# "It took a little bit of getting used to": Jonathan Garrard and Ssanyu Kalibbala of DMI on their Ugandan pilot project, generating awareness and the value of advertising

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**Ambika Samarthya-Howard: Can you start by telling me a little bit about your organization and the model that you're working with right now, specifically around the eyeglass initiatives that you're working on?**

**Ssanyu Kalibbala:** Well, this is new for us, this work in eyeglasses in Uganda. We refer to it as a study rather than a project, I guess because it was quite short term and it was really like a pilot. We're trying out a new model of distribution of eyeglasses, and also a new SBCC [Social and Behavior Change Communication] approach to uptake of reader eyeglasses in Uganda, especially in rural areas. Now this pilot in Uganda is coming to an end and it's starting in Zambia, but Zambia is a very different context with regards to eye care in general.

We started implementation in July 2023. The proposed project or pilot study was to distribute eyeglasses in four different districts. Two districts were selected to be the control districts, and two districts were going to be the intervention districts. And LIF were very interested in starting a new model of distribution. Eyeglasses had been distributed through various partners prior, either through eye care specialists, or through organizations such as BRAC in conjunction with VisionSpring. They usually distribute glasses at quite a small scale mostly with interpersonal SBCC interventions where they meet people in communities, either in churches, or at community activations, but usually with small mobilizations. So we were going to approach the intervention districts with intense media radio campaigns and marketing as well.

**Ambika Samarthya-Howard: Those are your experimentation districts?**

**Ssanyu Kalibbala:** The intervention districts are the districts where we were having both the radio campaigns and distribution of glasses. And then in the two [control districts] we just had distribution without the radio campaigns.

We were going to compare uptake in these four districts and see what impact our radio campaigns would have specifically on readers.

**Ambika Samarthya-Howard: In terms of the district themselves, were all four rural, and was the distribution of glasses all done through community health workers?**

**Ssanyu Kalibbala:** No, distribution was all done through pharmacies. We wanted to have a different distribution model to the approaches that were already on the ground. BRAC and VisionSpring distribute mostly through community health workers and then privately [through] their trained eye care specialists. But Uganda, I think we have around 200 OCOs (Ophthalmic Clinical Officers) for a population of over 45 million people.

In Uganda people have very little access to eye health and eye care, and there's very little knowledge about eye care and issues regarding sight in general. Most people assume that if you have issues with your eyesight, you need to see a professional and you need to purchase either from an expensive optometrist or get them through these community charity exercises such as the ones that are initiated through BRAC.

**Ambika Samarthya-Howard: That makes sense. And there's no other differentiating quality within your districts? All four were rural?**

**Ssanyu Kalibbala:** They were all rural. But in order to better determine whether radio had an impact on uptick, we needed to identify districts where one predominant language was spoken and where one main radio station was listened to, so it had to be quite isolated districts. I don't know if you've ever been to Uganda?

**Ambika Samarthya-Howard: Yeah, I actually was just there in November and I've spent some time filming and working there. I was mostly in Kampala.**

**Ssanyu Kalibbala:** So as you know Uganda is a very diverse country linguistically, with a fragmented media landscape. There are over 350 privately owned radio stations. Most regions have multiple radio stations broadcasting in different languages. Communities can listen to a variety of radio stations in a given region or district. So it was very difficult to find districts with one main radio station and one predominant  language of broadcast.

That's why we selected Kisoro, which is in the Southwest bordering Rwanda and Congo. And then we selected Koboko, which is in the West Nile, so northern region bordering Sudan and the Congo as well. Both towns are comparable in population and social context in the sense that they're border towns with quite a few refugees coming to  those towns. Both towns are isolated from the rest of Uganda, speak one predominant language and each have a popular community radio station.

**Ambika Samarthya-Howard: Before you go into the findings, can you tell me a little bit about how you developed these radio campaigns? Were they actually getting people to get screened and move people to the point of purchase? Or were they getting people to just know about eyeglasses, like a sensitization campaign?**

 **Ssanyu Kalibbala:** It was a little bit of the issues you mentioned. We carried out formative research to identify exactly what the barriers to purchasing reader glasses are. One of the main barriers was lack of knowledge of eye care in general. So our messages would, on the one hand, provide information about what presbyopia is, explain that it impacts, for example, people over 37 years old and symptoms include having a hard time seeing small things up close. And then at the same time, we would inform people about the pharmacies where they can get tested, and where they can also purchase the glasses at a very cheap subsidized rate.

