“We take it out to churches, markets, and places of worship, where people are in the community, and then screen people and dispense to them:” Representatives from the Christian Health Association of Nigeria on addressing presbyopia in hard to reach areas and partnering with faith leaders.

Rollo Romig
March 11, 2025

Rollo Romig: Please introduce yourself and share about your work.

Dr. Muknaan David Nshe: Hi, welcome to Nigeria. I'm Dr. Muknaan David Nshe. I lead the routine immunization portfolio here. The Reach Project was implemented in collaboration with the International Rescue Committee (IRC) in Nigeria. I also provide technical support on all the programs.

Meshik Nathan: My name is Meshik Nathan. I'm the coordinator of the Africa Clear Sight Partnership Project.

Suleiman Mshelia: CHAN [Christian Health Association of Nigeria] is using a unique approach to eyeglass distribution, the community faith-based approach. The Federal Ministry of Health wanted to learn more because most distributors use the government structures, the primary healthcare centers, to distribute eyeglasses.

 We use the community structures made up of religious traditional structures because they have the acceptability with the people, a comparative advantage. After all,

you need to integrate the health system with the community system. In low and middle-income countries like Nigeria, the community structures are strong.

Rollo Romig: Could you tell me a bit about the particular approach that you're taking?

 **Anointed David Oriaku:** I'll start with some data, then get into strategy. We do weekly reports. As of this week, we have screened 95,704 clients and we have dispensed 89,710. First-time users are 68,374. If not for this project, they wouldn't have gotten glasses. That's what it means. We have referred about 3,293 who after screening without finding suitable glasses, still weren't fine.

We're in four states, Benue and Plateau in the middle belt, Sokoto in the Northwest, and Kaduna in the northwest. For Benue, we have dispensed 10,903 glasses, Kaduna, 38,752 glasses, Plateau 22,399, Sokoto, 17,656. We have just distributed glasses for one month and dispensed 95,704 glasses.

We are addressing the key issue of distance, the barrier for the caregiver or client. The distance from the community to the health facility in Benue is quite far. In some locations, entering a health facility costs as much as 6,000 Naira [$4 USD], you go and come. Nobody wants to go that distance. We meet them where they are. If you go to the hospital, you have to spend money, but this is free. We have addressed costs, distance, and time.

 It has given us a good advantage in the past few weeks. We trained 272 people of which 75 are healthcare workers and 197 are community volunteers. We had to put some restraint. A community volunteer is only trained to screen and dispense glasses, without dealing with glaucoma or any other eye condition. Our first-time users are 76%. If we hadn't come, they wouldn't have gotten glasses.

In Oju, Benue, for example, a carpenter had to go to Makurdi, a distance of six hours on a bad road. He has money but it's not safe. The founder of the Dunamis Church [Dunamis International Gospel Centre] in Nigeria is from that village. Three years ago, they went for outreach and the carpenter was given glasses, which he has been using. Early last year, the glasses broke, so he has been looking for a way to get new ones. In his local community, they don't sell it. He has even ordered it from Makurdi and he's not getting it.

He was so happy when we came to his community. He was screened and he collected glasses. He said, "Now my stress is over." He squints to see and needs that near vision to do his work. This is just one of the stories.

If you're in communities around the state capitals, it becomes easier, but when you go far Nigeria's large landmass makes distribution more challenging. The infographics show the older people going for the higher optical power and for the majority in the youthful age, the lower powers are exhausted in most states.

Rollo Romig: Why are you reaching more youth?

Anointed David Oriaku: Youthful means below the age of 50. Life expectancy in Nigeria for a man is 48 years and for women 52 years. If you die at 70 in Nigeria you died a very good old man. We still have elderly people in the communities, but most of them are farmers. They're not actively engaged.

For occupation, agriculture accounts for the largest share at 47%, followed by service providers at 18%, artisans at 10%, mechanical at 4%, textile workers at 8%, and others at 8%. Those not currently working are at 4%.

