"The government has really made an investment in this": Rollo Romig, Manager of the Solutions Insights Lab, on scaling near-vision glasses distribution.

Ambika Samarthya-Howard
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Ambika Samarthya-Howard: You just came back from Ethiopia, and Ethiopia is the third country you visited to study their presbyopia program, after Nigeria and India. What makes Ethiopia distinct?

Rollo Romig: Among the places I've seen, Nigeria is perhaps most comparable to Ethiopia, because they're both doing free distribution using community health workers. But Ethiopia has an unusually robust public health system in multiple ways. Their community health workers, who they refer to as health extension workers, are salaried government employees.. Ethiopia invests a lot in community health workers. They're highly trained. They're highly engaged. They're not volunteers. They're not paid in stipends. They seem to be happy with their pay and enthusiastic about whatever new services get added on.

Ambika Samarthya-Howard: Community health workers worldwide have been fighting for those things. From the way you're describing it, Ethiopia's system is very professionalized.

Rollo Romig: Very professionalized, yes.

Ambika Samarthya-Howard: Everyone else is struggling to do that.

Rollo Romig: The government has really made an investment in this. Ethiopia also has a really impressive network of small local health posts. I spent a day visiting 10 or 12 of these

depots as Last Mile Health delivered eyeglasses to them. I was really struck by how well covered Ethiopia is by these facilities. They're close together, and there's so many of them.

Ambika Samarthya-Howard: Are they like hospitals?

 **Rollo Romig:** Much smaller. It's a place where you can get services from a community health worker. Some are bigger hubs. One of the depots we visited in Dire Dawa was more of a center that had multiple small buildings and a lot more services. The others peppered around that region were just one small building where people could go to get basic services and referrals and so on.

Ethiopia is a very rural country. I was really struck by that too. Dire Dawa is one of the largest cities in the country, and it's only half a million people, out of a total population of over 130 million people. A large majority of people live in rural areas. I don't know how representative the density of the health depots I saw was to the coverage nationwide, but I got the sense that it's similarly robust around the country. I was told that something like 80% of healthcare services happen at these health depots. That's so starkly different from Nigeria, where most people don't have access to a health facility of any kind.

Ambika Samarthya-Howard: Tell me about how eyeglasses got integrated into these systems. One of the ways that they did it in Bangladesh was through bundling. Is that the model here?

Rollo Romig: Yes. The health extension workers have extensive NCD training. It's a whole package of different conditions that they screen for, and they added eye health to that package. Then for every single person who they screen for presbyopia, they're also testing them for distance vision and hypertension and diabetes.

In Nigeria, they're only training the community health workers to screen for near vision. At some of the glasses distribution events I attended in Nigeria, there was also screening for distance vision, but it wasn't the same people. The community health workers who were screening for presbyopia were only doing presbyopia. They had a presbyopia station, and there might be another station that screens distance vision that other people were doing. In the Ethiopia model, every community health worker is trained and is doing these four things as a package.

Ambika Samarthya-Howard: What's your opinion on bundling these screenings versus keeping them separate, now that you've seen several different ways to approach it?

 **Rollo Romig:** I think bundling helps a lot. Obviously, it slows the process down when the health workers have four screenings to do for each person, so they're not seeing nearly as many people at once. In Nigeria, they could distribute glasses very quickly. In Ethiopia, they're seeing significantly fewer people each day, but they're trying to promote it as something that's not just an event, but as one of the services that is now available when you come to a health depot. It's there for you whenever you want it, as long as they have the glasses available.

I saw the launch of the presbyopia program in a couple of different locations in Dire Dawa, and this was a slight tension because many people showed up and wanted to get seen. Last Mile Health was trying to get the message across that this isn't the only day; this is just the day that it

starts. In one of the locations, the local organizers went all out with a launch program complete with a coffee ceremony and speeches. This wasn't Last Mile Health's intention; they wanted a softer launch, to better manage people's expectations. On the other hand, having a big launch event is great for word of mouth for anyone who wants to come on future days.

Ambika Samarthya-Howard: If people wanted to get screened on another day, then they would just go to the health depot?

 **Rollo Romig:** Yes. They can just come back, as long as the depot still has a supply of glasses. It's not event-based. Their regular community health worker who they know is now going to be able to provide that service going forward.