**Ambika Samarthya-Howard: Got it. So the radio campaigns would direct people to a pharmacy?**

**Ssanyu Kalibbala:** Yes. Specific pharmacies in both implementation districts.

**Ambika Samarthya-Howard: And what was happening in the other districts without the radio campaigns?**

 **Ssanyu Kalibbala:** We were just distributing glasses in the same number of pharmacies. We were able to identify four pharmacies in each of the districts. And so it was just a normal distribution with a few marketing materials. We had branding, and we also tested brand names. So they had some marketing materials at the point of sale sites as well as a few posters and leaflets to be distributed around, but it was mostly word of mouth that those glasses were sold and distributed.

**Ambika Samarthya-Howard: What did you find?**

**Ssanyu Kalibbala:** Many of the barriers that were commonly known to LIF, such as the assumption that readers are only for people who read or for rich people, those classic barriers were there. The biggest barrier we found was the lack of knowledge of eye health. Many of our participants in focus group discussions, people over 40 years old, usually thought that it was their fault that they could no longer see. They thought, especially women, that either they had cooked

with too much smoke, or were wearing too many heavy loads on their heads, and that somehow affected their eyesight. There was this fatalism as well. Many just assume that's what it is. You grow old and there's nothing you can do about it.

 It was interesting that even though we worked closely with the Ministry of Health (MOH) and with the district level leadership, and even among healthcare workers and district health professionals, there was very little knowledge about presbyopia and eye health in general. So you'd have a lot of healthcare workers or district officials who would tell us, we have to find a prevention for presbyopia. There has to be something we can do about the degeneration of eyesight when you get older. And we really had to explain that it's absolutely normal, and that the prevention is to wear reading glasses.

[We had to] explain what presbyopia was, what were the symptoms, how to identify them, and then what you could do about it. Then because we were in rural areas, we had to explain to people or sensitize people to the fact that it helps your livelihood or quality of life in general to wear readers. It can help for gardening, it can help for a number of activities or chores that need to be done, especially for women.

In our results, we saw that it was a majority of men who purchased our glasses. So there's still a gap with regards to women having that purchasing power and thinking that they would need glasses.

**Ambika Samarthya-Howard: Did you find any difference with the radio campaign? Did those people buy more?**

**Ssanyu Kalibbala:** Yes, absolutely. John, maybe you can talk a little bit more about the difference in uptick in our controls.

**Jonathan Garrard:** Firstly, we are just coming to the end of a very short period of intervention. So it's four months on air we're just coming to the end of now.

In terms of sales data, we started out with three pharmacies in each district, a month ago we increased that to four. So it's a very small number of data points. The sales that we have adjusted for population at the district level population, the two interventions outsell the controls by about three to one. And at the town level where the population is more concentrated, it's about four to one. We are just going through our data now.

We collated data at the sales point. We got, from every person who bought a pair of glasses, name, age, sex, home location and a phone number because we've been doing some qualitative follow up interviews over the phone in the last couple of weeks, and the location of where they were coming from. We are just looking at that data now. Predominantly it's in and around towns, although there are people that are coming from further away. A rough guess between town and

district, it's about three and a half to one intervention to control, roughly. But we will be able to tell more accurately once we look at the data, based on locations given.

**Ambika Samarthya-Howard: That's really powerful. Are you trying to do the same exact pilot next in Zambia?**

**Ssanyu Kalibbala:** Yes

**Jonathan Garrard:** Yes.

**Ambika Samarthya-Howard: Why not expand in Uganda?**

 **Ssanyu Kalibbala:** Those are good questions. Well, just to give a bit of context and then Jon, you can hop on. I just wanted to mention that no one had ever distributed eyeglasses in pharmacies before. That was the other barrier that we had to deal with. Not only were we sensitizing the general public about presbyopia, informing them about eye care in general, additionally to that was, "You can get these glasses and you can get tested for these glasses in a pharmacy." Nobody had ever seen or done that before.

Midway, after a couple of months, we designed new messages to reassure the general public that yes, pharmacists were qualified, they were trained to screen you for eyeglasses, and yes, the pharmacists were also vetted by the Ministry of Health and by the district authorities, and they were allowed to test you and to sell eyeglasses. That was also quite a challenge.