As we continue in the same location, it will get to saturation where everybody has received glasses, but we're not there yet.

Meshik Nathan: We want to create demand for eyeglasses. When we give you the first pair free of charge, we expect you to take care of that very well. Then when you see the need for it and something happens to this first pair, we encourage you to get the second pair, but you probably will have to pay for it.

We're bridging the gap by taking it to where the people are in the community. We are not being biased to stay in the facility because our people don't want to go to facilities. We take it out to churches, markets, and places of worship, where people are in the community, and then screen people and dispense to them. That's different from what other people are doing.

We train people on how to screen with practical methods. In one location where we've exhausted some of the lower powers, people are asking for glasses that aren't recommended for them. We have to stick to quality and standards so we're getting their details and we're coming back when we have more glasses.

Rollo Romig: Are you getting enough supply, and of the right kind of glasses?

Dr. Muknaan David Nshe: For now, we don't have enough supplies for a certain power. 1.5 is exhausted. We have enough supplies for the older, for the higher powers.

Rollo Romig: Is that because you were distributing faster than you thought or is the supply not coming fast enough?

Dr. Muknaan David Nshe: It's more about the condition. People might have presbyopia without knowing. They come for screening and find out that they're gradually developing presbyopia. It's a condition that happens with age and many people above 40 are coming down with the case. It's not that we don't have supply, but the demand on the ground is more than what we have.

Anointed David Oriaku: It's because they wanted us to start small, with 200,000 glasses. We use nine Local Government Areas (LGAs) where the working age of the population of adults is about three million people. If you do 20% of these people, it's around 750,000 glasses, far more than we have.

The Clinton Health Access Initiative (CHAI) has 1 million glasses throughout the entire state.

We have paper-based registers and we transcribe them into electronic form. However, it's just one team that uses it because not all teams have a smart device so we have not scaled. Our data is entered daily to ensure it's of high quality. The teams are quite far. When they finish their work for the day, they enter it in the form we shared with them. They snap it and send it to the coordinator who enters it into the Excel spreadsheet.

The daily report sums up the week and the month. It has been helping us triangulate. If I want to check what this team is doing for a particular day, I pick the register and check it versus what they have shared. This has helped us ensure quality because that's key for us.

Rollo Romig What have been your approaches for demand creation?

Meshik Nathan: Before we began dispensing the glasses, we made some advocacy visits to community leaders and religious leaders within each of the states, to inform them and help us through the demand creation. We also engage the local government mobilization officers to help us follow-up with the demand creation.

Anointed David Oriaku: We have three people in a team and about 97 teams across the states. Each team has three persons: a healthcare worker, a recorder, and a mobilizer. The mobilizers are to ensure that people come, they go to the community a

day before with their megaphone and announce that they're coming to this place tomorrow morning by this time and tell that people below 40 years old don't need to come. On another day, the screening will be announced in the Catholic Church.

Generally, there's high demand. It's not like a vaccine where there can be misconceptions because you're taking it in. With glasses, you see the difference immediately. It's easier to handle misconceptions.

 **Dr. Muknaan David Nshe:** CHAN has existed for over 50 years. We have been part and parcel of these communities demonstrating impact on different projects. The quality of service delivery is there and social trust is earned. When we distribute health commodities like drugs, they've seen the quality, they've seen how that has impacted their lives.

 Some of the healthcare workers and volunteers are people within the community. You know that somebody would not want to harm you. As they say, some of the best marketing and demand generation are from a satisfied user. Once someone sees it, it's easier to show the evidence.

Rollo Romig: You've worked on so many different health interventions, how are eyeglasses different from the other work that you've done?

Dr. Muknaan David Nshe: I lead the immunization program; reaching every child with vaccination in humanitarian settings. Most times you engage the men because Nigeria is largely patriarchal. Even to provide services to the children and the women, you would need demands, some form of permission, or some form of acceptance to access communities.

