"Without capacitating our local level health facilities like health centers, you can't reach to communities who are far from the big health facilities. Making the community health program stronger is essential.": Israel Ataro, of the Ministry of Health, on advocacy, resource mobilization, and integrating presbyopia into the Health Extension Program.

Rollo Romig
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Rollo Romig: Could you start off by introducing yourself, and tell me your role in the eyeglasses program?

Israel Ataro: My name is Israel Ataro. I work in the Ministry of Health. I'm leading primary health care and community engagement, which includes health center services, and our community health program, what we call Health Extension Program, as well. Professionally, I am a public health specialist, and my position in the Ministry is lead executive officer of primary healthcare in the community.

Rollo Romig: Tell me about the decision to add presbyopia services to what the health extension workers are doing. What do you think it was that convinced the government to add that?

Israel Ataro: Our government has a big commitment to expand primary healthcare services, especially to hard-to-reach areas. This is supported by policy and strategy to reach out

to people who are too far from health centers and hospitals but still need health care to reach them. The country designed this health extension program more than 20 years ago. The health extension workers are selected from the community, and they are trained in an organized way, in a well-designed curriculum. They graduate at the diploma level, and they are deployed to every village of the country. Their number is more than 43,000, and they're working with the community.

 Then the country planned to build their capacity, to update their knowledge, and also to support their activity. We designed 18 health extension packages they are trained in, and they provide these packages to the community. We also designed integrated refreshment training periodically to update those health extension workers. We have well-designed modules. Around six modules are in practice currently. The communicable and non-communicable disease modules are among the refreshment training parts.

 We started with the support of Last Mile Health to work together to cascade this training to health extension workers. They are expected to screen, they are expected to teach and communicate and solve the problems of the community, and also link the problems beyond their capacity to the health facilities.

Together with Last Mile Health, we planned to pilot this presbyopia screening program to ensure the feasibility of the screening and the distribution of the eyeglasses, and we learned from our pilot that it's very, very important, in every successful story we got. Then we planned to scale up this screening program as well as the provision of these eyeglasses to those who have a problem with short-sight and near-vision. This is part of our previously created and designed program of refreshment training.

Rollo Romig: The eyeglasses program is a little bit different from some of the things that the health extension workers do, because they're actually giving people a commodity, and there are all these logistics that go along with that. Did it take some convincing that they should add on these extra responsibilities, including dealing with merchandise? Was there any skepticism in the department about this?

 **Israel Ataro:** The provision of this commodity is a different approach. Screening also needs some skill. We saw that after their training, they easily differentiate the problems, and most of the cases were reconfirmed by ophthalmologists. That made us more confident to communicate and to work together with our stakeholders. Providing these eyeglasses freely for the community is encouraging them to come to screen for other non-communicable diseases as well.

Some of them are very happy. Because of their difficulty with near vision, their daily life has been affected. Some of them are teachers. Some of them are getting their livelihood by sewing. Some of them are farmers. Some of them are religious leaders. They expect to read and teach their followers, but after some years, it becomes difficult to teach and to read and to work. This made the community very excited to work together with health extension workers. As a government we are also happy to address this problem, and we are thankful for our stakeholders, Livelihood Impact Fund, as well as Last Mile Health.

Rollo Romig: Earlier, you were telling me about some of the impact that you heard about from the Sidama region. Could you tell me more about some of the things that you heard about the benefits that the glasses have had for people there?

Israel Ataro: Among the community members, some of them were teachers, some of them were farmers, some of them were religious leaders, some of them were using sewing machines. When they face these difficulties, they cannot work independently. Because of that, they become so desperate, and they don't want to communicate even with their family or their neighbors. Their dignity comes under question, they told me. This is a big problem for our community. This is directly linked with their age, but they don't have awareness to understand this problem. When they get support from the health extension workers, they're excited, and they are very happy. They take responsibility to mobilize the other community members as well. This is what we have from different regions, Sidama, Dire Dawa, and other regions as well.

