“You could see them coming in droves due to word of mouth:” Damilola Oyedele and Zainab Sageera Tukur of the Clinton Health Access Initiative on integrating presbyopia into existing government and public health structures.

Rollo Romig
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Rollo Romig: Can you start by introducing yourself and your job titles at Clinton Health Access Initiative (CHAI)?

Zainab Sageera Tukur: I’m Zainab Sageera Tukur, and I work as a program manager across a few programs. I lead CHAI Nigeria’s Assistive Technology, neglected tropical diseases and integrated campaigns digitization programs.

Damilola Oyedele: I'm Damilola Oyedele, and I’m an associate on the assistive technology program.

Rollo Romig: Can you give me an overview of what you work on?

Zainab Sageera Tukur: Campaigns are large scale interventions across disease programs that are meant to supplement routine facility services or interventions. For malaria programs, we have distribution of bed nets and seasonal malaria chemoprevention. For the immunization program, we have polio, yellow fever, and measles. Then for the NTD [neglected tropical disease] campaigns, these are tropical diseases that are much less common but are treated with drug distributions in communities. Campaigns are very robust, targeted and cost-intensive. Most campaigns are still very paper-based, even our polio campaigns. You can imagine some of the data quality, data availability, and data use issues that exist as a result.

 The campaign digitization grant is a proof of concept for how we can digitize and integrate the different campaigns across all these disease programs. All of the program and population data that is collected by campaign workers will go into one repository that the entire country is able to reuse. We have chosen a tool which has been developed by a technology partner in India and we have implemented it in 2 campaigns so far to demonstrate feasibility and how it can make the campaign processes more effective and efficient.

Rollo Romig: It was great to come out to the eyeglass distribution yesterday. I think you said that in Abuja, you just started distributing last week.

Damilola Oyedele: Yes.

Rollo Romig: It seems like you're collecting a lot of great data, but it's all on paper.

 **Zainab Sageera Tukur:** Following the development of a KoboCollect tool for our campaigns program, we decided to use a similar system for the presbyopia program. It required a very lean budget, was quick to develop, and something that we could develop in-house. So we developed a data collection tool on KoboCollect and a dashboard, and this is how we're tracking distribution of the eyeglasses.

The paper collection is the first step. We're collecting simple information like names, dates of birth, screening location, their occupation, whether they have presbyopia, and the power of glasses they have received. We do this on a paper register. At the end of the day, our data collectors summarize all this data in a summary form as aggregate data. This data is then entered on the KoboCollect tool, and it automatically updates the dashboard for visibility.

Rollo Romig: How long does that usually take? When will you have all the documentation that you collected at the market yesterday in the system?

Zainab Sageera Tukur: We have the populated registers. Next step is to work on summarizing the data and hopefully it can be entered on the tool and will be on the dashboard within the next 2 days.

Rollo Romig: Anecdotally, what was your impression of how it went at the distribution you did yesterday? Were you happy with everything?

 **Damilola Oyedele:** I think it went well, considering the time and resources invested. Compared to what we did in Abaji, and considering the amount of energy and effort we put into planning. It was a little less intense in terms of planning because it was within the city. It wasn't too far away. It was much easier to set up within the market as it was very easy to get there and was relatively easy to get people to join or to be screened because they were already there at the market. We screened 652 people at the market and dispensed 582 glasses.

Zainab Sageera Tukur: What we're seeing across the board is that a venue typically has 400 to 600 people. About two weeks ago, we were at several outreaches in Kano State, and I don't think we saw more than 500 to 550 a day because even if you have different screening points, there's only so much the health care workers can do in a day.

At the market and at other outreach venues, it looked like people were leaving and returning. Sometimes the venues had 50 people waiting, but then you'd see them disperse after 30 minutes of waiting. Then around 4:00 PM, everybody comes back. One thing we could try in the future is a system where you take a number, join a queue and return.

Rollo Romig: Why do you think there was a rush at the end?

Zainab Sageera Tukur: We suspect that people return from work or their daily activities.

Rollo Romig: It seemed like yesterday morning was the most popular time to be at the market. Do you think it's because it was cooler out in the morning?

Zainab Sageera Tukur: It's definitely cooler in the morning than it is at 1:00 PM.

Damilola Oyedele: For the Abuja outreaches, the system is set up such that we have multiple screeners and each screener has a recorder or data collector set up beside them, such that the person screening only needs to screen the clients and help them test the glasses. In addition, they don't get the glasses from the screener. The screener writes the most suitable power on a piece of paper and the client heads to the pick-up point to collect their glasses. The screener will simply find out what your power is and then send you to get that. This ensures that we don't have to resupply each screening point with more glasses as the day goes by. The screener only needs one pair each of the 5 powers available [+1.00, +1.50, +2.00, +2.50, +3.00], which they use to test each person to determine the required power.