 The difficulty, when it comes to adopting this approach elsewhere, is that it's completely reliant on having this incredibly robust public health system. It's funny, both of the Ethiopian government officials who I interviewed, when I asked them what advice they would give to a counterpart in another country who wanted to start a presbyopia program, they essentially said, "First, build an extremely robust public health system." That's a big first.

Ambika Samarthya-Howard: It seems like a huge outlier.

Rollo Romig: Yes. It certainly seems like an unusually strong public health system in my experience of countries in this economic category.

Ambika Samarthya-Howard: What was your impression from the community health workers you met with? How were they different from others you've talked to in different countries?

 **Rollo Romig:** Very enthusiastic. They seemed very connected to their communities. I spent a day with community health workers who were attending orientation. Their initial training was separate, in their NCD training package. What I saw was their orientation specifically for launching the eye health program. It was a long day—they spent 9 or 10 hours going over all the presbyopia and distance vision screening protocols and then practicing it on each other. Everyone got a chance in each role as a patient and as a healthcare worker. They were a notably engaged audience. Even when they were just watching the slide deck presentation, everyone was locked in. They had a lot of fun. They just seemed happy to be there learning this new skill, and excited about having a new service to provide.

Ambika Samarthya-Howard: I wonder if that relates to them having a lot of government support.

 **Rollo Romig:** Really, community health workers everywhere are mission-driven. They're doing it because they want this for their communities. But it certainly helps to be paid.

Ambika Samarthya-Howard: Is there anything you saw with the community health workers that could be applied in a place that doesn't have the system Ethiopia has?

 **Rollo Romig:** The lack of a strong public health system is a big hurdle. I think that bundling services is very sensible, because multiple community health workers told me that having these glasses to give away promotes what they do in general and improves uptake for other interventions. The problem is, unless you have a system like these health depots, you can't just say this isn't just a one-time event and that you can come back anytime, because there's no place to do it. Nigeria is more reliant on an event model because they have less of an infrastructure of buildings where people can just show up. That infrastructure is pretty tricky to reproduce.

Ambika Samarthya-Howard: What about distribution?

Rollo Romig: There are hurdles. They can't deliver everything by car because not everywhere is safe to drive. That is similar to Nigeria. Both have areas where there are heightened security concerns, so they have to navigate that. I think what Last Mile Health does in Ethiopia is comparable in a lot of ways to what CHAN does in Nigeria.

 They've come to rely on the postal service to mail glasses to certain locations. That, of course, required nurturing a relationship with the postal service. There's also customs to deal with when the glasses arrive from abroad. There are multiple government agencies who they've had to get on board.

 Last Mile Health has been really savvy about dealing with that. Their very clever approach, which everyone should do, is that when they know they have to build a relationship with a government agency, they hold a screening and distribution event at that agency for the employees of the agency. Then they're benefiting from it and they can immediately see how everyone else will benefit from it. That is something everyone can do and should do.

Ambika Samarthya-Howard: Abraham of Last Mile Health talks a lot about how community health workers love distributing glasses because it has improved their standing in the community. What does that look like?

 **Rollo Romig:** It's also what the community health workers said to me. Two health extension worker supervisors told me that there's a new level of enthusiasm for their work after they started distributing eyeglasses, where people are stopping them in the streets to ask about it. It's strengthened their relationships in the community. They've become better known. This is something that every community health worker I spoke to told me some version of.

Ambika Samarthya-Howard: Do you know why that's happening specifically for eyeglasses as opposed to something like diabetes?

 **Rollo Romig:** I think it's the immediate payoff aspect of the eyeglasses, and that they're handing out a commodity. That really makes it different, that they're giving people something for free that they wouldn't get normally. People are surprised and happy about that. Most other health interventions are time-consuming and indirect. You're not even sure which

part of the intervention helped improve your medical condition. It takes a long time. Maybe you tried three different things and you're not sure which one actually helped, or if it just would've gone away on its own. With eyeglasses, it's so immediate that people know that they can credit the community health workers for it.

Ambika Samarthya-Howard: Can we talk about what you saw as different in terms of the people receiving eyeglasses in Ethiopia versus India and Nigeria? It seems like the demand for glasses in Ethiopia is particularly high.