Rollo Romig: They're hearing about it from the community health workers, but it sounds like there's also a lot of word of mouth, where people in the community are now telling other people in the community about it.

Israel Ataro: Right. This is a lived experience among the community. They're waiting. We've addressed more than 74,000 by providing these eyeglasses, but the bigger number of community members are waiting. We are discussing strengthening our collaboration and mobilization. We have more than 43,000 health extension workers. Among them, 17,000 are trained and they are capable to provide and to work to support our community.

 It is a big program, and we call our stakeholders to work together with us to capacitate more of our health extension workers to identify these problems—not only vision problems but also other non-communicable diseases, like hypertension, diabetes, and other easily detectable problems.

Rollo Romig: The project is scaling quickly. It's right on target, but then, as you mentioned, there are such bigger numbers awaiting. It's estimated that 10 million Ethiopians ultimately need these glasses. What do you think is necessary in order to scale it to that level where you can actually reach 10 million people? What changes will have to happen in the program to make that happen?

 **Israel Ataro:** It needs more advocacy and resource mobilization, and also to maximize the commitment of the local government. Also this refreshment training of the health extension workers is mandatory, and networking their efforts and working with them closely and mobilizing the community to be with them is very important. The lesson we have learned from our previous exercise told us to do these actions to maximize our scale-up.

As you know, during our pilot level, about 27,000 eyeglasses were provided for the piloting sites. Currently, over 100,000 are screened, and 100,000 eyeglasses are distributed by the community. So our scale-up should not be lacking. We have to go with the demand of the community. Once the community demand is created, we have to meet the demand.

Rollo Romig: You were mentioning the importance of increasing the commitment of local government leaders. What do you think are the best ways to increase their commitment?

Israel Ataro: I think looking at the excitement of the beneficiaries is very important to increase the commitment of the local government and also the stakeholders. It is a quick solution. It is an issue of their life esteem. It's an issue of their dignity, an issue of their independence to work by themselves to improve their life. This easily excites the government. It easily supports us to mobilize our government commitment to boost this.

The other issue is communicating our success. Advocating for our program is very important at the national level as well as globally. Our government commitment is really amazing, because we successfully accomplished our targets for the Millennium Development Goals, and we are working to achieve the Sustainable Development Goals as well. So we have a big improvement to improve maternal and under-five and neonatal health conditions, and also remarkably reduce communicable disease.

Eye health is a part of non-communicable disease. It boosts the commitment of local government.

Rollo Romig: Ethiopia, as you noted, has an unusually strong community health worker program. You were saying that Ethiopians get 80% of their medical services from these community health centers. Is that right?

Israel Ataro: Yes.

Rollo Romig: Could you explain just how important this system is?

Israel Ataro: Definitely. We have a strong data management system that we call DHS2. We get this data from every district, from every facility. Currently, our data shows us more than 80% of our people are served at the primary health care health facility level. We call those health facilities PHCU. They include health centers and satellite health posts under this health center. Within these public health posts and health centers, more than 80% of our people are served there. Creating resilient PHCUs is also making our health system resilient. There are health posts for every person in each village, so no need to go too far, no need to detach from your family, no need to provide more costs for transportation.

The community is very happy to own, to support, and to get service from those health centers and health posts. That's why we are focusing more on primary health care services. This health extension program is not only set in health posts or health centers, but they are expected to visit every household, to communicate with and equip mothers and members of their family with information about health extension packages and teach them also how they can improve their life.

Health extension workers can also [support people who are not able to read the information themselves] with teaching materials that we call the family health guide. Pictorially, they can easily teach mothers how they can provide breastfeeding for their child. How they can use health facilities for their antenatal care or get support from the health extension workers. [Even] how they can improve their housing or manage their waste. Different packages are included within this health extension program. They can communicate with the mother easily. They can

communicate with the different segments of the community easily, especially those who have roles to influence the community.

