“Integrating into primary healthcare helps to build some level of sustainability for the program going forward:” Dr. Oteri Okolo

Rollo Romig
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Rollo Romig: Can you start by introducing yourself and the work you do?

Dr. Oteri Okolo: My name is Dr. Oteri Okolo, and I am the Coordinator of the National Eye Health Program at the Federal Ministry of Health and Social Welfare in Abuja.

Rollo Romig: Were you happy with the eyeglass distribution event on Monday? It seems like a lot to coordinate.

Dr. Oteri Okolo: Yes, considering all we have to do and within the time frame.

Rollo Romig: It seems like the screening downstairs is very popular, and there’s a lot of demand.

Dr. Oteri Okolo: Yes. It's a big opportunity for them to get a free pair. We also raised awareness on all media platforms about the screening.

Rollo Romig: What are your thoughts on pricing going forward, for the long term? Do you think you'll mostly stick to a free model for distribution? I know Maisha Meds is going to be coming in with a pharmacy model.

Dr. Oteri Okolo: In the past, we only used to give them for free during events like these distributions**.** This presidential initiative is the first time we're doing it at a population level, hopefully all over the country. This is the larger scale.

We hope this creates patient awareness and understanding about their need for glasses because after the first pair they hopefully can see the difference between not having a pair and then having a pair. Once they know that a pair of glasses can solve their near vision and near task needs, and those glasses will most likely last two years at best, they will need another pair. Some who we distributed to in 2023 will already need another pair this year. We're not going to give you a second pair free of charge. They will need to pay for that second pair.

Rollo Romig: What are your thoughts on subsidies for second pairs?

Dr. Oteri Okolo: Subsidies are a great idea. We're testing out a model at vision centers. We have three vision centers already working with OneSight EssilorLuxottica, where the glasses are not free but subsidized.

Rollo Romig: Where are those vision centers?

Dr. Oteri Okolo: They're in Idanre in Ondo State, in Ijebu Ode in Ogun State, and Alimosho in Lagos. They are all located in secondary health facilities.

Rollo Romig: Why did you choose those places for that program?

Dr. Oteri Okolo: We chose Lagos because Lagos has a large population of people, so there are bigger vision needs. Ondo state is not part of the initial 10 states we are working on, so as some form of equity, we're moving the two remaining vision centers to areas where we are not implementing the population-level interventions.

They're within secondary-level facilities. We worked with EssilorLuxottica, who renovated a space given to us by the hospital and provided equipment for refractions. Now, we're not only giving reading glasses in those places, we're giving all kinds of glasses, including prescription glasses tailored to each patient's specific refractive needs. They're not free, so people are going to pay something, but it's somewhat subsidized, so it's cheaper than what they would normally get.

Rollo Romig: What would you say are the advantages and disadvantages of Nigeria's health and bureaucratic government systems? What are the ways in which it's easy to do this work here, and what are the barriers, or the regulatory difficulties?

Dr. Oteri Okolo: Because we're the National Eye Health Program, we don't really have regulatory difficulties, because we implement our programs according to our own guidelines. That's an advantage. We already know our regulations, our policies, and our guidelines, and we understand how to implement them.

The structure of the health system in Nigeria can be a disadvantage because it's decentralized. You have healthcare at the federal level, where I am, and you also have another structure at the state level, then another structure at the local government level. You have to carry everyone at all of those levels along with you. You have to make them understand what you're doing. You have to make them buy into what you're doing and actually follow guidelines for implementation.

For instance, we've taken spectacles to some states, and they keep them and say, we want to use them for this other purpose, or we want to do a ceremony. Sometimes we use a carrot and stick approach to say, “If this is the way the federal government structured it, then you have to do it.” Other times we try to be a bit flexible to ensure that whatever we're implementing fits into their programs and activities. The fact that the health system is decentralized in that way means we have to wait for everyone to be aligned along all those levels.

