“Their uptake of near vision glasses is increasing”: Mohit Chelani and Juthika Talukdar of The/Nudge Institute on pilots in Meghalaya

Rollo Romig

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Rollo Romig: Can you start by introducing yourselves?

Mohit Chelani: My name is Mohit Chelani, and I’m Strategy Head and Chief of Staff at The/Nudge, as well as Head of Product. I’ve been working on developing and scaling the community cadre model for eyeglasses distribution.

Juthika Talukdar: My name is Juthika Talukdar, and I manage Northeast Operations at The/Nudge.

Rollo Romig: Tell me about how you’ve been working with the government of Meghalaya to help distribute near-vision glasses in the state.

Mohit Chelani: Our conversations with the Meghalaya government started on the back of our idea to initiate a state-level program in Meghalaya with the community cadre. At that point in time, we hadn't decided on the idea of *what* community cadre: whether it would be a rural development community cadre or a health community cadre. We were keen that the community cadre would screen people above the age of 35 and start distributing near-vision glasses. We started our conversations with the additional chief secretary. These are different ranks within the Indian state bureaucracy. The additional chief secretaries are the second in command after the chief secretary, who is the lead for the entire governance ecosystem in a state.

The Additional Chief Secretary that we have been speaking to is Mr. Sampath Kumar. He leads both the health and the rural development verticals, among others. The Secretary for Health and the CEO for Meghalaya State Rural Livelihood Society is Mr. Ramakrishna. On both fronts, from a rural development lens and from a health lens, Mr. Ramakrishna reports to Mr. Sampath Kumar.

These initial conversations started to anchor the fact that we need to understand how near vision glasses are effective, what value they offer, and at the same time, whether the community cadre

can screen and distribute these glasses effectively. That was the initial premise that we started with. Mr. Sampath Kumar suggested we do a pilot. He asked us to pick a block within a large district.

Within India, there is a concept called aspirational districts. These are districts that rank lower on development factors like education and health. In order to bring developmental priorities to the forefront, they've deemed these districts “aspirational districts.” There are close to 112 aspirational districts across the country. Ri Bhoi, where we have started the screening and distribution, is one of them. We picked up one block within the Ri Bhoi district, which is Umsning. Umsning’s population is approximately one lakh [100,000] people, and roughly 35% of the people in Rhi Bhoi are estimated to be above the age of 35.

The general data says that India is a young nation, and it suggests that 65% of the people are below the age of 35, leading to the idea that 35% of the people are above the age of 35. That is the target population we want to screen, which comes down to 25,000 - 30,000 people, and leads to the distribution of close to 15,000 pairs of glasses. That is the scope of work from which we started. We decided to do a pilot where we train the community cadre, and have them go on the field and screen people in VHCs [Village Health Councils].

VHCs are very strong and a very innovative institutional measure that the Meghalaya government has put in place. The VHC contains several member groups who are all key stakeholders in a village– the secretaries, the ASHA workers, the Anganwadi workers– and who are all community cadres who do different levels of work. ASHA looks at health, Anganwadi looks at early childhood development and also some level of health. Then there is the rural development cadre, CGHAs [Community, Gender and Health Activists].

For every 10 households within a particular village, there is one representative. From a power point of view, there is representation because all the key stakeholders in a village are there in the VHC. From a democratic point of view, every 10 households have a member representing them in the VHC.

The scope of work for VHC is largely looking at health interventions. How can general health and sanitation within the village be improved from an outcomes orientation, from an advocacy orientation, and from an awareness-building orientation? Figuring out those solutions is largely what the VHC does.

Mr. Sampath Kumar suggested we anchor this project in the VHC because there is already participation. He proposed that we use the VHC camp as a venue on the first day, and then we continue the screening over the next couple of days as distribution begins. That's what we started with.

Then, Mr. Sampath Kumar said we should coordinate with the health department, which is the NHM [National Health Mission]. We are working with Dr. Sapna, who sits at the civil hospital. She's an ophthalmologist, and she leads the entire eye care aspect within the health department. She's one stakeholder. With her, we tried to anchor the idea of how the training should run, and how we should be thinking about the distribution and the supply chain aspects, like where the glasses will be stored, who will distribute them, and who will do stock management. All of that is anchored in health.