That's what we've been testing out in the different venues, and so far it's quick and it looks like it's working. I tried that in Plateau as well when I went.

Zainab Sageera Tukur: The good thing about doing fieldwork is you can improvise and course correct.

Rollo Romig: After doing this work for just a week and a half, what kinds of adjustments have you made on the spot in how you approach it?

Damilola Oyedele: Initially, we wanted to have a registration spot and then have people move in to be screened. We quickly realized that would be a bit awkward because the health care worker sees the person and asks, Have you used glasses before? Then they have to write it down and send the person back to the registration point, which wouldn't work.

The best way was having someone sit beside the health care provider to write down the answers. That way, the person who's asking the questions is not the person writing, and they can quickly screen you while asking questions.

Zainab Sageera Tukur: Another thing that we realized very early on was that these health care workers are only recently trained and are bound to be overwhelmed. So we made sure to have optometrists and ophthalmic nurses there for support and supervision. In all our outreaches in Kano, Plateau and now Abuja, we have our primary health care facility workers, community health extension workers and the nurses that we trained through our programs. Then we have optometrists and ophthalmic nurses that have been doing this for years there as well, this reinforces the learnings and acts like an on-the-job supervision.

There were some other things that I saw in Kano that could be improved, where they'd diagnose someone with presbyopia, try on the 1.0 eyeglass and the person says, "I can see," but then they don't try on the next one to see if the vision is even better.

We had to remind all the health care workers on our WhatsApp group that just because 1.0 is making reading better, it doesn't mean that it's the best. It might be better, but it is imperative that we find the appropriate power.

 Another thing that I saw in Kano was that a lot of the health care workers were not using the 40cm ropes to do distance testing. That was one of the negative impacts of introducing the optometrists and the ophthalmic nurses. They don't typically use the ropes because they are used to screening and claim that it wastes their time because they know where 40cm is. I had to flag that it doesn't matter that you're doing it all the time. You're teaching a nurse or CHEW [community health extension worker] who only started this two weeks ago to do it without a rope.

Damilola Oyedele: In Abaji, I separated the optometrists from the CHEWs. The optometrists did their screening in a separate room. The training we did in Abuja was only a peer training for maybe three to four hours, so I was a bit nervous going into Abaji that the health care workers would not know what to do. But they surprised me. I was very impressed. We did go round the HCWs to observe the screening being done and corrected any errors we saw along the way, including errors in documentation.

Zainab Sageera Tukur: Maybe the trainer was good. You see a big difference as you move from cluster to cluster according to the type of trainer and the method of the training.

Rollo Romig: What works best in the clusters that have the best results? What kind of patterns have you noticed in terms of the newly trained screeners? When they learn it well, what do you think helps?

Zainab Sageera Tukur: I thought the Bwari trainer was good. He was very engaging, cracking jokes, giving practical examples, and not just reading the slides.

Rollo Romig: At yesterday's market, there was one optometrist in each of the three tents, right?

Damilola Oyedele: There might have been more than one optometrist. We couldn't get the health care workers to be released, so it was optometrists and ophthalmologists there yesterday. We didn't have the community health care workers that we'd trained.

Rollo Romig: Why couldn't you have them yesterday?

 **Damilola Oyedele:** We typically have to pay an advocacy visit to the HOD [Head of Department] of Health for that area council in order for them to release those health care workers to be outside of work in their PHCs for a period of time. Unfortunately, for the Abuja Municipal Area Council, we were not able to visit that person because she just couldn't make time. She was not available for a meeting discussion regarding the release of the Community Health Extension Workers. Therefore, we couldn't secure the release of the health care workers.

The screenings held this week in Abuja Municipal Area Council are to ensure that we take advantage of World Glaucoma Week and screen as many people as possible. Then we'll potentially still plan to come back to AMAC after conducting outreaches in the other area councils, and aim to work with the health care workers that we trained.

Rollo Romig: Is it a bit of a challenge sometimes to get the approval that you need to reach people?

 **Damilola Oyedele:** I think just in this instance. The health care workers just came back from a strike, as well so there really wasn't enough time to engage the authorities for their release.

Zainab Sageera Tukur: When we did the training in Abuja, they were on strike.

Rollo Romig: Did they come for the training while they were on strike?