An advantage of being on the federal level is that you have some level of authority to say, “This is the way the federal government wants implementation.” The fact that the president's name is on the intervention is a big advantage. It opens the door easily at all levels.

Rollo Romig: What do you think needs to be in place to keep the eyeglass program moving forward in subsequent administrations, when there might be a different president? What evidence is necessary to show that it will automatically continue?

Dr. Oteri Okolo: We're collecting data. Data is very powerful. We're also collecting stories. We have some patient testimonies.

A seamstress came in and picked her glasses, then we sent a team to her shop and saw firsthand the difference that one pair of glasses made. She could thread her needle, which she’d needed someone else to do before she had the glasses. Threading your needle on your sewing machine is near work, and she was already over 40, so that means she has presbyopia. You needed to see her face, to see her, Wow. It was drastic. For the first time in a long while, she could see clearly enough to thread that needle. That's a compelling testimony that I feel can convince anyone of the importance of having glasses.

The data is able to tell the story. That's why we're big on ensuring that we not only dispense the glasses, but we collect data. If you looked closely at what was happening downstairs, you could see how much data we were collecting. We need to demonstrate who is picking up the glasses, then get stories of the impact.

Rollo Romig: When you collect stories like that, are you taking video?

Dr. Oteri Okolo: We have some on video, like the tailor story. We have an elderly grandfather who talked about how he needed to ask his children to send messages for him, but now, he can do it himself. Things like that. We have a few videos like that, but we don't always have videos because you have to pay someone to get the videos. However, the data is all there.

Rollo Romig: Yesterday, I was talking to folks from both CHAN [Christian Health Association of Nigeria] and CHAI. What's your thought on how they are dividing up the states? What's your strategy there?

Dr. Oteri Okolo: We planned this implementation. We discussed the states. First, the National Eye Health Program and CHAI picked ten states. Then CHAN decided to leverage where they already have existing programs and existing manpower. For now, they're implementing in four states, working within specific local governments. I had a discussion with them this morning, and they're doing really well. They've distributed over 80,000 pairs in about four weeks. They also complained that their model is more expensive.

Rollo Romig: Is it?

Dr. Oteri Okolo: Probably, because they have to pay their volunteers every day of those four weeks, and they have to pay them a full salary or a full stipend of some sort. If it’s a primary healthcare worker, you either pay nothing or give them a stipend.

Rollo Romig: Because they're already getting paid.

Dr. Oteri Okolo: Yes.

Rollo Romig: Is that the main reason why it's more expensive, or are there other reasons?

 **Dr. Oteri Okolo:** They're also going to very hard-to-reach areas. They have the capacity to be able to go there. They have structures in place, and they have already been offering one service or another in those areas. They've even been able to get into areas that have security problems. Whereas for us and for CHAI, we train the primary healthcare workers and leave them to dispense. We leave the glasses with the primary healthcare workers, but CHAN is there on the field. They have volunteers, and they're able to get to very hard-to-reach places.

Rollo Romig: Has that been their focus? They seem to have a lot of expertise with these difficult places.

 **Dr. Oteri Okolo:** Yes, they do. They're also using religious structures, so churches and mosques, [to reach the population]. I think that that's a very good model, too.

Rollo Romig: Using religious leaders as mobilizers is interesting. I know mobilizers are used here in the city too, but they're not religious mobilizers. What, to you, is the difference between the religious and the non-religious approach?

Dr. Oteri Okolo: CHAN is a faith-based organization. They're Christian, but they have partnerships with the Muslims, which are the two major religions in this country.

Religion is very important to people in Nigeria. Once a religious leader approves of something, people are more likely to assess it, or the uptake is more likely because their religious leaders have approved it. That approach also breaks the barrier of religion. Working with religious leaders is a strong point for CHAN.

