"They see the value": Paulette Ibeka of CHAI on incentives, price points and training community healthcare workers to screen

Ambika Samarthya-Howard

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Ambika Samarthya-Howard: Can you start by telling me a little bit about the model and approaches you're using?

Paulette Ibeka: Right now, our primary client and partner, in line with our values at CHAI [Clinton Health Access Initiative], is the government. We're working with the National Eye Health Program out of the Federal Ministry of Health to strengthen the decentralization of primary eye healthcare services. There's now a policy for primary healthcare providers—nurses, doctors, community health extension workers, and community health officers—to screen for primary eye health conditions like presbyopia and recommend/dispense reading glasses.

Ambika Samarthya-Howard: Do you work through the government or directly with CHWs?

Paulette Ibeka: We're currently working together to expand on what they've already worked on. So, in the past, they did the training and had direct contact with them.

We started to work with them last year around the commemoration of the World Sight Day event. Part of that was to go into the field and continue to do some of this eye screening. At that point, we supported the Ministry of Health to then work with the primary healthcare facilities.

However, we're working on a project to work with the Ministry while also having access to the primary health care workers. One of the things that came out of that initial work was that training takes about three days.

 One of the questions we're asking is whether it requires three days to train a primary healthcare worker to use the curriculum designed to screen for basic eye conditions. So, we're going to be testing a shorter version that is only two days, potentially even testing out if we could do something virtually alongside some in-person, with the goal of upskilling more healthcare workers to do the screening.

Ambika Samarthya-Howard: I'm not familiar with World Sight Day. How was CHAI involved and what did you do? If you could share more details about that, that'd be great.

Paulette Ibeka: October 12th is World Sight Day*. For the 2023 World Sight Day, we worked with the presidency, the Ministry of Health, and a number of other development partners that do work in the eye health space to host a big ceremony where eye health was put on the agenda for health. We worked with the National Eye Health program, which was led by Dr. Oteri Okolo and her team. We had associations of optometrists and ophthalmologists participating and representing primary health care.

It was a half-day meeting during which some policy documents were launched, including the policy around the decentralization of primary healthcare, which means it is now available for utilization across the country. All the strategies in there can guide the expansion of eye health services.

Ambika Samarthya-Howard: When you say that there are changes in policies, was that something CHAI worked on? Did you work on those policy changes with the government?

 **Paulette Ibeka:** Yes. We worked with the government to finalize those documents. They had been developed with support from other partners and we supported finalizing them so they could be launched.

Ambika Samarthya-Howard: What were the policies that changed, or what were you trying to change from the regulatory perspective?

Paulette Ibeka: From a policy perspective, it was about standardizing the curriculum for the training of primary healthcare workers to include conducting [eye care] screening, then naming what goes into that tool and what services they can [and cannot] provide. Ultimately, they refer to higher levels of care for services they cannot offer at the primary healthcare level. So the policy was focused on task shifting and task sharing.

** World Sight Day launched the Nigerian President's campaign to distribute 5 million readers to Nigerians with presbyopia*

Ambika Samarthya-Howard: And when did that policy take into effect?

Paulette Ibeka: Pretty much that same day. Usually, a launch means that's the date it's been approved by the government for utilization. So October 12, 2023 at the World Sight Day commemoration event.

Ambika Samarthya-Howard: And how was that received?

Paulette Ibeka: It was received well. The optometry and ophthalmology group is pretty powerful. It regulates where people get eye care services and, to a large extent, where you can procure glasses, including reading glasses.

If you walk into a supermarket in most Western countries, you could just go to an area where you could pick up a pair of reading glasses. That's not quite the case here because there's a lot of regulation around it. So it was great to get their support on having primary healthcare workers trained to provide the basic service of having more Nigerians access reading glasses.

Ambika Samarthya-Howard: Is it the primary healthcare workers or the community healthcare workers who are trained?

Paulette Ibeka: Nigeria's primary healthcare system is set up with several cadres of healthcare workers. In some facilities, you can find doctors, nurses, and primary healthcare workers. Basically, this means that whoever is at that primary healthcare facility should be able to be trained [to screen for presbyopia].

Ambika Samarthya-Howard: Got it. So the primary care worker oftentimes can be the community health worker.

Paulette Ibeka: Correct.

Ambika Samarthya-Howard: That's a really big policy change. I'm surprised, because I know that the optometrists are a huge group that you had to really convince.

Paulette Ibeka: Right. But they see the value. We have taken lessons from other program areas to show that if you can activate the primary healthcare facility fast, which is where most of the population will go to seek healthcare, you could improve access to patients.