Zainab Sageera Tukur: Yes, the facilities in Abuja were already on strike. However, we were leveraging an ongoing CHAI MNH [Maternal and Newborn Health] training to conduct a three-hour presbyopia training at the end. Abuja isn't one of our program states, but since the health care workers were already doing the MNH training, they were asked to stay for three additional hours. We've done 10 states plus Abuja now. The training had already commenced before the strike action.

Rollo Romig: Were they negotiating a new contract?

Damilola Oyedele: It was around the lack of payment of salaries and hazard allowances. They don't get paid enough by the government, so they're still protesting.

Rollo Romig: I was really interested yesterday in the power of word of mouth. I arrived around 2:30, and everyone who I spoke to was saying how they heard about the distribution from other people, and that they were telling other people.

Zainab Sageera Tukur: That happens all the time. In Kano, you could see them coming in droves due to word of mouth. It was obvious that people were getting glasses, then going back home or their neighbourhoods to tell people about it. Glasses are exciting, and highly sought-after.

Rollo Romig: Why do you think it's exciting?

Zainab Sageera Tukur: When I got diagnosed with refractive error as a child, I was so excited to get glasses. I'd had headaches for weeks, and I didn't know it was my eyes. So I was happy to get it solved.

Damilola Oyedele: I think Nigerians actually like glasses. At the beginning of the program, there were some fears that there would be some stigma around wearing glasses. But we're finding that Nigerians really want to get glasses. People think they're cool. Everyone wants to get screened.

Zainab Sageera Tukur: I have two nieces who wear unmedicated glasses because it's a vibe for teenagers. They buy frames with unmedicated lenses, and wear them all the time.

Damilola Oyedele: People think that people take you more seriously when you wear glasses.

Zainab Sageera Tukur: I also think people like receiving stuff. It's one thing to say, I'll screen you for HIV or cervical cancer and send you somewhere for treatment. It's another thing to say, I'll screen you, and here are a pair of glasses, a case, and a cloth for cleaning it. It's exciting. It's like a souvenir.

Damilola Oyedele: What's also interesting is yesterday, I was at the dispensing point, and one woman came to get the glasses and asked, How much do I pay? I said, It's free. I found it interesting that people thought they might pay for it and they still came.

Rollo Romig: Everything has been free so far. Do you think you'll continue with free?

Zainab Sageera Tukur: These are public health interventions that are being funded by donors, so we can not charge people from low-income households for them. For now, it is free.

Rollo Romig: In some other places we're looking at, it's a very different model. It's in the pharmacies, so it's entrepreneurial, and they're often subsidized.

 **Zainab Sageera Tukur:** For the second phase, we are proposing to explore distribution in the private sector through the PPMVs [patent and proprietary medicine vendors]. These are the small "chemists" that you see everywhere.

 **Damilola Oyedele:** There are conversations around how people value things that they pay for more than things that are given to them for free. Even if it's a bit subsidized, and you pay ₦500 Naira ($0.30 USD). But there's the question of how you regulate the pricing.

Zainab Sageera Tukur: We don't have stringent regulatory processes or associations that exist in the country. If the glasses are meant to be ₦500 Naira across stores, what is going to happen when someone in a remote LGA [local government areas] somewhere is going to sell them for ₦5,000 Naira ($3.10 USD). It will be difficult to regulate.

Damilola Oyedele: If it's PPMVs that you're already working with, you can regulate them.

Zainab Sageera Tukur: The issue then is if you want to scale up, how are you going to regulate?

Damilola Oyedele: We'll have to do the regulatory work. I know the malaria program has done some similar work with Rapid Malaria tests and the ACTs. We might need to discuss strategies with them.

Rollo Romig: It'll be interesting when and if a paid component is introduced. I know Maisha Meds is going to come in with a pharmacy model at some point in Nigeria.

 **Zainab Sageera Tukur:** I think at a small scale, it can work. You can work with the Pharmacy Council of Nigeria or the PPMV Association and choose pharmacies and PPMVs that we've worked with in the past to implement the model. But when it's time to scale up to the entire country, how do you regulate it?

Rollo Romig: If there's one program where it's paid, and then another where it's free, there will be tensions, yes?

Zainab Sageera Tukur: We might have to transition completely to paid or subsidised programs, most likely.

Rollo Romig: Where can reading glasses be purchased now? Pharmacies?

Damilola Oyedele: Optometrists, markets, maybe some pharmacies stock them, but those would be more high-end. Some people coming into the outreaches or the facilities are people

that need to change glasses they've bought previously, usually from optometrists. But I've never heard someone say they bought glasses in a pharmacy.