Using the primary-level healthcare system, which we're doing, is also important because it's closer to the people we are targeting. These are people who ordinarily don't have a pair of glasses, probably never had a pair of glasses, or cannot afford a pair of glasses. Beyond that, we're also training primary healthcare workers, which means we're building a pool of workers with the skill to continually dispense spectacles.

Rollo Romig: How do you feel about how the trainings are going? What have been the challenges with training community health workers?

Dr. Oteri Okolo: In the states, we have what we call senatorial zones, and each state has three senatorial zones, but the distance within those senatorial zones can be a challenge. Sometimes, primary healthcare workers arrive late for training, especially on the first days. Some don't get to a 9:00 training until 12:00.

 We had already shortened the training from three to two days, which means we lost some hours of training. That was a challenge in some of the places, but in the end, we found out that this was something they learned easily, and so far, they've been implementing it well.

 What the training has also helped us do is integrate primary eye care, of which dispensing glasses for presbyopia is an important part, into the primary healthcare system. This ensures that after this initiative ends, the primary system can remain a source for reading glasses. Integrating into primary healthcare helps to build some level of sustainability for the program going forward.

Rollo Romig: The folks at CHAN were telling me that people don't need much convincing to get reading glasses. They're already interested and just need to hear about it. What's your experience with that? Do you find any stigmas associated with glasses, or is it something people generally have a positive perspective on?

Dr. Oteri Okolo: In a country like Nigeria, the stigma associated with wearing glasses is mainly for younger people. When people start getting older, they feel like a pair of glasses is justified. However, when they have to get a pair of glasses for their kids, they start getting worried that once you start wearing glasses, you're never going to stop wearing glasses. You're going to wear glasses until you die.

Additionally, people feel that if you have to change your glasses every two years, it means your eyes are getting worse. That's okay if you're older, but not if you're a child. There's a misconception that wearing glasses will make a child's eyes start to go bad at an early age. Often, with children, it's not presbyopia. A child can have refractive error and need glasses. However, most parents are very reluctant.

Rollo Romig: Glasses do seem trendier now than they were in the past though. Is that true in Nigeria?

Dr. Oteri Okolo: It is. Now, some people wear glasses just as fashion items. But there's another misconception that when you wear glasses, they work like a drug.

Rollo Romig: What do you mean by that?

Dr. Oteri Okolo: If you wear them, after a while, they will correct the eye, and then you can stop wearing them. That would be nice, but that's obviously not the case.

Rollo Romig: Glasses are just supplementing or correcting.

Dr. Oteri Okolo: Correcting is a confusing term for people in Nigeria. As an eye health professional, I understand what correcting refractive error is like, but using that same word when you're speaking to a patient is confusing. They'll come in two weeks later and ask you, Why is my problem not corrected? I stopped wearing the glasses, and I'm still unable to see.

Rollo Romig: Can anyone be trained to screen for presbyopia in Nigeria, no credentials necessary?

Dr. Oteri Okolo: Yes. We're testing out that model with CHAN, and so far, it's working well.

Rollo Romig: CHAN is training people who aren't even community healthcare workers, right? Just community members.

 **Dr. Oteri Okolo:** Yes. I had a discussion with them. I think the only barrier with that is the cost because they don't have a salary like primary healthcare workers, so it's more expensive. If you had the money to train non-healthcare workers, I think you'd have more reach, because that's all they'll do all day. Primary healthcare workers have to do immunizations, treat diarrhea, and then do glasses. Someone who has been trained, and who's going to be paid for the period of time, is focused only on that.

Rollo Romig: In terms of training community healthcare workers this past month, while the projects have been running, have you made any adjustments to your approach, or to the trainings? How have you changed things after seeing how things work?

 **Dr. Oteri Okolo:** Before we started this particular program, we were already training primary healthcare workers; we just didn't have glasses to give to them. We had already learned some things about training them, which we corrected ahead of implementation.