Because everyone who goes to a primary healthcare facility gets screened and needs more care than the primary healthcare center can offer, that's an automatic referral to optometrists.The value proposition to them is to demonstrate that there are more people out there than optometrists [can serve] who are more willing to go to a primary healthcare facility first before they start to explore a secondary or tertiary facility.

We also have people who will ultimately only speak to [primary healthcare workers] because of what part of the country they're in before they ever get access to a doctor. That shouldn't stop them from getting the services they need, especially regarding eye care.

Ambika Samarthya-Howard: What have you seen – in terms of policy or regulatory wise – that hasn't worked well before? What have you seen working?

Paulette Ibeka: In the maternal/neonatal health program, we still have many communities with traditional birthing attendants. For the longest time, the assumption was they were directly linked to the high mortality cases. But the reality is that it's not that they're directly related, it's that their practices, or the lack of training for traditional birth attendants to understand and recognize danger signs in pregnancy, was the challenge.

By working with traditional birth attendants in a number of states, we were able to train them to become first responders. Again, we're not asking a traditional home birth attendant to deliver a complicated pregnancy, but a lot of the women in the community trust them. As a result, they would be the first to recognize that if a woman is having headaches during pregnancy, that's not normal; that it could be eclampsia or preeclampsia, therefore, they should go to a facility to get checked.

Traditional birth attendants already know during a woman's pregnancy it would be best to advise them to get all of their antenatal care and do their prenatal visits. Working with them, we significantly improved pregnancy outcomes because they could recognize the danger signs and had a referral pathway. There were also mechanisms to get the women from their homes to the facility in the event of a complication. Even when they still chose to deliver at home, the traditional birth attendants recognized that care was best achieved with the proper medication and not traditional remedies. For example, if a woman had delivered and was bleeding beyond a certain point, they recognized that it was postpartum hemorrhage and could quickly apply an anti-shock garment and take the woman to a health facility where she could get the services that she needed.

We've been able to say that if you train traditional birth attendants and community health extension workers to be first responders who can identify complications appropriately and be equipped with the tools to address them and referral pathways, you could improve livelihoods, outcomes, and mortality. So that applies here.

The data consistently confirmed that many people don't even know that just a pair of glasses could improve their near vision and their livelihoods. So, if we can expand and equip community health extension workers to provide the simple screening and then link folks to reading glasses, we'll be able to improve their livelihoods and health through the process as well.

Ambika Samarthya-Howard: Since October, how many community health workers have you worked with? What has the reception been?

 **Paulette Ibeka:** For now, we've only worked with the community health extension workers who have been previously trained by the National Eye Health Program. They've trained community health extension workers across five states.

However, for the WSD commemoration, we could only support implementation in three states. In those particular locations, we have worked with over 600 community health extension workers, and they've been able to screen about 6,000 clients 40 years and over.

Ambika Samarthya-Howard: Mostly in rural areas?

 **Paulette Ibeka:** It's a mix of rural and peri-urban locations. About 50% of those screened needed a pair of glasses and were given a pair of glasses.

So, to your point about the mechanism, they screen with the Snellen chart for presbyopia, which is age related far-sightedness. Once they [confirm they] have presbyopia, they try to work out the right power of glasses, and the patient walks away with a pair of [reading glasses].

Ambika Samarthya-Howard: So community health Workers are giving the glasses directly? What's your current price point? What's your pricing system for that?

Paulette Ibeka: They've been donated. VisionSpring donated the quantities used for the World Sight Day screening.

 I think you're hitting a very valid point about having the right price points because donations can only last for some months to years. With time, we'll need a system where folks can [get re-checked and be given] a different power. Even after a client receives one, they will need to replace them. Part of our plan is first to scale up distribution through healthcare workers for the donated pairs; as we're doing that, we learn the best price point and who is paying. That is critical.

Ambika Samarthya-Howard: How do you plan to learn what the price point is if you're giving them away for free right now?

 **Paulette Ibeka:** That's a great question. We are working with several partners. So for us, we are working with the government who is focusing on donations for now and will collaboratively explore the application of research methods to determine the right price for a pair of reading glasses.

Ambika Samarthya-Howard: The government's not donating, right? VisionSpring donated to the government, and that's the pathway?

Paulette Ibeka: Correct. That's the pathway, and other folks might be interested in doing the same thing. But there are also other players in this space who are interested in social distribution.