Zainab Sageera Tukur: I don't think the PPMVs are stocking them.

Rollo Romig: Back to the power of word-of-mouth. When you're in a busy marketplace in the middle of the city, that power is easy to see; it becomes exponential. Does the same thing happen when you're in a less populated place?

Damilola Oyedele: Yes. Last week, when we were in a facility in Abaji, the first day we saw 570 people, and then by the next day, we had 967 people who wanted screenings.

Zainab Sageera Tukur: I was shocked in Kano by the numbers. The community engagement focal person said that distributing 50,000 glasses was going to be a piece of cake, because Kano is very highly populated. Within 2-3 days, we had about 10,000 on the dashboard.

Rollo Romig: Do you think it's a word-of-mouth thing?

 **Zainab Sageera Tukur:** Community engagement and mobilisation play a big role. The community engagement focal persons are government staff who have mobilizers and volunteers that work with them. They were running around and mobilising people all day. When it was time for prayer and people were congregating for prayers, the Imam announced that people over 40 could get screened outside and get glasses for free. People listen to radio as well, but word of mouth is more powerful.

Rollo Romig: Are you also doing radio spots?

Zainab Sageera Tukur: We haven't done that yet. We thought of it as a strategy at the beginning. But, how many people listen to radios anymore? Maybe people who live in rural areas, or people who drive cars.

Rollo Romig: Even in the car, people are often playing things from their phone.

 **Zainab Sageera Tukur:** I think that's what's happening. Doing radio jingles has always been the traditional method, but I don't think people listen to radio as much as they used to do. Drivers and older Nigerians who listen to radio programs like BBC Hausa service or news programs still listen to radio.

Rollo Romig: That's your target demographic.

Damilola Oyedele: I think we'll get an idea if radio jingles are effective because Dr. Okolo mentioned screening spots yesterday, and this morning she sent me something from the radio.

Zainab Sageera Tukur: It would be very difficult to measure [the impact] because you don't know whether people have heard it on the radio, unless you ask directly, where did you hear about this distribution?

Rollo Romig: Are you asking people how they heard about it on the intake form?

Zainab Sageera Tukur: We're not. Maybe through the Appleseed research because with that, we're trying to understand the barriers and the motivations for accessing care.

Rollo Romig: Tell me about the community mobilizers. What exactly do they do?

Damilola Oyedele: They're pretty much going into the community. They already exist for other programs.

Zainab Sageera Tukur: Yes, they are existing government staff.

 **Damilola Oyedele:** The expectation is that [community mobilisers] already have connections and networks within the communities. They're people that the community members already identify with and know well. They can then go into communities and let people know, This service is available in so-and-so place from now until whenever. It gets the information out there.

 **Zainab Sageera Tukur:** They're domiciled in local government areas under the Ministry of Health. The Ministry of Health in every state will have community health educators, community mobilizers, and community volunteers. These mobilizers and volunteers live in the communities, they know exactly where to go and who to reach. However, they are paid stipends for mobilizing.

Damilola Oyedele: They know the communities well enough that they can tell you this is a good spot to have an outreach, for instance.

Zainab Sageera Tukur: You use them to determine your venues. In Kano, after the first meeting with them, they said they were going back into their communities and would get back to us with venues. They told us which mosques and communities to visit. They also had relationships with the Imams, so they would call certain Imams and have them make announcements about outreaches during prayers.

It's an entire structure that already exists. One of the lead community engagements focal persons was saying, “We do this every week. It's the same approach. It's nothing new to us. We're very good at doing these things.”

Rollo Romig: The training is in English, but then they're doing their outreach in multiple languages. Were some of them out yesterday morning with microphones in the market?

Damilola Oyedele: Yes. They had megaphones. The ones we had yesterday were from the FCT [Federal Capital Territory] Public Health Department because Dr. Goodluck [FCT Eye Health focal person] had said that the Public Health Department has a health promotion unit and they had some megaphones. They were using them to say, “There’s screening going on here. You can get glasses.”

Rollo Romig: What languages were they using in the market?

Zainab Sageera Tukur: Hausa and Pidgin. To be honest, if you speak Pidgin in Abuja, you're good. But it depends on where you go. If you go to Kano, you're not going to speak Pidgin but Hausa. In Lagos, it will be Pidgin and Yoruba.

Rollo Romig: Did that seem to help? Could you feel the effect of when they went around with the megaphones?

Damilola Oyedele: I think that was why we had a big crowd in the morning.