We reviewed the training model before we started this implementation. We changed some things, simplified some things. We reviewed the training kits. They have a kit that has a visual acuity chart. All of that was reviewed ahead of this implementation, so most changes happened at the beginning because we had done it before without glasses. Now we have the glasses, which makes the training more effective.

Does training someone to do something without actually giving them the tools they need make them feel like the training is worth it? Now, you give them the glasses immediately

after the training, and they're able to start dispensing. I think they feel like it's more rewarding to practice immediately after the training.

Rollo Romig: That immediate result, that instant gratification, is the beauty of reading glasses.

Dr. Oteri Okolo: Yes. When we were in one of the very first states, we noticed that there was a long queue, so I went to the primary healthcare worker and asked, “Why are you so slow?” She told me couldn't see the register. At that point, we realized that even the primary healthcare workers needed prescription glasses.

 One thing we’ve changed from the first time we did the implementation in 2023 is that on the last day of the training, we do a pair-to-pair reflection, so those who need a pair of glasses get their glasses immediately because if they don't, they won’t be as effective. They will take too long to dispense glasses and to collect data because they can't see, and they don't have glasses. So on the last day of training, they do a screening, and they get their own glasses. Then, when they go into the field, they can see. I think in this whole implementation, that has been the most surprising and most significant learning.

Rollo Romig: Have there been any other unanticipated challenges in these pilots, or assumptions you've had about how something would work that maybe turned out differently?

Dr. Oteri Okolo: In some states, at the health system level, they want to stop dispensing glasses at particular times of the year. For instance, in the northern states, they want to stop dispensing during Ramadan, while they are fasting. We did not anticipate that.

Rollo Romig: Why?

Dr. Oteri Okolo: I don't know. I had to call them and tell them to start dispensing again. The test is not difficult. It's not something that will affect someone who's fasting, so it shouldn't be a reason not to go ahead.

The challenges in Lagos have also been surprising because I assumed at the beginning that the numbers would be there simply because it's the most populous state in Nigeria. Then, it ended up not being as easy as we thought it would be.

Rollo Romig: I was talking with Damilola and Zainab at Clinton Health Access Initiative (CHAI) yesterday, and they said that of all the places where they've

distributed, Lagos was the hardest and least cooperative. Why do you think that is?

Dr. Oteri Okolo: Lagos is a richer state. Most people doing public health interventions go to Lagos State because they're looking at the population. I've learned that population does not necessarily mean that your program will be easier to implement, or that it'll be easier to get out the numbers. But a lot of people go there to provide health interventions.

We have learned that the fact that a state is big doesn't mean [the numbers will be high.] You have to look at other factors, like the fact that they have major private sector coverage in Lagos.

Rollo Romig: Is Lagos a destination for medical care?

Dr. Oteri Okolo: Yes. Unless you are going to target the very rural parts of Lagos. I don't know that those more rural areas are easy to get to from Lagos.

Rollo Romig: Do you mean the roads are tough, or is it a safety concern?

 **Dr. Oteri Okolo:** It's a structural thing, from what I've seen, and it has to do with the state health system. They have a lot of partners, and they have a lot of interventions and programs, so to fit in yours is usually not so easy. They have so much going on already. We almost had to postpone in Lagos because they had an immunization program going on. We normally spend five days in other states, but in Lagos, we only had two days.

 **Rollo Romig: How is supply going for you? Are you getting the right glasses at the right time so far, or is it sometimes behind?**

Dr. Oteri Okolo: So far so good. However, CHAN is now saying that most of the people to whom they have dispensed are between 40 and 50, and they have run out of the plus ones and plus twos. They have ordered another set to come in, but they have more or less run out of those powers. From the data I saw for CHAI initially, that was also the case.

Since the power you use largely depends on your age with presbyopia, I'm wondering if the more elderly people are less likely to come out to screenings.

Rollo Romig: Why do you think they're not coming out?

Dr. Oteri Okolo: They're older, so maybe they have other comorbidities.