**Ambika Samarthya-Howard: Did you have that same challenge with the pharmacists themselves? What was their comfort level of selling glasses?**

 **Ssanyu Kalibbala**: It was also a challenge to recruit pharmacists because they'd never done it. They really were afraid of losing their licenses, for example. They usually deal with business transactions. They rarely collaborate with the NGO or the development world. So many were a little bit wary, and it took a little bit of getting used to. But then once they were reassured that we were vetted by the Ministry of Health and the National Drug Authority, [they felt] reassured and realized that we weren't there to give them any trouble, and that they would also benefit financially.

**Ambika Samarthya-Howard: Did you provide training or supervision for them?**

 **Ssanyu Kalibbala:** We did. We provided training to the pharmacists because it was also really difficult to convince the Ministry of Health that we could distribute glasses through pharmacies and that we could train pharmacists to screen for presbyopia or to screen for eyes in general, while also giving references to clients who had issues beyond presbyopia. It was a

convincing game, convincing on the one hand the pharmacies to partner with us, and then also convincing the Ministry of Health that it would be okay for us to try this, that it was a study. And so there was pushback, but we explained that, this is a pilot, we're trying this out.

The Ministry of Health are also the gatekeepers. They wanted to ensure that their OCOs [ophthalmic clinical officers] and their eye care clinics in general hospitals and the referral hospitals were not going to lose clientele. So we worked very closely with the district authorities and the OCOs. Usually OCOs were appointed to us and worked at district level or at referral hospitals. In the end, we were able to get buy-in not only from the Ministry of Health at national level, but also at district level. And we ensured that the OCOs were involved with this project and could access the data and see the benefits of de-medicalizing presbyopia or reader glasses.

Additionally they could see the impact of an SBCC campaign on knowledge and uptick of eye care in general and purchase of reader eyeglasses. Most of the supervisors we worked with were district OCOs or district pharmacy supervisors, they were part of the MOH structure.

**Ambika Samarthya-Howard: Do you know how much you got them for and how much you sold them to the consumer? Did the pharmacist set the price or did you set the price?**

 **Ssanyu Kalibbala:** We set the price at a very affordable cost because we knew that these were rural communities, and that one of the biggest barriers to accessing glasses was cost. We set it up at 5,000 shillings, which is approximately $1.50 or so.

**Ambika Samarthya-Howard: Did you ever find that some people thought that price was too low, that maybe it wasn't genuine or that it was fraudulent because the price was too low?**

 **Ssanyu Kalibbala:** Yes, the issue of price was in our messages as well. We knew that it was a barrier. We had collaborated closely with BRAC and VisionSpring, and they usually sell their glasses through their community workers at around 15,000 [shillings]. So three times the price that we were selling at, and they said that they had identified this particular price point because when they went any lower, clients would usually assume that the glasses were either fake or bad. So that was one of the barriers that we addressed in our messaging, especially in the second phase of the campaign.

**Ambika Samarthya-Howard: You went lower than what BRAC and VisionSpring were selling at and you were still able to sell?**

 **Ssanyu Kalibbala:** Yes, we were very transparent with BRAC and VisionSpring with regards to our exercise. They were also very interested to see the results of the pilot. We got buy-in from the Ministry of Health, and we also got buy-in for other eyeglass projects in the country. We collaborated closely together, and it's actually VisionSpring and BRAC that were

providing the training to our partner pharmacies. It was nice to see all of these different players interacting. We were transparent with them about our prices. Our rationale for bringing the price point lower was that [Vision Spring's] healthcare workers usually travel to the consumer in rural areas, and in our case, our pharmacies were in towns, and we knew that people had to spend money to reach the commodities.

**Ambika Samarthya-Howard: That makes a lot of sense. Did you feel like anybody bought a second pair of glasses or did everybody just stick to one pair of glasses?**

**Ssanyu Kalibbala**: It was mostly the first pair, but there were quite a few people who already had a pair and were buying a second pair. And then we had a few clients from our phone interviews, we're still looking at the data, but it seemed that there were also a few people who would buy a couple of pairs.

**Ambika Samarthya-Howard: Do you know why the people who bought second pairs bought them? Was it just style and being outdated? That their glasses weren't great anymore?**

**Ssanyu Kalibbala:** I can't generalize because our data is mostly qualitative, but it seems like people who came from far away, especially people who came from outside the district, like refugees from Sudan, sometimes picked up more than one pair.

**Ambika Samarthya-Howard: How did you do the screening? Did the pharmacist do the screening, and did the screening and the point of purchase happen at the same time?**

 **Ssanyu Kalibbala:** If clients came in and said, "I'm interested in buying these glasses." The pharmacist would say, "Great, we'll have to screen you." And this was also mentioned in the radio messages that when you got to the point of purchase, you needed to get a screening and it was free.