 At that point, we will definitely go with the research approach by associating prices to several quantities that are made available through implementation research to really understand what the pricing could be. I mean, we've also done this in other diseased areas, like improving access to zinc and ORS [oral rehydration solutions] for treating diarrhea in under-five children, so we'll replicate relevant approaches, with the perspective to test who can afford what, what prices are they willing to pay, and also, who else is paying for it.

Ambika Samarthya-Howard: For your particular program with the Community Health Workers, is there a point this year that the donations will stop and you'll start charging?

Paulette Ibeka: Not at the moment, no.

Ambika Samarthya-Howard: So your current program right now is free of cost?

Paulette Ibeka: To the recipients, right.

Ambika Samarthya-Howard: When you scale into more states, it'll still be free of cost?

Paulette Ibeka: Correct.

Ambika Samarthya-Howard: Okay. So mostly what you're scaling and experimenting with isn't necessarily the distribution and uptake of glasses, but the training of community health workers to screen them. Is that right?

Paulette Ibeka: Yes and no. A major chunk of it involves rapidly scaling up community health extension workers. Another is introducing reading glasses into the country. Right now, it's still seen as a commodity that attracts taxes and not as a tax-free health commodity.

 We'll also be testing out the distribution cost because we would need to know that even if we were to set the price point for commercial distribution. In this process, we will also be testing that out. It will be a combination of importing it into the country, clearing them, getting it to primary healthcare facilities, and also having the primary healthcare facilities dispense it to the clients who come in.

Ambika Samarthya-Howard: Let's go back to the community health workers training; how is that going? Is there anything about their training that you think has been working or not working that you're trying to test?

 **Paulette Ibeka:** What we're trying to test is [if it can be] shorter. The National Eye Health Program has been running the three-day training. We're going to work with them to test a shorter delivery time.

Ambika Samarthya-Howard: Do they come to you, or do you do it virtually, or do you go to them?

 **Paulette Ibeka:** The National Eye Health Program travels to them so they do not leave their states. They stay in their states, and they're usually clustered for the training to happen.

We're planning to continue doing it that way because primary healthcare workers also have responsibilities like providing vaccines, maternal health care, etc., so they definitely can't be away from the facility for too long. So we go to them to conduct the training.

 If we are going to rapidly train or activate that many healthcare workers to provide eye health services, we want it to be affordable. We work at the service of and in partnership with the government; they are communicating that the best approach they have tested in the past is a two-day training. So we are testing that out and seeing if it's possible to have it even shorter.

 One approach we're considering is hybrid, where healthcare workers can access parts of the training virtually. The other things can be done in person because you actually have to make sure they can use the Snellen chart. You could potentially have them test each other because, who knows, some healthcare workers should also be using glasses but are not because they haven't had access to them. Those are some of the models we will explore.

Ambika Samarthya-Howard: Can you tell me a little bit more about compensation for healthcare workers? Who pays them? How much do they get paid? What does their compensation involve? Is there additional compensation based on the number of glasses they sell?

 **Paulette Ibeka:** Right now, the expectation is that the healthcare worker is employed by a primary healthcare facility so there isn't additional pay for dispensing glasses. They are on staff at the primary healthcare facility. We're going to see providing some incentives to add on this additional task until it becomes integrated into the system. The first feedback has been that this is an additional task to what they [are already responsible for.]

Ambika Samarthya-Howard: Exactly. That's exactly where I'm going with this.

Paulette Ibeka: Okay, yeah. We've tested out a lot of non-financial incentives, including certificates that show they have been certified to screen and provide primary eye healthcare. That has gone a

long way. [We also train and certify them] on using other data tools. We may explore the campaign approach.

[Some other considerations are] when primary healthcare workers have to leave the facility and go into the community to provide services, you have to provide transportation. We're exploring that as well.

 But for now, the expectation is that this should be integrated into their everyday services. That's why the National Eye Health Program is pushing back on training just for presbyopia. Their main interest is integrating primary eye healthcare, beyond screening for presbyopia, into the system. That's why we're reviewing the curriculum to see if we can shorten the delivery time while still training the healthcare workers to provide the entire gamut of [primary eye healthcare].

They want to be able to say, "This is not primary eye healthcare," and be able to refer to secondary facilities for them to confirm [a complicated eye condition like] cataracts. The other [piece is that if a patient were to need ointments or medicine for a condition] they need to be able to offer that commodity. Right now, it's only glasses that would be made available. So that's the argument we're making: we want to train them on all of that, but because glasses are the only thing available to distribute, we should focus the training heavily on that until we find a way to have those other commodities available.