The other department that we started coordinating with is the rural development department. There, the anchor institution is MSRLS [Meghalaya State Rural Livelihood Society], and we are working with Mr. Ronald, the Chief Operating Officer. Both Dr. Sapna and Mr. Ronald report to Mr. Ramakrishna, and Mr. Ramakrishna reports to Mr. Sampath Kumar. That's the hierarchy.

Now, coming to the operations part, or the logistics part of it, the Umsning block has close to 172 villages, of which we have already trained the cadre for 130 villages. Juthika will be training the rest of the 40 villages in the next week. It entails training to do primary vision screening.

We tell them how to do effective screening from a distance vision standpoint, where you put the Snellen chart at three meters, you close one of the eyes, and you ask them to read the entire chart. For near vision screening, we ask them to hold it at 40 centimeters and read the entire line. If they're able to read the N6 font, they should be good. If they can't, then you give them glasses based on their age, and then ask them to read the N6 line again. If they're good, then you just distribute them.

Rollo Romig: You're screening for both distance vision and near vision. For distance vision, are you just giving a referral?

Mohit Chelani: Yes. Wherever we see that the person is not able to read the entire Snellen chart from a distance vision standpoint, we ask them to go to the nearest district hospital or the nearest CHC [community health center]. The health infrastructure is structured like so: at the lowest level, there are health and wellness centers, or they're sometimes called sub-centers. Every two to three villages will have a sub-center. These are basic facilities. If I had some non-communicable disease, like diabetes, I would get regular medicines from a sub-center.

Above that is a PHC [primary health center]. That is where you would get a little better service from a scope of work perspective. That is usually where an ASHA worker is anchored. ASHA workers are health workers who have general nutrition and health-related capabilities. They're usually trained for six months to two years, and then they can dispense medicines for things like anemia, or vitamins for lactating mothers.

Juthika Talukdar: They will have basic medicines or samples.

Mohit Chelani: There is generally one PHC for every five to six villages. After a PHC, at a block level, we would find two to three CHCs. Again, the services increase.

Juthika Talukdar: At a population of 25,000 - 30,000 people, a PHC is the norm.

Mohit Chelani: At a block level, we would usually have two to three CHCs. That is where the first level of eyecare starts. You usually have an ophthalmologist come once or twice a week to screen people. That's why whenever we are referring for distance vision impairment, we either refer them to the CHC or to the district hospital, which is above the CHC. When we are training, we train everyone for all of these capabilities.

The distribution part is split between two community cadres. All the logistics, inventory management, and inventory uptake are done by ASHA. When I say logistics, I mean collecting the glasses from the warehouse and bringing them to the village for distribution. ASHA also

coordinates with the VHC to ensure lots of villagers come in for the VHC camp, and they ensure that there is proper support on the day of the VHC camp. The other cadre, CGHA, does most of the screening and distribution work.

 We generally use an app called KoboCollect, or Kobo, to screen people on the day of the VHC camp and for data management. CGHA creates the entries on Kobo. The backend is called KoboToolbox, and that's where the data collection happens.

We also train them on counseling because near vision glasses don't have to be worn all the time. They are only used for work purposes, and for near-vision, nimble work. We tell them that when you're walking on the road, you don't have to use them. When you're riding a bicycle or motorcycle, or driving a car, you don't have to use them. When you're watching TV, you don't have to use them. However, if you are a garment factory worker or an artisan, or even a farmer doing pest detection or pesticide spraying, and you need to measure how much pesticide to put in the spray, near vision becomes significantly important. We train them on educating people on where to wear these glasses and where not to wear them.

Rollo Romig: What are the main professions in Umsning? Which professions have you found benefit the most from near vision glasses?

Mohit Chelani: Roughly 65% to 70% of the folks in Umsning are either farmers or daily wage workers. Daily wage workers include landless farmers, who go on other farmers' land and help with cultivation, harvest, and other farm activities. They can also be construction workers or those who do contractual work, like mason work or plumbing.

We have also seen some people who are artisans because in Meghalaya, there is quite a lot of intricate work related to bamboo and textiles, so you find a decent population of artisans as well. Then there are other folks who are teachers or office-going people.