This is a male and a female approach; it differs from the other interventions. Once we go to these communities, one of the common questions is, why are you targeting just women and children? Why are there not many activities or interventions that are targeted at men? This approach cuts across the different gender barriers.

Secondly, it's more of a curative than a preventive intervention. When you're trying to convince a mother why she needs immunization, you have to tell her that you're giving her a drug or a vaccine that will prevent something that has not yet happened. People relate better to a curative intervention. The eyeglass gives you that form of immediate clarity.

In my former clinical setting, when you do cataract surgery, someone is blind and now can see. You can say the same for the glasses. Somebody's struggling to read, you do the visual acuity, and the screening and he thinks it's a miracle.

It gives a feeling of immediate result. If you want to discontinue your glass, feel free to. If you have seen the benefit, you wouldn't discontinue it. You're not engaging people with something that has any form of side effects. When we do vaccinations, we have to provide health education and tell people about the side effects of fever or an adverse immunization event.

And it's free, it can add to an aesthetic persona or aesthetic feeling; you wear your quality glasses.

If you're jabbed, you'll just look for a scar. When you wear glasses people think of you as literate. It can lead to some level of attainment in society. Somebody who couldn't read now can use this.

We've done immunization, maternal, neonatal, and child health (MNCH), innovations around reducing maternal and child mortality, and some projects around HIV. Presbyopia is not highly stigmatized. People may not know they need this. You are not creating the demand, you're providing a solution to a need they probably did not have.

When it comes to healthcare, it's criminal telling somebody they have a problem and you don't have a solution.

Anointed David Oriaku: We have 49% males who receive glasses and 51% females. Men receive almost 50-50, which is good for our work. Part of what makes this different is age. The age cohorts are adults who can make decisions for themselves. For intervention with children, the parents can refuse.

It's also about livelihoods; with glasses you see the things you can do better. The coordinating Minister for Health in Nigeria, Dr. Okolo, has a plaque in her office saying, "See well, do well." Once you can see well, you do well and get more money.

Priscilla is an example. She is a 53-year-old educated farmer and after receiving the glasses, she immediately went back to church to read the Bible. She was so happy because it was immediate. When I came back from Benue on Monday, I turned on the TV and saw someone on the news talking about Benue security wearing our glasses. I have a picture of it.

Rollo Romig: How could you tell they were yours?

Anointed David Oriaku: He didn't remove the sticker.

Rollo Romig: Is there anything more challenging with eyeglasses than with other interventions?

Meshik Nathan: Maybe transportation and packaging. Looking at the terrain in Nigeria, glasses are fragile. And issues around the space to screen and administer it. You need some level of privacy.

Something peculiar in engaging with the team is that the data to show what glasses are more likely to be prescribed are not 100% clear. When we're beginning to prescribe, we have to go with the lower powers. We might need to exchange for other forms of the glasses. The advantage is that it doesn't expire.

Dr. Muknaan David Nshe: Transport is also a challenge with our other projects, this project is easier for a local chain. However, the data is not yet reported. Eye care has not received much attention. With the introduction of Jigi Bola 2.0 and LIF/Restoring Vision, it's peaking. With the integration of primary eye care in primary healthcare, I see a difference in the next four, to five years.

Eye care has not received sufficient funding, and HIV, TB, malaria, and immunization receive more interventions.

Rollo Romig: What do you still need that you don't have yet?

 **Anointed David Oriaku:** We still need glasses. Even the 350,000 they're bringing is a small amount.

Meshik Nathan: We may need more training for more volunteers, for community healthcare workers to handle more. Especially including primary healthcare. Once you see somebody, it's important that you refer properly when you see anything that's not your field. We need more funding.

 **Anointed David Oriaku:** We need adequate remuneration for the field teams. Some of the distances they need to go are 20 kilometers. The road is bad, it's insecure. When they are remunerated well, they will not mind crossing the river because they know that at least they have something to pacify them for the stress they're going through.