Zainab Sageera Tukur: It might be better if we used the megaphone at strategic points in the day. Maybe we do one announcement with the megaphone in the morning and one in the afternoon, for instance?

Damilola Oyedele: That could potentially work.

Rollo Romig: Are they going to be out for the distribution tomorrow morning?

Damilola Oyedele: I think they will be. Tomorrow is within the FCT [Federal Capital Territory] Public Health Department. It’s a more controlled environment, with mostly government staff. The health promotion officers will be there tomorrow, but I am not expecting too many people as it’s only the civil service.

Zainab Sageera Tukur: I think it depends on how many civil servants they have because it's the age group as well as people who read a lot.

Damilola Oyedele: I think all of the civil service people will come, I just don't think that there are a lot. There cannot be more than 700 people in that building.

Zainab Sageera Tukur: I think you will be shocked that numbers in the rural areas might be more than the Abuja numbers.

Damilola Oyedele: Oh no, I wouldn't be shocked. I would expect that.

Zainab Sageera Tukur: Why do you expect it? Is it that people in the cities are just out and about and have other things to do?

Damilola Oyedele: That, and people are more educated. That's also why we don't have a lot of numbers in Lagos. When people are educated, they might be less likely to go for free things.

I might be wrong, because when we went to the store to pick up glasses at the FCT Medical Store, the store staff, who are also public servants, asked that we also come and conduct a screening for them in their office.

Zainab Sageera Tukur: I don't know. I thought the market yesterday would be more.

Damilola Oyedele: More than 500?

Zainab Sageera Tukur: I thought so. I was waiting to hear a thousand and something. I also think it depends on the market, maybe if it was a bigger market. There are so many people in AMAC [Abuja Municipal Area Council]. It is the city center, and densely populated.

Damilola Oyedele: That's what I think is the problem. Even within Abaji, when we went to areas of Abaji that were not very far, I think we did 500 and 700. The final day when we went to a more remote area in the area council, I think we did 989 on day one, which is not what we find in the more central areas of Abaji. Typically, we would see around 500 people on day 1.

 I think because we went really far away to a place where people don't typically have a lot of services brought to them, they were excited and eager to be screened and receive glasses. I think we'll get more people in the rural, underserved hard-to-reach areas just because they're really excited that services are being brought to their communities. They don't get services very frequently. When they do, they want to grab that opportunity.

Rollo Romig: Do you coordinate with CHAN [Christian Health Association of Nigeria] at all, or do you mostly have separate eyeglasses operations?

 **Damilola Oyedele:** It's mostly separate operations, but we work with the same donors, like RestoringVision, and we are both working with the NEHP [National Eye Health Programme], so the data tools are similar. The training materials are similar. I think we use the same trainers as well.

I know they did a presbyopia training only. Notwithstanding, that presbyopia module that was adapted from the primary eye care training curriculum and slides that we had used. So in terms of resources, we have the same resources because we're working with the NEHP. In terms of actual implementation, it's a very separate operation.

Rollo Romig: Do you coordinate at all in terms of divvying up who's working in which states?

 **Damilola Oyedele:** Yes. We're working in eight states where they're not working. They are working in Sokoto, Benue, Plateau, and Kaduna. We have two overlapping states: Kaduna and Plateau. In Kaduna, we selected LGAs where they were not going to work, so we're working in different LGAs. In Plateau, I'm not so sure. We are working with government-owned PHC

[primary health care] agencies. They mostly work with faith-based organizations and private individuals. So it's a bit different in terms of who they're working through.

Rollo Romig: Is dividing regions the main way you're coordinating?

Zainab Sageera Tukur: We also share lessons learnt and ideas.

Rollo Romig: What's a lesson that's come up that you've learned from them?

 **Zainab Sageera Tukur:** One thing that Dami flagged from the last call with them, which I wasn't on last week, was that they're using community volunteers to screen. For us, healthcare workers have competing priorities, where it is very difficult to get them out of facilities to conduct an outreach. However, CHAN has a private sector model, so they're training healthcare workers in private health facilities and using the volunteers. Whereas we always work through the government to ensure we're setting systems in place, and strengthening the existing health system.

Rollo Romig: How did you choose which states to roll out at first?

Damilola Oyedele: It was a number of things. In the past, the NEHP had done some trainings in a few states. They had done Katsina, and a few others. We wanted to build on places where they already had some structures existing.

 We also wanted to work in states where CHAI has some presence because that makes implementation easier for us. If you're bringing something new, and you already have relationships with the government, it's easier to implement. We couldn't also afford to employ new staff to work on the program in all of the states because of the lean funding, so we also had to leverage states where we had existing CHAI staff.