 We have seen that near vision glasses have immense value for artisans and people who do office work because when you have to read a document or weave a certain style on a textile, if you are not using near vision glasses, you will be less productive or less effective. Even farmers and daily wage workers who think it's not that useful for them will find that there are certain activities where near vision glasses will be extremely helpful. For example, if you're weeding, it is critical that you're able to see which is the weed and which is the actual crop, otherwise you may weed the entire plant out along with the weed. Or if a construction worker is finishing a wall or doing some level of design work as part of whitewash or painting, vision is critical. Someone who is doing plumbing work must be able to see up close or they won't be able to do the plumbing work well.

Those are the kind of audiences that we are looking at. We have already screened close to 2,700 people and distributed close to 2,300 pairs of glasses. Our target in this quarter is to saturate the block and distribute close to 14,000 pairs of glasses.

Rollo Romig: When someone doesn't take glasses, is that because they didn't need them, or do you find cases where they weren't convinced that they needed them?

Mohit Chelani: There are three general reasons. One, like you rightly said, is that they don't need glasses. They can read the entire near vision chart without glasses, so technically, yes, they don't need them. These instances would be close to 10% of the overall population above the age of 35. Second, there may be instances of complicated medical concerns. Someone like me, who has acute myopia, usually sees their near vision automatically become better. That would be some 5% to 7% of the overall 35-plus population. Then the third reason, which is a very rare occurrence, is that people are not convinced, which is roughly 2% to 3% of the overall population, not more. Usually, such people won't turn up for these camps because what we have seen is that the people who turn up exhibit high levels of adoption.

 We did a dipstick study a couple of weeks back, and we realized that almost 80% to 85% of people who have been dispensed these glasses have actually started using them as a habit. They've crossed that 21-day window where they're using the glasses in a mid-term way. They've started taking them to the field, they've started taking them to their office or workstations, and they've started using them for two-hour to six-hour windows. Again, it depends on their occupation. If you're a tailor or if you're a government factory worker, you would need them for six to eight hours, but if you're a farmer, you would just need them for an hour or two.

All three stakeholders are champions in their own way and have supported us in different ways. All the block coordination, all the work to ensure the trainings are happening in the right way, and all the cadre mobilization is all rural development led by Mr. Ronald. He's been very supportive.

As part of this intervention, we have to distribute some 14,000 to 15,000 glasses. Out of these, 5,000 glasses have been distributed by the NHM team because they also wanted to co-own the program. The glasses that are being distributed right now are government-sponsored.

Rollo Romig: NHM is led by Dr. Sapna, right? She's running the supply.

Mohit Chelani: Correct. She's also ensuring that the trainings are effective. We have Juthika, who's an optometrist as well, and there are also optometrists representing the NHM side, and their point of view is also captured. The training is all the more effective because their cadre is also involved.

Rollo Romig: Where is NHM getting the glasses?

Mohit Chelani: As part of the national mandate, NHM has a division called NPCBVI [National Program for Controlling Blindness and Visual Impairment]. As part of this particular program, they distribute near-vision glasses, but they primarily address acute vision conditions. Presbyopia, while widespread, has received less programmatic attention so far.

The requirement to be fulfilled is just one pair of $1 near-vision glasses. It is still a challenge from a logistical and delivery standpoint because these other eye diseases, like myopia, cataracts, and glaucoma, are more acute and overriding; if not corrected, they all can lead to blindness. You tend to feel the pressure to solve these acute challenges. At the same time, a very simple yet very effective solution gets deprioritized, and that is what we are trying to bring to the fore.

Rollo Romig: We've seen this tension between urgent, vision-threatening, or even life-threatening conditions versus less severe, but easily correctable conditions, everywhere. In Nigeria, people were very happy to receive glasses through their free distribution program,

but sometimes people who had more serious conditions, such as glaucoma, were frustrated that they weren't getting immediate service for those issues, especially in more inaccessible areas.

Mohit Chelani: Juthika did an extensive exercise of going into the field to talk to folks. Quite a lot of people said they value the glasses.

Juthika Talukdar: We saw professionals like teachers, who are in their mid-40s and first-time users, come to us and say they're really benefiting. There were also professionals in the weaving industry saying it was really helpful.