Suleiman Mshelia: The choice of the communities initially is fragile and complex areas and have their layer of problems like insecurity, conflict, and disrupted health systems. Health interventions in humanitarian settings are costlier than in areas without problems.

For our approach, because we leverage the immunization project, we wanted to bundle this together so that we're intervening more holistically. You vaccinate the child and then you also distribute glasses to the adults. We wanted to compound that.

 It's a unique approach, we're learning, adapting, and integrating this into our programs and we're open to scalability. We also want to see how we can implement this with the eye of sustainability and strengthen the whole system. In the past few months, we've learned a lot about integrating digital technology. We want to include Geographic Information Systems (GIS) to improve and strengthen this intervention.

Anointed David Oriaku: One of the master trainers is a consultant ophthalmologist at the Benue State University Teaching Hospital. She was with us for two days in the field and said as ophthalmologists, they can't handle hundreds of people. They are too few for this number.

 The National Eye Health Policy (NEHP) mentioned task shifting and sharing. How we have shifted optometry or ophthalmology is a big portion. You just pick the 1% presbyopia, and share it with the community volunteers. We used to address the distance with a training model called SODOTO; see one, do one, teach one. We couldn't visit the 14 teams in three days.

 We had two teams trained in a church with two decks. You screen and dispense 10 for 10 persons while the next team watches you. While you're through your shift, the next team joins. As this one is doing, the other one checks whether you are doing it right. See one, do one, teach one. It's a Japanese model. It helps us ensure they're doing it right, even if we can't go to the community far off the road.

Rollo Romig: It sounds like you've deliberately chosen some of the more challenging states. Why did you make that choice?

Suleiman Mshelia: We wanted to use the states where we already have structures of community entry and layers of advocacy engagement, for quick wins. Because for a new state, you need to start from the state-level advocacy engagement. Benue is the only state not under the immunization project. Then you can see the reaching the unreached.

Rollo Romig: Who do you think is underserved so far with the eyeglasses?

 **Dr. Muknaan David Nshe:** For the 40 to 50-year-olds who require less than 2 power, glasses have finished. They are not getting as much as they want. The

government had to limit it to 40 years due to resource constraints. In the future, we consider 35 years because there is an early onset of presbyopia.

The early age between 35 and 50 is the active working age. Most of them don't need the 2.5 or 3.0, they are more on the 1.0 to 2.0, around 1.5.

Rollo Romig: It's easy to not realize how bad the vision has gotten.

Anointed David Oriaku: It is for the majority that is not literate. But for those that are literate, the first thing they notice, when they're Christians, is that they cannot read the Bible. The ones that are not literate would not even notice. One day when they're picking the rice or the beans, they're not seeing anything, they're just saying it's not easy and they don't even know that you can get the glasses and make it better.

Rollo Romig: It's an easy solution but the access is not easy.

Anointed David Oriaku: Yes. You get normal glasses along the road, but for presbyopia, reading glasses, it's not so easy.

 **Meshik Nathan:** We forgot to mention that these glasses are quite expensive. The Benue State Chairman of Eye Health who runs his personal eye clinic, sells presbyopia glasses—normal reading glasses—as high as ₦ 9,000 Naira ($6 USD) for one pair.

Rollo Romig: What is your plan with pricing?

 **Meshik Nathan:** For now, we are giving all the first pairs free, but when you damage your own and come back to get it, we refer you to a location where you have to pay for it.

Rollo Romig: How are you engaging religious leaders, and how are religious leaders helping you with this work?

 **Meshik Nathan:** Religious leaders are helping us with demand creation and some of them have been taught how to do the screening. If you have challenges with your work, especially when it has to do with vision, religious leaders use their positions to share information about where to get help and how to go about it.

Rollo Romig: Are you helping them with sermon guides?