It was very important for the FMOH [Federal Ministry of Health and Social Welfare] that we cover all the geopolitical zones in the country. That's why you see we have faces in all six: northeast, northwest, northcentral, southeast, southwest, and south south. Those were the major factors that impacted where to begin: geopolitical representation, places where the NEHP had existing structures, and places where CHAI had existing structures. Population size also played a role in the selection process.

Rollo Romig: What's your thinking around how you'll roll out to some of these other states where you have a little less of a presence?

Damilola Oyedele: We're currently trying to plan for Phase II. We're looking at a number of states where we don't necessarily have a lot of presence. We have not selected the states yet. We'll work based on Dr. Okolo's conversation with the states, the available data, and or choose states that align with the government's priorities. She's mentioned that Jigawa State is quite

interested in doing some of this work. Niger State has also said that they are interested in being part of this.

We'll look to build on political will and interest as well as Dr. Okolo's experience working in these other states. They're doing some work with vision centers in Ondo, Lagos, and Ogun. Maybe based on what they find there, and if there's interest generated, we can potentially scale up to those areas as well. I think the factors that will come in are: political will, government priorities, and existing partnerships.

Rollo Romig: When you roll out in certain states, do other states get more interested?

Damilola Oyedele: Definitely. Even within CHAI, when we started doing the work in Katsina, I definitely got calls from people saying, Why didn't you guys come to our state? We would be interested in doing this. Not many people, but the other states definitely expressed an interest in the work and in being involved in it going forward.

Rollo Romig: How reliant is your ability to scale on Dr. Okolo's particular interest? I know the president is personally invested in this work, too. Do you ever have concerns around this being sustainable beyond this administration? How established would you need to be to make sure that this can keep going forward over a longer time period?

 **Damilola Oyedele:** Dr. Okolo is building structures. As much as possible, she tries to ensure that we're doing things that are sustainable. We're carrying the state governments along. She tries to make sure that if there's a system in place and there's a structure in place so things can still be done even if there's no presidential initiative.

 At present, although the president is very invested, I think a lot of it is still Dr. Okolo's work and our work engaging with state governments. For instance, Lagos isn't distributing as many pairs of glasses as we expected, so we've been working with the state government to troubleshoot and plan outreaches. The fact that we're working directly with the state governments to solve problems, that we're encouraging our healthcare workers to dispense, and that we're building these systems will help to ensure that the program can go on, even with a tenure change and things like that.

Rollo Romig: What was your first distribution? Can you give an overview of how you feel it's gone over these first few months? Where have you found successes and where has it been less successful than you hoped? What have been the surprises?

Zainab Sageera Tukur: Delta, which is in the riverine area of Nigeria, started in December. We conducted the training in the first week of November, and then we started distributing in the first week of December. Delta has been topping the charts since then. They distributed 12,000 pairs in December, which was actually quite good.

Damilola Oyedele: In December, we did Bayelsa, Ekiti, Plateau and Gombe.

Zainab Sageera Tukur: Because we'd done the training just before the Christmas holiday, we didn't have any distribution until the New Year. In January when we returned from the break, we did Kano, Kaduna, Katsina, and Lagos. Then Katsina and FCT [Federal Capital Territory] in February. When we returned from the Christmas holiday, those four December states also started to do well. Then we activated Kano, Kaduna, and Katsina, which are in the northern part of Nigeria and highly populated. We also have strong CHAI programs there, experienced staff, and very good relationships with the government. It's relatively easier terrain to work in. However, the numbers in Lagos are low despite Lagos being the most populous state in the country.

Rollo Romig: It's interesting how the Lagos numbers are way lower than the rest.

 **Zainab Sageera Tukur:** Some of this is because the public health terrain in Lagos State is quite different from other states in Nigeria. They have processes that are a little more complicated than most other states. It's not like in Kano, where we went on a Wednesday and said we wanted to do an outreach to distribute 50,000 pairs in the next month, and we engaged all the key stakeholders within a few days and began the outreaches within a week.

The process is a little longer in Lagos because of the different layers of approval required. Healthcare workers in Lagos also generally expect to be paid better than those in other states, because the cost of living in Lagos is higher than the states. All of these factors combined have an impact on HCW motivation, as well as speed of getting screenings conducted.

Rollo Romig: You're not having those kinds of problems here in Abuja?

 **Zainab Sageera Tukur:** No, we are not. The healthcare workers have been more easy going and willing to work, even without receiving any stipends. They continue to screen and distribute, even without receiving payments. Although paying stipends serves as an incentive and motivates them.