On the other side, we have also seen people in their late 50s and 60s who have cataracts. They were not improving even with the glasses. We have referred most of those cases to the CHC because they need more intensive services. However, their concern is that the CHC is very far away. It is not easy to go there and get the services. We have spoken with some authorities who may plan to do cataract screening camps right there in the village itself. They usually do it from the government side, the health department side. They can do it in the village, eventually.

But otherwise, getting glasses is making people very happy.

Mohit Chelani: Meghalaya's government has written a document titled "How do you encourage health-seeking behavior?" The near-vision glasses are a health-seeking kind of intervention. As soon as you make people aware that they require near-vision glasses, and that their near vision capabilities, or their distance vision capabilities, have dropped, not only is their uptake of near vision glasses increasing, but so is their uptake of general eyecare behavior.

When we ask the cadre to do counseling, we ask them to explain health-seeking behaviors, like how you should clean your glasses, and how you should go for annual eye checkups instead of waiting for eye challenges to arrive. I know we can't take credit for all the health interventions that will come because of health-seeking behavior, but at least we are encouraging people to go to the nearest health center and get their eyes checked. If their eyes have glaucoma or cataracts, it will be detected. Before this, there was an awareness challenge. People tended to feel, I am aging, my knees are weak, I can't run that fast, and the same goes for my eyes—I'm losing vision capabilities, but that is how life progresses. As soon as we make them realize that this is not a challenge that can't be corrected, they start saying, I'll get my eyes checked annually. That is what will invite more and more people to get treated for cataracts, glaucoma, and other medical issues as well.

Rollo Romig: Are the VHCs unique to Meghalaya?

Mohit Chelani: There are similar institutions everywhere, but from a strength and spread point of view, Meghalaya seems to be a pioneer.

Rollo Romig: There are so many different ways that people organize themselves. Do you feel like having these different options or organizations to plug into is unique to India?

Mohit Chelani: When it comes to these community institutions, the social fabric is very strong in India. We have close to one million SHGs [self-help groups], which are connected to close to nine million individuals or households. That is equivalent to the number of ASHAs we have in India. It's crucial to have groups like SHGs to power interventions, especially in a country

like India, where a lot of these cadres are overwhelmed with tasks. ASHAs have close to 75 tasks that they have to perform on a daily basis.

Rollo Romig: Presbyopia is just one of 75?

Mohit Chelani: Correct. It is a very recent addition, and not a prominent addition.

From the spread point of view, it always helps to have a diverse set of community institutions. Let me share an example from Odisha. In Odisha, there is a cadre called CRPs [community resource persons] within the SHGs. The role of CRPs is largely to mobilize all the villagers, pick up people who are poor, and have them join SHGs because that is where their financial inclusion journey and their general financial well-being journey start.

We have trained close to 162 CRPs in Odisha, and now, they will be going door to door, screening people and distributing near-vision glasses. That is what the diversity of these institutions offers. While an ASHA may be overwhelmed, if there is a parallel cadre that is equally efficient and effective, we can train and deploy them.

In Meghalaya, we are doing camps through a CGHS cadre, while in Odisha, we are not doing a camp model, but doing door-to-door through a CRP cadre. That diversity offers a certain level of hedging and a certain level of effectiveness because whoever has better bandwidth can be deployed. Studies have proven that both the health and non-health cadres are equally effective when it comes to screening and distributing near-vision glasses.

Rollo Romig: What do you find are the differences between working with the health cadre, those who already have health training and credentials, and the non-health cadre, who do not?

Mohit Chelani: It's just the initial sensitization. ASHAs, a health cadre, would initially have an edge because they've worked in this domain for a while. At the same time, that same edge can be created or nurtured through a training process, so that’s what we do. From an effectiveness standpoint, we have seen that there are largely no significant differences. Both the health and non-health cadres are equally effective. It's just that the health cadres, because of their experience and their sensitization, can give responses that are a little more contextual.

For example, if I am a person being screened, and I am diagnosed with near distance vision impairment and I ask, Where should I go? the ASHA worker would know what particular days the ophthalmologist would be at the CHC. The ASHA worker can recommend, Go on a Tuesday or a Thursday between eight o'clock and twelve o'clock in the morning to see the ophthalmologist. Due to their experience in the field, they're a little more aware and they can give a little more contextual information. However, that same response can be replicated by providing the right information to a non-health cadre.

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

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.

** This interview has been edited and condensed.*