“Faith leaders are in communities with or without funding for projects”: Nkatha Njeru of The Africa Christian Health Associations Platform on the ways they are integrating faith leaders into bringing reading glasses and eye care to communities.

Ambika Samarthya-Howard
September 4, 2024

Ambika Samarthya-Howard: Tell me a little bit about your background. How did you get involved with eyeglasses and eye health?

Nkatha Njeru: I am Nkatha Njeru, the Chief Executive Officer for the Africa Christian Health Associations Platform [ACHAP]. We work with Christian Health Associations (CHAs), which are organized through Mission Health facilities and programs nationally. Our work is to support the work of CHAs in different countries. We've done a lot of work in public health, [particularly] maternal and child healthcare and non-communicable diseases, but we had never quite done work in eye health. However, I've always been aware that that's an issue. And just to say, because I myself am over 40, I know at some point you actually need those glasses to be able to function.

One of the forums that we take part in is the Christian Connections for International Health. In 2022 at the conference for the Christian Connections for International Health we connected with Mark Lorey of RestoringVision and began our journey to providing readers through faith communities.

🤝 One of the biggest challenges for us with the resources we get is clearing the glasses or other in-kind support to get into countries. One of the things we were trying to do since COVID is to use the faith sector, especially the churches and the faith leaders, as a connection to health. Because with COVID, we learned that we needed to involve the faith leaders more as advocates

and champions for health. So we talked about it, held meetings, and we wrote a concept or a model where we were going to use faith leaders and faith places to help people access reading glasses. That's how we began. And there's quite a bit of very good impact.

Ambika Samarthya-Howard: I was wondering if you could tell me about another initiative that ACHAP has done, whether it be COVID or malaria or HIV, that has been really successful. Could you talk me through the details of that?

Nkatha Njeru: One of the things we've been asking ourselves as a part of the faith-based health system is, what value do we add to health? What's different about us? There are a lot of INGOs, there are a lot of ministries of health, and a lot of other people working in health. What makes us different? We realized it's our values and our connection to the faith community. And so we started thinking, if we have a connection to the faith community, how do we make a difference to health?

One of the things we thought about is the fact that in a lot of African societies where we work, faith leaders are held in high regard. And what the faith leader says is what is believed. COVID actually impacted Africa in both ways using faith. Where faith leaders did not believe in the COVID vaccine, there was hesitancy. And where we went in and helped the faith leaders to understand the vaccine and why it was necessary for people to have the COVID vaccine, then we were able to get that.

The other one is we have used the faith leaders as champions for pediatric HIV. There are a lot of children that have not been tested for HIV. I mean, the world has not been able to achieve the 90, 90, 90 [treatment target of UNAIDS, where] 90% of the people know their status, 90% of them are put on treatment, and 90% [achieve viral suppression]. And so that is even lower for children.

 We started to teach faith leaders, because faith leaders are in communities with or without funding for projects. People come to their congregations. So we started talking to them about the importance of talking to communities about which children need to get tested. If a newborn has lost parents to HIV; if children have been unwell for a long time and nothing is really being diagnosed. I have some statistics where we started to see that higher numbers of children tested were referred by faith leaders than by community health volunteers, which is the system we all know in the communities. And the same [approach] was used even for non-communicable diseases, where we got faith leaders to talk to their communities and congregations about the need for people to get screened for both hypertension and diabetes.

Those are some of our success stories. So we thought we could use the same model to get people to get reading glasses. And of course, because reading glasses were going to help people to read their religious texts as well.

Ambika Samarthya-Howard: Let's go back to the COVID example. So you are speaking to a faith leader who does not believe in vaccinations. Who do you send in to speak to them, and how does that conversation go?

Nkatha Njeru: What we did is we identified champions within the faith leader groups, within the Christian community. The communities have respected faith leaders, and most of the time it has to do with their religious beliefs. But if they hear it from another faith leader, it becomes easier to have an open conversation. I have seen it work especially when we did the pediatric HIV training. Because you would find faith leaders who believed that [a person with] HIV is a sinner and they got it because they had unprotected sex and they were not married—all those myths. But when they interact with fellow faith leaders who talked to them about how HIV is spread, how it is not necessarily as a result of sin—it's from another faith leader. When it comes from a clinician, it doesn't make sense. The other thing we use is what we call sermon guides. Sermon guides are developed by theologians supported by clinicians. So we get texts from religious books that help to explain science.

Ambika Samarthya-Howard: Your group created these books?

Nkatha Njeru: Yes. We supported theologians that are trained to create this, because they know the theology, we know the science, and so we marry the two. For instance, we have documents that we called Faith and Science for COVID and other topical sermon guides on our website.

Ambika Samarthya-Howard: Tell me a little bit about the team that creates this book. How did you decide your approach?