Rollo Romig: Is it sometimes a challenge to get the payments on time? What causes the bottleneck there?

Zainab Sageera Tukur: We've been restructuring our payment processes, which has caused it to slow down a bit so healthcare workers get paid within a month of completing an activity.

Rollo Romig: What has been your approach around paying stipends to healthcare workers? Have you made adjustments over time?

 **Zainab Sageera Tukur:** No, we only started paying stipends last week. At the beginning, the government didn't want to set a dangerous precedent where we have to pay health workers before they work because they're government staff. However, other programs are paying them.

If you begin a new program and say you're not going to pay them, then they might not prioritize your program.

Rollo Romig: You, the healthcare workers, and the mobilizers are working on so many different kinds of health problems, and a lot of those other problems are a lot more life and death than reading glasses. What's your feeling about the prioritization across all those different groups, and about getting people interested?

 **Zainab Sageera Tukur:** I don't think healthcare workers prioritize the disease programs based on life or death. The economic situation in the country is bad, so it has affected the HCWs attitude. Incentivizing the health workers seems to be a tried and trusted method to motivate them.

I doubt the motivation behind the health workers prioritizing the HIV or malaria programs is because they think a child with HIV or malaria is at a higher risk of dying—even though this is true. There's a correlation between how deadly a disease is and how well funded it will be. I believe the motivation is based on the fact that it is easier and more rewarding to work on well-funded and better structured disease programs.

We see the same even in the campaign space. The polio program is fondly called "polio eradication and poverty alleviation." We have noticed that key stakeholders are always excited about the program and regularly check when it will be implemented. The reality is that it puts money in people's pockets. Well-funded programs have the resources required to build better structures, procure what is required, and pay health workers, community workers, and key stakeholders well. Unfortunately, the resources get things done.

Rollo Romig: In terms of what you've done so far, do you feel like there are demographics that are especially well-served, or especially underserved, by this approach? Are there any groups–whether by region, religion, or age–that you feel you need to figure out how to better reach?

 **Zainab Sageera Tukur:** Civil servants. I don't think we've reached them enough. Maybe because we've prioritized PHC facilities, and civil servants are typically in more urban areas. I don't know if we've reached them enough.

The dashboard breaks down the data by gender, age, and occupation.

Rollo Romig: Your event tomorrow is targeted for civil servants, right? Are the events today through Thursday at the health ministry similar?

Damilola Oyedele: Yes. Civil servants are a high population here.

Zainab Sageera Tukur: I think overall, we're giving out more glasses to women.

Damilola Oyedele: Yes. Definitely. Women generally have better health-seeking behavior. Men seem to think PHCs are only for women and children. They think it's pregnancy, labor, delivery, and family planning.

Zainab Sageera Tukur: Even men with serious diseases don't like going to facilities, it boils down to the poorer health-seeking behaviour.

Damilola Oyedele: I have to sign off now. Thank you so much.

Rollo Romig: Thank you for your time, Dami.

Zainab, how are you thinking about security challenges from region to region as you continue to roll out?

Zainab Sageera Tukur: It depends. Security challenges do exist in some parts of the country. In places like Katsina and Kaduna, you would expect that. For instance, our state focal persons know which local government areas to avoid. We also have a security and safety officer who has to give clearance before you travel out. However, you just don't know what's going to happen. You have to take precautions. Generally, the security challenge is a bit better than it was a few years ago. People feel a bit safer. We have fewer incidents than we used to.

Rollo Romig: What kinds of incidents?

Zainab Sageera Tukur: There has been some kidnappings and banditry in the northwest part of the country. It used to be very bad. Three years ago, people were kidnapped from a train. However, this currently looks like it is on the decline. This particular case of robbery sounds more like it was just to get food, and not to cause any harm.

In Abuja, petty theft such as stealing phones is also common. With our CHAI programmatic activities, we try to avoid the security-challenged areas.

Rollo Romig: Do you travel with security or anything like that?

Zainab Sageera Tukur: No, we don't. If you're going to travel with security, it will be very expensive and draw attention. In CHAI, one of our values is frugality. Wherever possible, we try not to spend money if it's not impactful for the patient.

Rollo Romig: How has the glasses supply been? Do you feel like you're getting what you need, when you need it?

 **Zainab Sageera Tukur:** We have about 600,000 pairs in the country currently. We are just about finishing the distribution of the second tranche to health facilities. We also have 440,000 coming in by May. I do suspect we'll run out of 1.0s and 1.5s because we had an even distribution of powers for the first 600,000 pairs.