Rollo Romig: In some places they've considered limiting the supply to just three different diopters, the most common ones, to make the supply easier. Do you think it would make sense to have a smaller number of diopters available, or do you need the full range?

 **Dr. Oteri Okolo:** I would prefer the full range, because if you have only three diopters, that means you might not be correcting the person properly. For instance, many people want to use their reading glasses to read the Bible or Quran, and most of all Bibles and Quran have very tiny prints. If you don't solve that problem, they will think that you haven't helped them.

Rollo Romig: If you were to talk to a counterpart in another country, someone else who was the head of their national eye health program and was starting from scratch with a program like this, what kind of advice would you give them?

 **Dr. Oteri Okolo:** I'd advise to have a mixed model like we have now. The primary care level is the more sustainable model. That can remain a pathway for dispensing of glasses beyond the time of implementation. Then, to get more numbers and reach more people, you might need to use volunteers, like CHAN is doing.

 For any country or national eye health coordinator to do this kind of intervention, they need to get a powerful voice behind it. Once you have a powerful voice behind that intervention, even if the person is not there, it opens the door, and the likelihood of success is higher.

The coordinator also needs to be able to monitor what's going on wherever implementation is happening, and they need to be willing to learn quickly on the job while implementing so they can make changes as necessary. For instance, we have state desk officers. My counterparts are on the ground in the states, but I'm not in the states. I can only communicate with them by phone or on visits.

You need to work with the people where the implementation will take place because apart from this screening particular screening for this week, the implementation is not taking place at the federal level. It's taking place in the states.

You need to ensure you have a structure at that level to monitor what's going on and ensure that they're dispensing, because it's the state desk officers who call me to say they've stopped dispensing. I give the instructions to continue. You need to have a structure in place for whatever level the dispensing or implementation is happening that helps you implement and that helps you monitor what is going on.

Rollo Romig: Can you say a bit more about the mixed model approach you have for different geographies?

 **Dr. Oteri Okolo:** Primary healthcare workers may not be able to go to hard-to-reach areas, so you might have to train members of the community in those places, or to have volunteers who are able to go there to do the dispensing.

Rollo Romig: In some of those places, there's a challenge to get any kind of healthcare at all. You can't expect that health infrastructure to be in place, but you can piggyback on other things, right?

 **Dr. Oteri Okolo:** Exactly. Countries also need to look at their specific health model. For instance, if they have a model different from Nigeria's model, they can look at their own model and use the existing structures and design their programs around what already exists. We're designing our structure mainly around the states and the primary healthcare level, which is local government here, because that is the way the health system is structured in Nigeria.

Rollo Romig: How do you stay in sync with CHAI and CHAN? How do you keep those relationships working?

Dr. Oteri Okolo: We're on the phone almost all the time. We have meetings. For instance, CHAN was here this morning. They'd briefed me before they came, and had already sent emails telling me what's going on on the field. Then, when they went to implement, some members of my team went with them to provide supportive supervision and ensure the volunteers were doing the correct thing.

Rollo Romig: What did you learn in the meeting today?

Dr. Oteri Okolo: We learned about their challenges on the field. The fact that it's expensive. Initially, I thought it was a cheaper model, but by the time he explained, I understood why it's expensive.

 We also discussed some security issues that they're having in one place where they're implementing. They can't do long hours because it's not safe to get there too early and they have to leave quite early, by 2:00 PM, so they can travel back on the roads in the daylight hours. They don't have the full day to be able to do the glasses dispensing because of these security challenges.

Rollo Romig: So far, do you feel like you're hitting all the various demographics that you want to hit in terms of gender, religion, age, geography? Are there groups that you feel are still underserved, to whom you'd like to provide better access?

Dr. Oteri Okolo: Elderly people. Then, there are still some areas that don't have primary healthcare centers, that I feel we're not reaching. For instance, we went to Kogi last year, and while we were traveling back to Abuja, we stopped at a village and asked around if there was a place we could dispense because we had some glasses in the car. There was no primary healthcare center where we could dispense, so we had to set up in the markets. We ran out of glasses.