 **Rollo Romig:** I would say the demand is similarly high in each place, and the demographics seemed roughly similar in terms of men and women. The distributions in Ethiopia were a bit different because they're bundling, doing several different screenings, including non-vision-related screenings, at one time. So it's more time-consuming. I felt a touch of frustration from the people who showed up in Ethiopia that there was a long wait. The Last Mile Health folks noted that they needed a little more crowd control and to manage expectations a little more around their particular approach.

It's important to note that Ethiopia is a very diverse country: culturally diverse, linguistically diverse, geographically diverse, religiously diverse. We were in a very Muslim part of the country in eastern Ethiopia. When I asked recipients in this region why the glasses were useful to them, many of them named reading the Quran first. My first thought was that reading the Quran isn't really livelihood-related for most people. But then I heard a really interesting comment from one farmer. I asked him if the eyeglasses are useful for his work. He said that they're not directly useful for his work—he's not wearing them when he's out in the field. But the glasses are very important to him so that he can read the Quran. And in his mind that does support his livelihood, because this is something he's going to do every day without fail. Before he got his glasses, he could only read during daylight hours, when he could see really well. That cut into his good working hours out on the farm. Now he can read the Quran anytime, including when it's dark, which, he said, actually does improve his livelihood, because it gives him more good working hours in the day.

I thought that was a really useful point. It's so difficult to track impact, because often it's indirect in this way. Where if you're improving someone's quality of life or if you're saving them time in general, then you are still improving their livelihood. This guy is going to spend a significant amount of time reading the Quran every day. Improving his quality of life in that way does improve his work, but it's less direct and maybe less easy to track than other activities. Other farmers told me that they use the glasses to sort through seeds; that's much more direct. But both are supporting livelihoods.

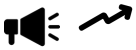
Ambika Samarthya-Howard: What does provider trust mean in Ethiopia? It sounds like they already have a very high level of provider trust.

 **Rollo Romig:** Yes, but they're always looking for more. Health extension workers are always looking for people to be more aware of their services. There's always more connection that they can have with their communities. There's so many services they can provide, and lots more people they could be reaching. I think they see the eyeglasses as a wonderfully

concentrated way of getting attention and getting positive word of mouth that can bring people in for all the other things that they do. It's got an outsized effect that way.

Another thing is that the perception is often that community health workers are focused on women and babies. Glasses are a nice way to also bring men in for health interventions. They get the word out to men that this is also for you. The health depots are also for you, and all the various services that they provide. In a lot of places, men lag behind in health-seeking behavior, so they need all the help they can get to show up to the clinic. This can be a big entry point.

Ambika Samarthya-Howard: How else do you think health systems have helped the scaling of eyeglasses, or eyeglasses have helped the scaling of health systems? Is it mostly about trust?



Rollo Romig: Trust is a big thing. But it's not just about trust; it's also about awareness and engagement. The eyeglass distribution serves as a nice form of advertisement for the community health workers and these health depots. For example, we were dropping off glasses at a small health depot. We were there long enough that it just got the attention of curious locals. After we were there for a half an hour, this delegation of village elders showed up to say, "Hey, we noticed there's something happening. What's going on?" We told them we're dropping off glasses because they're going to start distributing them tomorrow. They were all very interested. They said they'll spread the word in the community. Just the fact that there's this delivery of this physical commodity, that alone attracts attention, and then helps spread word of mouth.

Ambika Samarthya-Howard: Did you see examples of people coming to get screened for presbyopia and then getting treated for anything else?

Rollo Romig: Yes. There were definitely people who came for presbyopia but then got referred for hypertension or diabetes. The way that they approach it is, they do these screenings in a particular order, and the presbyopia screening comes last. If they find that the person has a distance vision problem, then they refer them to an optometrist, and they don't give them near-vision glasses on the spot, because what the person might need instead is bifocals. Same with hypertension and diabetes—if they screen positive for those, they stop there and give a referral, because the vision problem might be related to the diabetes or the hypertension. They tell the patient to get that checked out first by an optometrist at a higher facility, and then come back for eyeglasses for presbyopia.

Ambika Samarthya-Howard: That's really interesting. To me, that's very much about building trust. That's why partners like Last Mile Health are great. They're not just eye care providers.