 There are locally very influential people, with strong bonds within a community, who take responsibility for the care of the community and the family. These leaders are very important for us to own and to support and boost utilization of healthcare services. This is a way we work with the community. We push our services to the community level, and we strengthen our services from time to time. We have optimized our health extension program, and we try to increase the number and the mix of the professionals to support these health extension workers as well.

We also pushed our services from hospital level to health center level, such as the screening of non-communicable disease at the health center and the comprehensive health post level. Also, we are trying to reach out to people with easily screened near vision problems, and they are getting this support from the Health Extension Program. We are helping the health centers to provide cesarean sections and to handle emergency surgeries as well. More than 200 health centers in this program are very far from a hospital. This is how the government of Ethiopia is trying to reach the communities in hard-to-reach areas and also try to improve the quality of the service simultaneously.

Rollo Romig: What advice would you give to other people in government who want to develop an eyeglasses program or a presbyopia program?

 **Israel Ataro:** My advice is, making the primary healthcare services stronger is crucial. Without capacitating our local level health facilities like health centers, you can't reach to communities who are far from the big health facilities. Making the community health program stronger is essential.

Then, from our scenario, I can tell that piloting and checking the feasibility of the program is very important. We tried the pilot and we checked its feasibility, and then we became confident to scale up. To scale up, you have to get the commitment and the support of the government as well as the implementing organization and the implementing facility, and the health workers as well. To bring those all efforts together, you have to be based on evidence. Our evidence was from piloting. Before the scale up, you can see if this program works or not. You generate the evidence, you communicate, you advocate, you bring all efforts together, and you can scale up. My advice is this.

Rollo Romig: Is there anything you'd like to add?

Israel Ataro: In a country such as Ethiopia, focusing on primary health care and making a strong connection with hospitals and health centers and health posts, and making the community health workers stronger, especially health extension workers, connecting them to get support from health centers and nearby hospitals, is very important. Your integration of different programs is crucial to reach the community who are far from big health facilities.

Currently we can trace every district, every village, and we can easily get information from every village within days. We can respond to those problems with our regional health bureau, zonal

health department, and also the woreda [sub-district] or district health offices and from different facilities. PHCUs can easily communicate with the central, regional, and middle level health officials. Making these bonds stronger is very important.

Also, you have to [design and implement] a program supported by policy and get the buy-in of higher officials. The higher official's attention is very important. Currently, our government is trying to solve every problem from every district to get information easily. We have a digital health revolution, and a digital revolution as a country. This is helpful for us to easily communicate, to easily address, to easily get support from the government as well as from our partners.

I want to call on our partners to support our effort. We are committed to work together to reach out to these people who are difficult to reach.

 Presbyopia is not an easy problem for our people. Screening is ongoing; we can easily screen and reach 10 million people because we have health extension workers, we train them, and we start to scale up, but providing these eyeglasses is not easy for us. It's a commodity, as you said. Supporting this, donating these eyeglasses, is very important for us. I want to call all our stakeholders to support us in providing these eyeglasses to those who are waiting to get them.

Rollo Romig: Could you comment on the blended training approach for presbyopia?

 **Israel Ataro:** Refreshment training for those more than 43,000 health extension workers is not easy. It is costly. To reduce this cost, we designed a way to provide this training to health extension workers. This is a new design we call integrated refreshment training. Every training can be blended. Blending has many advantages, because we don't bring all health extension workers for all the days to the training center. Some days after the orientation, they can go back to their working sites and they can easily train. You can easily assess their status, and you can also support them. It is one of the motivating factors for health extension workers, because they are electronically updating them. They are work-friendly with tablets, and then there is no need for big training materials. Hard copies not needed.

 When you want to update the content, there is no need for reprinting. You can easily update your content and you can easily communicate with your health extension workers. The training cost becomes minimized almost by half, and it's easy to reach and to meet your training needs. Blended training is very important for us. It is approved and owned by the Ministry of Health. We work together with our partners; Last Mile Health especially is working together with us to update and to standardize the training materials. Currently we are approved to provide our trainings in this blended way countrywide.

Rollo Romig: Thank you so much.

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.*