 Just to mention something about the price point and our messaging. We also had to, in the second phase of the campaign, address the fact that younger people wanted to purchase the glasses because the glasses look cool. So we also had to sensitize the general public to the fact that you might want to wear glasses because they look cool and they're cheap, but you need to be of a certain age and to suffer from presbyopia. So even if you're young and you've got cash to buy the glasses, you can't buy them.

**Ambika Samarthya-Howard: Did you find that some pharmacies were more successful than others? Was there anything particular about the pharmacy or the pharmacist that was something to note?**

 **Ssanyu Kalibbala:** It seems like location is really key, [and another factor is] the size of the pharmacy. A centrally located pharmacy that has a lot of footfall will sell more. We're still looking at the data, but it seems that in the control districts where there are no radio campaigns, the pharmacies that did well were usually pharmacies with either very active pharmacists, who were able to explain things to people or owned by an OCO or where OCOs referred that if you need cheap glasses and you can't afford glasses, you can go to the pharmacy and get glasses.

**Ambika Samarthya-Howard: That makes a lot of sense. I'm just curious why Zambia, and not expanding in Uganda?**

**Jonathan Garrard:** We would really like to expand in Uganda. We are delivering projects we designed six, seven months ago for the amount that they were. First of all, I think we would want to go for longer in Uganda as well as expand out because obviously this is a location that had no glasses before or very low access.

 I think it's fair to say that what we've experienced both in control and intervention is a huge uptake, but partly that's solely based on the fact that it's novel, and access has been massively improved for the first time. So it would be very interesting to see particularly how radio keeps up the sales compared to a drop-off from that initial low hanging fruit in the control areas. If we could show that we can sustain maybe a hundred pairs a week in each district as we are seeing sales drop off in the controls, that would be really interesting. I think at the moment, the power that we have from the numbers we have is limited because of the few data points, so having wider [data] and in more context would be really beneficial.

 If we had the chance to expand, we would also, for example, look at differences in messaging. So what Ssanyu has described is a combination of DMI type messaging, which is very focused on research. It's all about behavior, looking at barriers combined with much more straight advertising promotion. So the branding is pushed very heavily. The specific locations of pharmacies are pushed heavily, the price itself.

So it would be very interesting to do a campaign in one area that combined all of that and then separate out maybe just a very hard promotional campaign without any of that behavioral aspect. And then somewhere else, something very behavioral based without a promotion, we are going to be doing something like that in Zambia.

 Zambia is a different context because glasses are already available there, available in pharmacies, available in rural areas. So the supply chain [is there], and we are just starting to scope now. We're talking to different pharmacies, so it will be similar. We'll also be partnering with VisionSpring. VisionSpring will probably play a more prominent role in terms of how we work with them to support engagement with the pharmacies.

 Learning from Uganda, we will be looking more at the quality of servicing in pharmacies and potentially looking at, for example, the conversion rate from someone going to a pharmacy to actually buying. Because as I said earlier, we basically [assume] that if we can push people to the pharmacies, it will end in a sale, it's been the assumption, and we've unpacking that a little bit more.

So it will be similar on a slightly bigger scale. We'll be trying to get up to six pharmacies per district, minimum, ideally up to 10. But it all depends on what we find when we do the scoping. There's a lot of similarities with Uganda, but other things that we've adapted for, and particularly what we'd really like to do is to be able to get data from other pharmacies on their existing glasses sales and then look at how we drive aggregate sales of all glasses overall, not just the brand that we are going to be providing.

**Ambika Samarthya-Howard: In terms of the regulatory frameworks around what's happening with the pharmacies in Uganda, do they feel like they have any legal concerns about selling glasses?**

 **Ssanyu Kalibbala:** Yes. That's one of the biggest concerns of the pharmacies. They're afraid of overstepping, and rightfully so, because glasses are considered to be a medical commodity in Uganda.

**Ambika Samarthya-Howard: How have you worked with that or what have you seen works with that?**

 **Ssanyu Kalibbala:** It's pilot research and we're working hand in hand with the Ministry of Health and with the National Drug Authority. We do realize that glasses are a medical commodity and that usually in Uganda, you need to be screened by an OCO or another professional in order to get a prescription. That was the other barrier for pharmacies. They said they would be happy to distribute but we want a prescription from a doctor in order not to get in trouble. So we had to explain that we had permission to bypass that. Obviously what helps is that the Ministry of Health is also very much aware that in many countries, readers are not a medical commodity.