Meshik Nathan: For now, no.

🤝 **Dr. Muknaan David Nshe:** CHAN has a rich history of working with religious leaders in different interfaith forums. Though we are Christian, our work is not evangelical. We have demonstrated that in the different projects we've implemented, the HIV project, the routine immunization project, we have created a system where there's a mutual trust between the Christian faith and the Muslim faith and people of other faiths. We've had the privilege to present at national and interfaith fora, for PHC strengthening in Nigeria. That already erodes any bias and gives us an entry point to say, you've worked with us on this.

📣 Part of the advocacy that went into this work was leveraging the existing relationship with the Nigerian Supreme Council for Islamic Affairs. That platform has helped us to bridge the barriers because, in Nigeria, religious leaders are major stakeholders who do not necessarily serve as just religious leaders. In many places in northern Nigeria, religious leaders are community leaders.

The subdual purpose is done; on Fridays, they're in the mosque teaching, on other days, they're the ones making decisions on behalf of the community, they have that level of influence over the people. When we leverage the existing relationship with them as we deliver other projects like the immunization project and the Management Sciences for Health (MSH) project, we're able to assemble them and have these conversations within those kinds of technical working groups.

I would say it carefully, but Nigerians view many things through the lenses of their faith. If we're able to advocate through their religious leaders and people they respect, it also increases the level of acceptance. Sometimes what the religious leaders say is like the law in some of these places. We leverage those kinds of relationships to deepen the conversation.

📈 In projects like the HIV Stigma and Discrimination project, CHAN had the document on sermon guides. There was no need to create new sermon guides because there's no particular hesitancy. We already have a platform that we can easily build on to continue the conversation. They've been an advocate, they've been the people leading these conversations.

We tell them how they can help us achieve more, knowing that this also impacts their faith practice. The same way a Christian would read the Bible, a Muslim uses it to read the Koran. It doesn’t reduce their spirituality but enhances them.

Our big game is improving the quality of life. If faith helps doing that, we are providing the platform. It's like a double-pronged approach or two sides of the coin in the conversation.

Anointed David Oriaku: Small data from the Sokoto state, the seat of the caliphate in Nigeria, the headquarters for Muslims, shows that from the first to the seventh of March, they dispensed 4,157 glasses, 999 in the market, 227 in the church, and 741 in the mosque. The mosque is almost 300 times higher than what was dispensed in the church, despite the fact that we are a Christian Health Association.


The religious leaders give us a platform to carry out our service delivery. If you go to a state like Benue, the reverse becomes the case. We have very few in the mosque, and high in the church.

Rollo Romig: Are sermon guides especially useful for interventions where there's some hesitancy and there's no distinct hesitancy with the eyeglasses?

Dr. Muknaan David Nshe: Yes, that's right. It's also related to interventions that have some stigma and discrimination that are probably propagated through that. If you look at the anti-vax conversations, you will see that it has some relationship with faith. For eyeglasses, there is no evidence to show that the practice of faith has something in support, in favor of it, or against it to create that hesitancy.

Rollo Romig: It's more about leveraging their community leadership to spread the word.

Suleiman Mshelia: Absolutely. CHAN participated in developing sermon guides for HIV stigma and discrimination because we realized that a lot of the culprits were from the pulpit. For example, you wouldn't wed a couple if there are issues with HIV status, if they're serially discordant. They were propagating stigma and discrimination from HIV status.

We had to bring the religious leaders together to develop sermon guides to bring out the verses in the Bible and the Quran that are against stigmatization as a result of your status, and then use those guides for them to use on their pulpits to preach in their congregation to reduce stigma and discrimination. That worked well. Right now, in some churches, HIV status is not used as a criterion for pre-wedding qualification. That has been removed in some churches and some mosques as well. That has helped.

Rollo Romig: Are there any stigmas associated with the eyeglasses?

Anointed David Oriaku: It's rather the opposite way. Wearing glasses makes you feel like you're intelligent.