Nkatha Njeru: The team has both theologians and health experts. For example, the clinician or the people working on the side of health are saying, children need to be taken care of, and taking care of children means taking them to hospital. And then the people from the theology side help us to find a text that can explain that from the pulpit.

There's a lot [of groups doing this]. If you go online and search for sermon guides for maternal and child health, sermon guides for COVID, you'll get them both. We do not just [make] Christian [guides], because our communities don't have just Christians, they have Muslims as well. So we get theologians. A theologian is someone who is well-educated and will therefore understand theology and a bit of the health side. We get theologians, and we do maybe a three-day workshop and talk to them about the messages we want to pass and they tell us about the texts. When you go to places of worship on worship days, someone talks about a certain topic and has prepared something using their religious book. We do the same thing, and it's not just about spiritual things, but it's also about health. How do you use the Bible to talk about health?

Ambika Samarthya-Howard: How do you decide the content? Let's say specifically for COVID, how do you decide the content, and how do you also decide things like language and length?

Nkatha Njeru: Of course, one of the things we look at is the messages we want to pass [on]. When COVID happened, people couldn't believe that anybody could close a church or a place of worship. So for faith leaders that understood that we needed to close places of worship because people were going to get infected, we needed to find, is there a place in the religious text that can help people to understand that? For example, I think in the Bible, and I think even in the Quran, there's something about [how] church is not the building, it's the people. That you don't have to be in the building to be able to worship, that you can worship from where you are, for faith leaders to feel comfortable that we are closing the churches for this reason. So you look at what messages you want to pass and see if there's a relationship between them and the religious sect.

Ambika Samarthya-Howard: And then how do you decide how to actually write it? What language do you use? And then how do you disseminate it?

 **Nkatha Njeru:** These are meant for faith leaders. Depending on where you are—for me, I worked mostly with English and Swahili in East Africa. But you can have them translated to local languages. After we've written the texts, we organize capacity building sessions where we talk to the faith leaders, build their capacity, and help them to understand the text. We even pre-test them, because sometimes the theologians might think they have nailed it, but then a faith leader actually says something about it and they're like, yeah, maybe this one doesn't make sense.

Ambika Samarthya-Howard: What's been your biggest challenge? Has there been a specific faith group or specific health issue that you found particularly challenging with this approach?

 **Nkatha Njeru:** The latest ones have been, of course, the issues around COVID because of the many myths around vaccination. HIV has been a very hard one, continuously. There have been a lot of myths over the years we've had to work on. But overall, I think eye health is an easy one, because places of worship are places that people congregate often. And so using them as, for lack of a better word, distribution centers has worked. And you get the results instantly for the reading glasses. You have people in places of worship who want to be able to read their Bibles or Qurans, and immediately after you give them that pair of glasses, it makes a difference to them. So that has been a very easy one for us using faith leaders as champions.

Ambika Samarthya-Howard: What are the current barriers? I think there's about 800 million people in the world today who need eyeglasses who don't have them. What do you think prevents that?

 **Nkatha Njeru:** One of the biggest [barriers] that we are working on right now is policy in different countries. Because in a lot of places, only health workers that are trained in eye health can distribute reading glasses. So that's a place we are trying to see how we can best work on it.

And I didn't know this until lately, but there are people, I don't know if you can call them cartels, who are involved in the sale of reading glasses that are finding it hard to accept that we can be providing this for free. So they're not helping with making the policies easier. Already Africa has a problem [getting enough] health workers, and so getting health workers that are opticians, in the optical spaces, has not been a priority. So you see that doesn't help the problem.

 And then we have the reading glasses with us, but the hospital is probably not the place where people will come for reading glasses. So we need to go to them, and that has a cost. So we've been trying to be as innovative as possible to get reading glasses where they need to be and to get them distributed. It's definitely still a challenge.

Ambika Samarthya-Howard: Do you think that this is all about money and finances? Do you think it's an issue of not having enough money to put towards community health workers? What do you think are some of the underlying issues that are preventing more community health workers from doing this work?

 **Nkatha Njeru:** I don't think it's just money. Money is part of it, but I think it's also just the awareness and the prioritization of eye health. I think the more of us that get in this space and try to help to prioritize eye health, the easier it's going to become for it to be prioritized. Our health workers and community health volunteers are already stretched with many other priorities that are funded. So the incentives to be able to go out and test people, the incentives for people to go out and do other things, are probably none.

Ambika Samarthya-Howard: For the next few months on this project, what are the current plans and what are you hoping to achieve?

Nkatha Njeru: It's been under one year. We are learning. One of the things we want to do is to look at how the different countries are handling the distribution and to learn from one another. [Our work in] Malawi is starting. Nigeria is starting. We are in Kenya, we are in Zambia, and we are in Sierra Leone. And we are just going into Eswatini. We are hoping to go into Ethiopia and Lesotho. So quite a number of countries.