Rollo Romig: I don't know if this has come up for you, but I know in some other places there's been experimentation with only making the three most common diopters.

Zainab Sageera Tukur: We've talked about it, but the FMOH was not on board with it. They were adamant that if there's an option to do the five diopters, it is better to do the five. This is because you don't want the negative impact of someone getting 0.5 or 1.0 higher than what they need, and then they start to have headaches or they're coming back into facilities with issues.

I do understand the supply chain and logistics issues that come with using all 5 powers. Packing and sorting them by diopters at the central medical stores takes a lot of work and time. After it gets transported to the states, they get sorted and packed up again for delivery to facilities. So from a supply chain perspective, you'd want to have less options, but that results in diminished user experience.

Rollo Romig: What do you feel that you need, or that would be useful, that you don't have?

 **Zainab Sageera Tukur:** If we had designated staff in each of the 10 states, we could have done this more efficiently. Instead, we've had to pull in existing CHAI staff from other programs to support us. They also have their programmatic responsibilities that they need to prioritize, in addition to the eyeglasses distribution. If we had more manpower, it would've been easier. Even at the national level, we're quite stretched.

Rollo Romig: This is no one's only thing.

Zainab Sageera Tukur: Exactly. I always say that we should have at least 10 staff members because of the number of states and the intensity of the distribution in such a short timeframe.

Rollo Romig: What do you wish you could do that you haven't yet, or you're not able to do yet?

Zainab Sageera Tukur: To be honest, we have done our best and explored a lot of approaches. If we do not reach 240,000 by the end of March, it's not for lack of trying. The team has worked so hard to get it done, and tried to brainstorm and course correct as much as possible.

 The approach from the beginning was not to conduct outreaches at this pace. The approach was to institutionalize the distribution of eyeglasses in PHC facilities and each facility would conduct three community outreaches. However, due to the delayed training and delay in commencing the payment of stipends, we had to commence distribution via large-scale outreaches. A state like Kano has distributed more glasses through outreaches than in facilities.

We have also been integrating the distribution into our existing CHAI programs. In Kano for instance, we've integrated it into our vaccines program where they're trying to understand the

drivers for women not getting their children immunized. We're using the glasses as an incentive for mothers or other caregivers to get their children vaccinated.

 We also saw an opportunity to integrate a 3-hour Presbyopia training in a CHAI training for Maternal and Newborn Health. This allowed us to increase our pool of healthcare workers in a cost-effective manner.

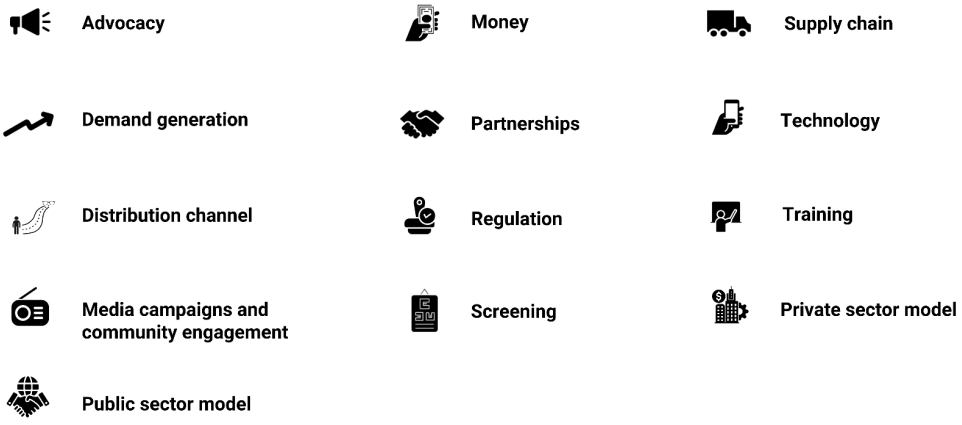
 We are trying to do innovative things in order to meet our targets. Eventually, we'll revert back to our original approach of institutionalized distribution in PHC facilities, which is a more sustainable approach.

Rollo Romig: It's a tough balance because this outreach approach seems very nimble and flexible, and it's getting results.

Zainab Sageera Tukur: Yes, but it's not sustainable. It is feasible as a one-off campaign. However, we need to ensure that PHC facilities are institutionalizing screening for presbyopia and distribution of eyeglasses.

Rollo Romig: Thanks so much for taking the time to talk.

ICON LEGEND



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** This interview has been edited and condensed.*