**Ambika Samarthya-Howard: The ministries of health were really supportive of this approach for you in Uganda?**

 **Ssanyu Kalibbala:** Well, the MOH knows that there are not enough OCOs in the country. They know that there is a problem with presbyopia in rural areas, or that there are issues with eyehealth in general that are not being addressed. So they were enthusiastic about the program, yes, because people could access affordable commodities in rural or poorer communities. But at the

same time, they were also very curious about the data. They're very curious about our SBCC approach and they're looking forward to seeing the results and want to see if this could be a sustainable model to roll out in future.

**Ambika Samarthya-Howard: Is this the first time your organization has worked with the Ministry of Health, or did you have an existing relationship?**

 **Ssanyu Kalibbala:** We had an existing relationship. That's why we're able to hit the ground running with this project. We have a close relationship with the health promotion department, which is the department in charge of all communication and all messaging with regards to health in the country. And in this case, we also collaborated with the Department of Community Services who are very open to also de-medicalizing readers. They're aware of this problem, but eyeglasses also fall under the Department of Clinical Medicine, and that's the department that's more protective of their OCOs, eye care providers, and the current eye care system.

So it's that department that we really have to advocate for change, and that BRAC and VisionSpring and other eye care NGOs have been lobbying to but it's an ongoing process.

**Ambika Samarthya-Howard: How long have you had a relationship with the Ministry of Health?**

**Ssanyu Kalibbala:** We're fairly new to Uganda, we opened an office in 2019. That's new for Uganda. When you consider that many US SBC organizations have been here since the '90s for the HIV/AIDS pandemic and through the Global Fund and other funding institutions we're fairly new.

 **Jonathan Garrard:** Our previous projects in Uganda were part of a bigger family planning project, and our closest working relationships were in Uganda of all the countries we've worked in. We've done international conferences where MOH staff are on panels with us. MOH has actually absorbed some of our kind of working processes into their health promotion protocols around messaging and media campaigns, so it's been new-ish. But it's been a very functional relationship for some time, and I think that it is a definite value that we brought when looking at VisionSpring and how they were working and the fact that perhaps they didn't know MOH as well as DMI. We've really been able to help with that.

**Ambika Samarthya-Howard: In terms of your relationship with the OCO folks, with the optometrists, is there anything that you feel like you did with your partnership with the Ministry of Health that you think was effective to get their buy-in?**

**Ssanyu Kalibbala:** They were also really interested in the data as well. They're really curious.

**Ambika Samarthya-Howard: You mean, the optometrists were really curious?**

**Ssanyu Kalibbala:** Yes. And the MOH at district level really want to know what increases uptake of reader eyeglasses. Is it access? Is it messaging? Is it information? Is it making the commodities more available, more affordable? This is all quite interesting for eye care professionals.

**Ambika Samarthya-Howard: So essentially because you were sharing the data and sharing the findings, they sort of felt like they were part of the initiative?**

**Ssanyu Kalibbala:** Yes they did.

**Jonathan Garrard:** We haven't necessarily talked about it on this project, but I would say it's the kind of truism that I've encountered through a long time working in development and in the field is the guys in the fields at district, village and sub county level, they are really interested in the practical stuff. If they see something that's going to bring a benefit, they're always interested in doing it. And anyone that comes with positive solutions, they will generally always be interested. You meet one or two kinds of individual characters, but in the main, they're very practical. It's usually when you get to the central level, the bureaucracy where people are less interested in actually doing something good because they're not seeing it in action. They're kind of removed from it. I mean, I don't know if that's a more general truism, Ssanyu, but do you think that's in play here as well?

**Ssanyu Kalibbala:** Absolutely. Time and time again, especially the control districts, questioned , “why aren't we the trial districts?” We would've loved to have an SBCC campaign to inform communities about eye care. Even though we couldn’t include them, they still said, “we want to benefit our communities.” We want to help our people, and therefore, yes, we are willing to collaborate. When we look at the data from the phone interviews, most of the respondents say, "I would've gone to an eye care specialist, I would've gone to the eye clinic. That's where I thought I needed to go for the eyeglasses."


