feel, one of the most powerful examples of integration and bundling of services so that you are using resources meant for other diseases to [cover more topics] integrated into the same training. This is a good example of using funds dedicated for HIV, TB, malaria, for non-communicable diseases and eye care specifically as well.

Rollo Romig: That makes a lot of sense. What kind of feedback have you been getting from the community health workers since you introduced presbyopia to the program?

 **Abraham Zerihun:** Community health workers love distribution of glasses because they're providing a valuable commodity to community members, and there's high patient satisfaction as well. Because of that, you can clearly see that this is a part of the work they really enjoy, and also improves their standing credibility in the community. It's been very satisfying for community members and community health workers as well.

In public health, I feel like we usually overlook these very simple solutions, which have a powerful impact. The problems we deal with are quite complicated, and usually, I feel like we are hardwired to look for complicated solutions as well. It's not natural for us, designing interventions in public health, to look at very simple solutions and see their impact.

That's one of the lessons I've learned from this, that a very simple device which has an impact on whether you can see an object near you, can be a solution for you to get your high blood pressure managed, or your diabetes managed, or can have a huge impact on how much you trust your community health workers, or your overall satisfaction with the health system which is near you. Near-vision glasses, which cost less than a dollar, can have a huge impact on someone's day-to-day life and their health as well.

Rollo Romig: Thank you so much, Abraham.

ICON LEGEND

Rollo Romig is the manager of Solutions Insights Lab. He is the author of I Am on the Hit List: A Journalist's Murder and the Rise of Autocracy in India, which was named a finalist for the Pulitzer Prize in General Nonfiction.

** This interview has been edited and condensed.*