Meshik Nathan: Our data shows there are no stigmas around acceptance and opt-in with glasses.

Rollo Romig: Do you typically do post-assessments or surveys?

Dr. Muknaan David Nshe: Yes, it depends on the project and depends on the funding. If it's something that we are expecting, if it's part of the questions we're trying to ask in the course of implementation, then we do that but not necessarily.

Anointed David Oriaku: 60 Decibels is an organization that does assessment, but in the site of RestoringVision, they're looking more to how it has improved their livelihood. We are looking at the proposal, and we are still trying to see where we can increase it, but 60 Decibels is coming on board to do some evaluation of where we have worked.

Rollo Romig: In these states where you've worked so far, what have been the unanticipated challenges? What assumptions did you have about how it would work, that didn't turn out that way?

Anointed David Oriaku: It's something we need to process, but the first, top of my head, was that we train this day, the next day we'll go to supervise, and in two days we have covered the 14 teams. At least, we have visited all of them like this, and it was not possible because of the distance.

📣 **Suleiman Mshelia:** Because of our unique community-based approach, which is novel and new, we had to do a lot of advocacy, we had to align with the government, and they had to understand that approach to be sure that quality is not compromised. That delayed us a little bit, to be sure that we have all the boxes checked. Now that we have hit the ground running, we're learning, we're adapting, and we're scaling up.

Rollo Romig: If you imagine talking to the head of an organization like yours in another country, an organization similar to CHAN, if they wanted to get started with this, what kind of advice would you give them?

Suleiman Mshelia: Doing a gap analysis first, leveraging on your strength and being clear about the approach that you want to do would be key, even before the start.

If they have existing data on presbyopia, and a unit in the government that handles eye care, it's good to engage and know what has been ongoing, what are the gaps, what are the challenges, what are the approaches that they have been doing and then look at the uniqueness of positionality and strengths.

 How to bring the strength to cover the gap of the national Ministry of Health and look at the geographies. There will be fewer challenges if there is a complete alignment. Even though the government of Nigeria and the Ministry of Health are strong, you can't implement without aligning but it depends on the context of the country. If the private sector has a smooth sail in terms of implementation they can achieve much more. But in Nigeria, you have to align with the government.

Rollo Romig: It seems like there was a lot of aligning. Dr. Okolo is such a strong advocate. The Health Minister spoke about how he has glaucoma and the President seems very invested also. I imagine it would be a huge challenge if you didn't have this alignment.

 **Suleiman Mshelia:** Yes, exactly. Very critical.

Dr. Muknaan David Nshe: Stakeholder management is important at the beginning and then add a data system. If you get to the field and start dispensing glasses, you have to document the data, how to get it, how to sum, and how to report it.

 We started a bit late because we are trying to ensure that we fix the data system. Once the system is set, you can just start pouring in data. The data system needs to ensure quality. With a community approach, it's easy for a few teams to falsify data. You have to have different methods of triangulating their data. We do spot-checking, where you get to the field and meet the team to make sure that they are there and they are not doing anything fishy.

Stakeholder management, a good data system, ensuring quality and manpower. Manpower is very important. When using volunteers, you have to make sure that the ones who record, the healthcare workers, and the organization team, can read and write. If you don't have good manpower, you can't supervise. In Nigeria, plenty of people are unemployed. You can easily pool up. In other countries, the population is smaller, so it becomes more challenging.

Meshik Nathan: Mobilization is also key to reach the people and inform them and create demand before you start working on location.

Rollo Romig: If you've been working in four states, is there one state that you wish you could do over from scratch based on what you've learned, or maybe not?

Dr. Muknaan David Nshe: We would rather look at adding more states. CHAI is in 10 states, we are in 4 states, and we intersect in 2 of the states, so there are 12 states, and Nigeria has 36 states. We still have 24 states to go.

ICON LEGEND

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.*