And I also wanted to add something with regards to some of the differences between the control and the implementation districts. Although we were targeting a general public, all listeners in a given community, what the campaign also did was [result in] the pharmacies – and especially the pharmacists providing the tests – being much more responsible and more ethical with regards to ensuring that they test every client. They were much more accountable to providing adequate services, information, and sales in the districts where we had the campaign, compared to the districts where we didn't have the campaign. In some of the phone interviews we had in the control districts, people said, “no, the glasses I have, they're not working well. The pharmacist didn't really test me.” It was much less thorough in the control districts. So that was also interesting to see.

**Ambika Samarthya-Howard: That's really interesting. I wonder why that was. That's not related to the radio campaign at all?**

   **Ssanyu Kalibbala:** No, but I guess you become kind of a celebrity, right? As a pharmacist they're talking about you on the radio, they're saying that you're conducting these eye screenings, you have this new commodity, it is cheap, it's helping people. So from one day to the next, you become an eye care specialist of sorts. And I guess pharmacists really appropriated their role because it was non-stop messaging about them on the radio, and they really stepped up with regards to ensuring that they provided adequate services and proper screening, which wasn't always the case in the control districts. I guess they felt more supervised with these nonstop radio spots heard in the community.

**Ambika Samarthya-Howard: Yeah, I often find that when you report on specific instances, if the people know that they're being reported on, you just end up getting much higher levels of output because they know they're being supervised.**

**Ssanyu Kalibbala:** Yes. But all the districts had supervisors, so they were all being supervised by individual professionals. But I guess that in the districts of intervention, they felt like they were supervised all the time. Right? Because the community is expecting them to sell these glasses and screen appropriately, whereas in the control districts, they knew that they were not supervised 24/7 [and there were no expectations from clients].

**Ambika Samarthya-Howard: That makes a lot of sense.**

**Jonathan Garrard:** I think going back to the kind of data points and the variety that there is between across all districts, [we saw] quite strong performers. We don't really have the data to understand either. Before we kind of get too much conjecture on some of these things, we don't really know or understand it.

**Ambika Samarthya-Howard: Just a final question that I forgot to touch on, was there anything that you did with the private sector or do you see a role with the private sector with some of the stuff that you're about to do in Zambia? I was just curious if you've worked with that in terms of the supply for the glasses?**

**Jonathan Garrard:** Supply for the glasses all come through VisionSpring, and obviously the radio is a private sector. The pharmacy is a private sector, but we haven't been involved in the Uganda project in any of the actual supply chain, partly because it really exists apart from the two eye clinics, and yet the glasses come straight to us.

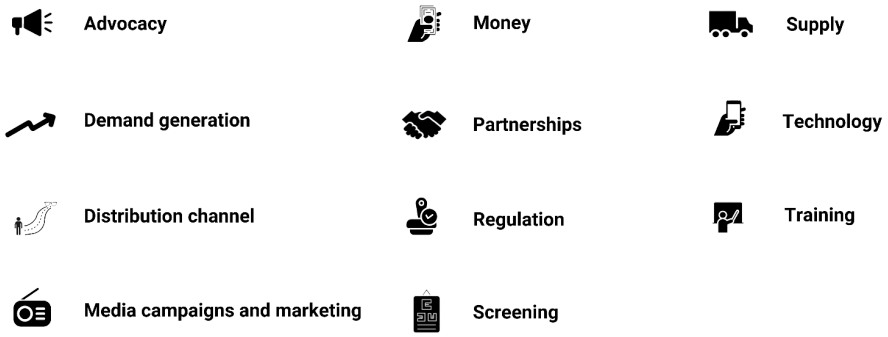
 We did use a private sector design company to help us with the branding a little bit. In Zambia, we will be trying to understand those supply chains a bit more, I think, because unlike in Uganda, the initial idea for distribution was really to just make sure that there was access there for the demand that we were driving. It's not going to work if people can't get the glasses. So we were sort of backfilling that space. I think in Zambia it's going to be more nuanced and we're going to look at trying to understand those pharmacies and if there are any other locations that

are selling glasses, where they're coming from, understanding the kind of distributors and wholesaling chain a little bit more.

And then looking at our supply, which is again coming through VisionSpring as augmenting that. So maybe we're going to find that there are some pharmacies that have actually got a pretty good turnover and replenish quite often. Some others that really hardly sell any, and it's almost a kind of forgotten commodity that we've probably tried and revamp a little bit by adding our brand in as well. So I think there's a lot more thinking about that for Zambia.

**Ambika Samarthya-Howard: Okay, that sounds great. It's really great to speak to you both. Thank you.**

## ICON LEGEND

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** This interview has been edited and condensed.*