Ambika Samarthya-Howard: What is it that they would get at the pharmacy that they wouldn't get at a primary healthcare facility?

Paulette Ibeka: I understand that primary eye healthcare is not just screening for presbyopia; it is also screening for more uncomplicated conditions that an ointment should be able to address. In the instance that a primary healthcare facility is fully equipped, they should have the ointment on hand to give to the client with directions on how often to apply it over how many days. But right now, they're having to prescribe for the client to pick it up at the pharmacy. That's still a primary healthcare condition. Then there are the other more significant complications, such as cataracts, glaucomas, etc., which you would need to refer them to secondary or tertiary facilities, and that's when they would have to be referred out.

Ambika Samarthya-Howard: Got it. Thank you for that clarification. In terms of the community's reaction to different things, there are many more urgent issues people in Nigeria are dealing with, especially in terms of maternal health, malaria, and other stuff. How have you been able to get people to care about eye conditions?

Paulette Ibeka: I mean, full disclosure, we have not started implementing. Everything we share is based on knowledge from research and interacting with the National Eye Health Program and other partners in the space, like VisionSpring.

The reality is that there are some myths and misconceptions out there, one of which is "that glasses make my eyes worse". So, how do you then convince someone to start using them? The other is tied to the first one, where they believe they must keep going back for another pair with a different prescription because the glasses have worsened their eyes.

One of the components of the programs that we're looking forward to rolling out will have components around awareness creation. Again, working with the primary healthcare workers but also working with community leaders – key opinion leaders that's a combination of village heads, community heads, and even religious groups – to create very engaging communications. [Using] communication [from] these leaders to support community understanding that this could improve their vision. So yes, they'll need to go back [to get another prescription], but it's not that your eyes were not already deteriorating; it's the fact that you need a new pair to help with the deterioration that is already happening, and we offer them an opportunity for better vision.

Ambika Samarthya-Howard: Can you talk a little bit about what those next parts of this process will look like? For example, can you talk a little bit about how you plan to do the awareness campaign?

Paulette Ibeka: So, off the bat, TV and radio can be expensive. Radio can be great because most people have access to it, but it can be really expensive. So, we will try other approaches that we've seen work in other programs.

Again, you get a set of community and religious leaders to communicate the value of reading glasses—what presbyopia is and what it's not—and they cascade that to their audience. They have pretty large audiences, whether you're talking about an Imam at a mosque, a preacher at a church, or a woman leader who encourages and leads all the market women. Whatever it is, whoever it is.

There are also what we call in Nigeria wards, which are the lowest political segmentation compared to county, state, and local government areas, and they usually have ward development committees and typically have access to the community. So again, working with these WCDs [ward development committees] to create awareness on what presbyopia is, what reading glasses can do, and how community members can benefit from them will go a long way to disseminating information.

Ambika Samarthya-Howard: Direct, one-to-one awareness?

Paulette Ibeka: Right.

Ambika Samarthya-Howard: What else are you testing? What are you doing from now until the end of the year for these projects, in terms of scale?

Paulette Ibeka: So there's the primary healthcare worker training, the training of the CHEWs [community health extension workers], nurses, doctors where they're available.

We're doing that in different states and different local governments within each state. The goal is to have more primary healthcare workers who can appropriately screen, dispense glasses, and refer if it's not presbyopia, so that's what we're working on – to have healthcare workers who can do this. A large proportion of people who have been screened, those who are positive for presbyopia are receiving glasses, and those who need more care are referred to a secondary facility.

The other thing we'll be testing is the introduction of the product, for example, how long it takes to bring it into the country and the cost for clearing [customs]. Even when it's a donation and there are tax waivers, products still need to be cleared. We'll need to test the cost of moving it from where it's been cleared—either at an airport or by sea—to a central medical store and then to the last mile.

We have expectations now, but the currency has been fluctuating pretty significantly, so it would be good to test out what that looks like and then build on a larger scale. We're starting in chunks, learning from the first couple of thousands that come into the country, and extrapolating from that. I mean, there's economies of scale. The more we bring in, the more we can better negotiate clearing rates, distribution rates, and all of that. But we'll only know that as we bring in the first batch of glasses.

Ambika Samarthya-Howard: In terms of the training that you're giving to the community health workers, aside from shortening it, what do you think will be some of the other significant things you're testing in that model?

Paulette Ibeka: We're still going through the government because we're going to public facilities, and the government still gives you access to those public facilities. This is the first time [CHAI is doing the training].