Rollo Romig: Exactly. I think in some cases, people were disappointed because they were hoping to walk away with glasses, but Last Mile Health is very scrupulous about this.

Ambika Samarthya-Howard: Do you think there's anything The/Nudge does in India that Last Mile Health could apply or vice versa? The/Nudge has been working with private entrepreneurs who sell near-vision glasses door to door. What can the public sector learn from the private sector?

Rollo Romig: In Ethiopia, there's not currently a plan to eventually charge money for glasses. That's not the model they're looking at. In Nigeria, they're thinking of free distribution as a stepping stone to get people to buy glasses later. That was very explicit. That's not how people talked about them in Ethiopia.

But I think that there's a lot that everyone can learn from The/Nudge's approach. As we noted in the insights from India, the thing that I learned the most from The/Nudge was that an entrepreneurial approach is a powerful data and customer feedback mechanism. Because if you're giving people something for free, they're not going to look a gift horse in the mouth. They're not going to question it. They're not going to say, like, "This is okay, but I'd like it a little different." They're just going to say thank you. But The/Nudge found that, even though they're charging small amounts of money for glasses, people are telling them all sorts of things: "I wish it were a little bit more like this."

 That's how they found out that their customers overwhelmingly prefer near-vision glasses in the form of bifocals with the top lens clear, so that they can just leave their glasses on all day. With regular near-vision glasses, the community health workers have to coach everyone not to wear those glasses all day. Then it's easier to lose them, it's easier to break them. You're taking them on and off. But if you have a bifocal and wear them all day and then you just look down when you need the near vision part, it saves a lot of hassle and doubt. That was an insight that emerged from the entrepreneur model and from getting critical customer feedback.

I think that to some extent, it's worthwhile for every country to have an entrepreneurial pilot, even if they don't ever plan on scaling an entrepreneurial model, just as an information-gathering tool. But even if they don't do that, everyone should study what The/Nudge has been doing.

Ambika Samarthya-Howard: Let's compare Ethiopia a bit more to Nigeria. From your experiences in both of those places, how did the urban-rural divide come into play?

Rollo Romig: Nigeria's certainly a more urban country than Ethiopia. Ethiopia's large rural population certainly presents challenges, but I don't know that it's more challenging than Nigeria, because even though Nigeria has a bigger urban population, Nigerians outside of the biggest cities are overwhelmingly not served by healthcare facilities. From what I saw, because Ethiopia has such a robust system of healthcare depots, they're actually better served in a lot of ways.

Ambika Samarthya-Howard: Why doesn't Nigeria do what Ethiopia does?

 **Rollo Romig:** Because Ethiopia's got a huge head start with the physical infrastructure of these healthcare depots. Nigeria would need to have a huge change in policy and investment. The Nigeria presbyopia program is going very well, but one thing that makes me a little nervous is that on the national level it's personality-driven. If there is a big change in government, will that be a setback? Whereas in Ethiopia, I think that's much less of a concern. Everything they're doing is baked in. Presbyopia has been added to their NCD package for community health workers, and there's no reason to think that it won't stay there.

Ambika Samarthya-Howard: But could the same thing be said in Nigeria?

Rollo Romig: My sense is that the way that the government is working in partnership with the implementing organizations is very different. In Nigeria, CHAN and CHAI are implementing, they're the ones who are out there on the ground, and they're the ones who need to keep running these programs going forward. In Ethiopia, very explicitly, Last Mile Health is getting it started, but the plan is to hand it off to the government. When everything's up and running, Last Mile Health will not be running it anymore. The government will take it over. That seems very sustainable. It's the difference between an actual government program and the government funding an organization to do a project.

Ambika Samarthya-Howard: Thank you.

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Ambika Samarthya-Howard (she/her) is Solutions Journalism Network's Chief Innovation Officer. She strategizes on communications, metrics, impact, product and technology, leveraging platforms for the network and creating cool content. She also leads the Solutions Insights Lab, an initiative of SJN that uses targeted research and analysis to identify and interrogate what's working and what's not in a particular sector or field. She has an MFA from Columbia's film program and has been creating, teaching and writing at the intersection of storytelling and social good for two decades. She has produced content for Current TV, UNICEF, Havas, United Nations Population Fund (UNFPA) and Prism.

** This interview has been edited and condensed.*