Ambika Samarthya-Howard: What makes them similar and what are the differences?

 **Nkatha Njeru:** The policies are the difference in all of them, the policies on eye health and especially on the distribution of glasses [in each country]. The similarity [is that we] are working through the faith sector in all of them.

Ambika Samarthya-Howard: Can you take me through an example? I think you've had the most progress in Kenya, right? Can you tell me a little bit about what the model is?

Nkatha Njeru: This is my hypothesis; I need to test it. I think that in the countries where we've been able to distribute a lot, [it's] because we are piggybacking on other things that are happening in the country. So Kenya, for example, has a lot of other projects happening in many places. So people are going out to the field and they carry the glasses. And where that is not happening, it becomes harder. because you have to wait until you have somebody going out somewhere to do something to distribute the glasses.

Ambika Samarthya-Howard: Let's say you have community health workers in Kenya who are going out. Do you come in as ACHAP and explain to them how to relate to faith leaders? Or is your role to go with them to make sure they meet with faith leaders in a particular location?

Nkatha Njeru: Well, ACHAP is coordinating at a country level. The Christian Health Association of Kenya has people on the ground. They have health facilities that they send the glasses to. The good thing with them is that they are able to go almost everywhere. So they get the glasses to them, and then the facility will work with a congregation and talk to maybe a priest and say, this Sunday, we would like to come and talk to people about eye health in your church, and then we would like to set up a tent to do screening. That might be a Health Sunday. Or in another place, there's probably a camp happening for a non-communicable diseases project where they're going to be screening people for diabetes and hypertension. Then they carry the glasses as well.

Ambika Samarthya-Howard: So your team shows up in these religious spaces and makes sure that glasses are integrated in those community health days?

Nkatha Njeru: Yes. For sustainability, we are trying to integrate.

Ambika Samarthya-Howard: That makes sense. How is your model different in Kenya than in Eswatini or in any other place? What do you think will be the major differences within each of the countries or within each of the regions?

Nkatha Njeru: I think the model is very similar, it's just the opportunities that are different. In Kenya there might be more things happening around the facility than might be happening in Sierra Leone, just because the Christian Health Association of Sierra Leone probably does not have a lot of things happening in the field.

Ambika Samarthya-Howard: How is your organization funded?

 **Nkatha Njeru:** We have a small member subscription, so, the Christian Health Associations are our members. But we go out and look for funding like any other non-governmental organization would. We go out to USAID, we go out to other funders and find funding, just like we did with RestoringVision, and partner with them.

Ambika Samarthya-Howard: What is your relationship to government?

Nkatha Njeru: Because we are a regional organization, for us we probably relate more with the World Health Organization and the Africa CDC. So we've been trying to ensure that we stay connected to them. We tell them what's happening, we advocate for our different countries. For the governments, different settings, different things. In some countries the relationship between the faith sector and the government is very cordial. In a few countries there's a perception of competition between government and faith sector. But in a lot of places it's cordial. And actually in some countries there's support that is even resource support by governments. I have seen that in Ghana, Zambia, Lesotho, Tanzania.

Ambika Samarthya-Howard: When there is tension, what is the tension about?

 **Nkatha Njeru:** The faith sector also would like accountability. There are places where the government doesn't want to be accountable, so they clash a bit on that end.

 For example, one of the things that I have seen happen is that there are countries where 60% of healthcare is provided by the faith sector. And so the faith sector is saying, could you please allow resources, because we're providing healthcare to the country. Can you please provide us resources? Can you provide us with health workers? In such cases the government doesn't even want to acknowledge the numbers and the reports because they do not want to have to provide these resources.

Ambika Samarthya-Howard: Do you feel there's a specific reason why these faith groups work in Africa versus maybe elsewhere in the world?

Nkatha Njeru: One of the things that I acknowledge, having traveled around the world, is that the place of faith leaders in Africa and the place of faith leaders in the rest of the world might not be the same. The percentage of people that ascribe to faith in Africa is more than 80%. And so faith therefore plays a very big part in Africa in many ways.

Ambika Samarthya-Howard: As you go forward with eyeglasses, are you starting to see more long-term trends? Do you feel that people who've been getting glasses through your organization or through these faith groups are earning more money? What do you feel is the long-term potential of this work?

Nkatha Njeru: Yeah, I think eventually, because a lot of people have skills that require their eyesight. One of the things that our teams are doing is trying to study the economic gain. We have tea pickers, we have bead workers, we have people that are using their eyes and their hands to work. People are sending money to them on their phones. Someone else has to read for them how much money was sent [by] phone and things like that. So there is a long term gain that is bigger than just being able to read the bible.

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.*