Ambika Samarthya-Howard: Are you using their curriculum?

Paulette Ibeka: Yes. So, the goal will be to use that same curriculum and shorten the delivery time. The questions right now are about whether there are things that currently take hours to deliver that can be done in minutes. I don't think we want to shelve any part of it, especially when the government is very confident that the curriculum meets the needs of integrating primary eye healthcare across the primary healthcare system, so I think it's really about delivery time and exploring if parts of it can be done virtually.

Ambika Samarthya-Howard: In terms of the states that you are currently working in and the ones that you're going to, how did you choose those states versus other states?

🤝 **Paulette Ibeka:** The first step is looking at the states where the government has done the work. That means finding the states receptive to eye care. We're scaling up to other facilities not activated in those states. More critically, because we're also doing this work, we're selecting states where we have a relationship with the government, [where] we have state offices, where we can leverage personnel and cut costs around delivery.

For us to go to a new state where we don't have those relationships, we will still apply the same expertise from other states, but it will take a bit more time because you have to convince the government to trust that you're there for their interests and the interest of those they serve. For the most part, it helps to start with the states where we have relationships. But it also doesn't hurt to test out states where we don't because it creates an opportunity to develop the relationship there, especially if there's an opportunity to drive change and achieve impact.

Ambika Samarthya-Howard: That makes sense. And there's no time this year that you're planning to charge for the glasses, but maybe in the future?

Paulette Ibeka: I mean, it may happen this year. Everything will happen as quickly as we roll out this component of equipping the primary healthcare facilities to provide these services. Also, it very much depends on willingness to coordinate. The other thing we're doing is working with the government to coordinate all partners in this space so we are doing everything correctly and taking advantage of everyone's capacity.

We could get to July, [for example], and VisionSpring says they're ready to test charging for glasses and want us to figure out what that will look like. We'll be part of the coordinating group overseen by the Ministry of Health, and we'll be able to get that going. It depends on how quickly we can get this going.

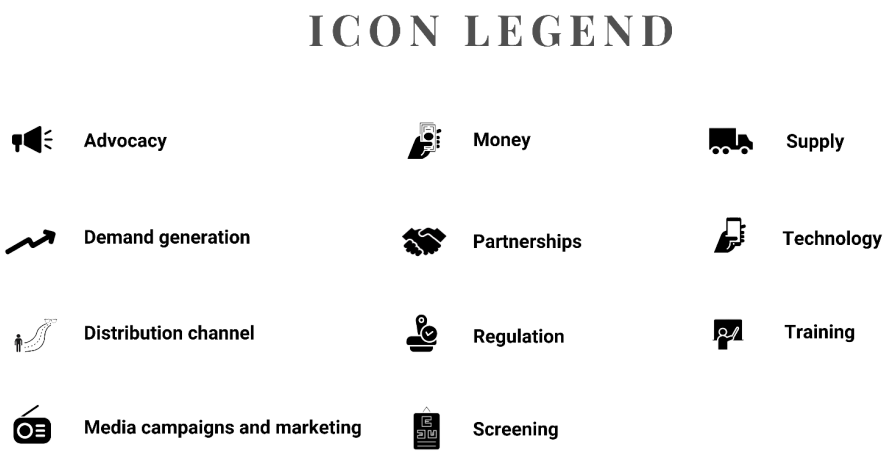
Ambika Samarthya-Howard: Is there anything I didn't ask that you would like to share?

Paulette Ibeka: I can't think of any off the top of my head except to say it's interesting to get asked these questions because it gets me thinking about our model and our approaches and things like that, even questioning the value of applying them to achieve the impact of getting more glasses out there. I think the only other thing to keep an eye on would be what that commercial approach would be. We have a few ideas for other places.

I don't know if you've heard of the term patent proprietary medicine vendors, PPMV. Everybody calls them a chemist. Many community-based drug stores are not run by pharmacists; some are run by someone who's learned the trade or does not have a health background; these are PPMVs. In some communities, they're the first point of contact when people are not feeling well. That's where they buy things like anti-malaria, anti-diarrhea, or an analgesic for a headache.

We've worked with them to improve access to zinc or ORS for treating diarrhea in children under five, so that could be one way. But again, that would require a lot of policy and coordination of the different partners and professional groups. As you might imagine, the optometrist who initially challenged community health extension workers providing primary healthcare could also push back on that. But we'll see how that goes.

Ambika Samarthya-Howard: Thank you for your time this morning. It's been great to talk about your work.



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.*