A number of those villages that are deep within the country still don't have primary healthcare centers. I'd like to do some kind of targeted outreach program for those locations. It could be to set up shop in a village center, or bring primary healthcare workers or volunteers in to serve those populations.

Rollo Romig: How do these communities that don't have a healthcare center get healthcare?

Dr. Oteri Okolo: They have to travel. And they will only travel for life threatening stuff, not for glasses.

Rollo Romig: Is that because it's expensive to travel?

Dr. Oteri Okolo: Yes.

Rollo Romig: What's your thinking right now about how to roll out to the remaining states?

Dr. Oteri Okolo: We've covered ten states. We've done all the trainings, dispensing is happening. I think the other part of the implementation that is needed is for us to go back sometime soon to physically see what is going on, to see how primary healthcare workers are dispensing to be sure that they're doing the right thing, and to reengage the state government. You need to keep these people engaged to ensure that on their end, they're also doing the correct thing.

 When the glasses come into the country, they're kept at the central store in Lagos. That store belongs to the Federal Ministry of Health. From the Federal Ministry of Health store, we move the glasses to the state store. From the state store, we move them to the primary healthcare system stores, from where they're distributed to primary

healthcare centers. We have experienced some challenges in that regard in some of the states.

When we go back, we will iron out all the issues, engage them again, let them understand why we cannot interrupt distribution and why the supply chain needs to be maintained at all times.

Rollo Romig: Maisha Meds is going to come in with a more pharmacy-based model, right?

Dr. Oteri Okolo: Yes. They came here last year to discuss it, and then they're putting forward a proposal to LIF [Livelihood Impact Fund]. It's still in the early stages.

Rollo Romig: What's your thinking in terms of a timeline for rolling out to all the rest of the states?

Dr. Oteri Okolo: The only reason why we're not rolling out in the remaining 26 Nigerian states is funding. That's what we're waiting on. Otherwise, we're good to go any day, anytime.

Rollo Romig: As you're rolling out in these initial states, are the states that you haven't reached yet getting interested? Are they asking why you haven't come there?

Dr. Oteri Okolo: Yes. We have a WhatsApp group for desk officers from the states, and they're asking about it. The desk officers in states where we have implemented share their pictures of implementation, and the others ask, "Why are you not coming to our states?" We have significant pressure from desk officers in other states. When are you coming? When are you coming?

Rollo Romig: You're trying all these different models: the CHAI model, the CHAN model, and soon, the Maisha Meds model. Are there any models or approaches that you're *not* doing, and that you've chosen not to do, and if so, why?

Dr. Oteri Okolo: At the beginning of this implementation, we never intended to use optometrists, but in Abuja, we're using optometrists. We wanted to push out more glasses, more quickly. I'm not sure if they're actually faster, though. We're using opticians to help us dispense, as well.

Rollo Romig: Is there anything that we haven't talked about that you'd like to add?

Dr. Oteri Okolo: Only that I wish we had started implementation earlier. The national eye health program was ready to go, but we needed CHAI for the funding to get started,

we needed structures to be in place. Implementation started at the end of October, but I wish we had started immediately, as soon as the funds were released, back in May. If we had, we would have much better numbers, big big numbers, by now.

The contract period for this first level of funding has almost elapsed. It's a one-year contract, so even though the funds were released in May, we only started implementation in late October, early November. Some states didn't even start until January because we had to physically go to all ten states, and we were traveling back to back to do trainings and figure out the logistics of moving the glasses. Now that we have these structures in place, we won't have any problem going forward. We've already moved a second batch of glasses to the states, and they're free to start dispensing those.

Otherwise, for me, so far so good. For the time we have spent implementing, 160,000 is a very good number.

Rollo Romig: Thank you so much for your time and your insights.

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.*