“The churches and the mosques become the points for screening [and] distribution to the last mile”: Peter McOdida of the Christian Health Association of Kenya on engaging faith-based health services, demedicalizing presbyopia, and shifting national policies.

Ambika Samarthya-Howard
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Ambika Samarthya-Howard: Please introduce yourself and tell me how you got into eyeglasses.

Peter McOdida: My name is Peter McOdida. I'm the Business Development Lead at CHAK, the Christian Health Association of Kenya, which brings together the health services of Protestant churches in Kenya. We are a technical support organization for member church health facilities and services in Kenya and membership is primarily protestant churches. Our vision is basically quality healthcare for all to the glory of God.

We have been in operations for almost 76 years now. CHAK predates the independence of Kenya. The membership includes approximately 600 health facilities distributed throughout Kenya. And some of our member health facilities predate independent Kenya when health services used to be provided by missionaries as part of the medical ministry. So based on our history eye care has been an integral of christian ministry not only to enable thousands to read

the bible but also to reach thousands of Kenyans in great need of vision care, primarily underserved populations in rural areas.

 Some of the members of CHAK are the largest eye care providers in Kenya, and they perform the largest number of cataract surgeries and eye treatment services, particularly for those populations that have limited access to services, either because of delinquency, because they don't have enough resources, or because the locations where they live are rural and remote. So our member health facilities have been reaching the largest number of Kenyans with eye care services. But that work has primarily focused on management of other eye conditions like cataract, trachoma, and other medical conditions. But we also realize we have a silent epidemic of presbyopia, which is basically incremental loss of vision as people age. And we know that if you look at our populations, older people tend to have challenges and are driven into poverty because when their eyesight fails, it means they're not economically productive.

A lot of women, even in rural areas, do near work. They're doing beadwork, and they have challenges with that. So we saw this opportunity based on the data. Currently up to 30% of Kenyans in need of eye care services, but only a small proportion of Kenyans are able to access that, because of policy barriers and access to services, like the availability of readers, for example.

 In the policy area, glasses are traditionally treated as a medical intervention, not necessarily something that can be done by community health workers. It’s something for a specialist. But we don't have enough eye specialists in Kenya that can serve the population. The ones that are there are only in the cities, and wherever they exist, in terms of consultation, even if the challenge is presbyopia, for you to be screened and diagnosed you have to spend a lot of out-of-pocket resources, and the main reason people are not able to access that is because of lack of money.

Traditionally, CHAK and its members have worked in eye care services as a medical and health intervention. But we're now looking at it as a question of rights. It's a question of livelihoods, and it's also a question of expanding opportunities for everyone. That's why presbyopia is an area of intervention that we need to look at. We have data that shows that investing even in near vision devices like reading glasses alone has huge economic benefits. It can increase productivity, particularly for those populations that are doing near work. It can also improve the quality of life. When your productivity goes up, the quality of life improves.

We also know that a loss of sight is one of the factors that contributes to abject poverty, particularly among older people. Kenya is leading in the area of mobile devices, [especially] the use of mobile phones to transfer money, and there is a need for better vision for people to be able to look at their phones. We are looking at it as addressing one of the silent epidemics in the world.

Ambika Samarthya-Howard: How did you get involved in all of this wonderful work?

Peter McOdida: I am a business development specialist, and my work has been looking at innovations. I'm a health economist. I previously worked for some international NGOs.

Ambika Samarthya-Howard: What is a health economist?

Peter McOdida: Basically doing economic evaluation of health interventions and providing justification for/where it is important to put resources. And also doing the costing of services—looking at what it costs to deliver services, how we finance that, and what is the return on investment by financing certain health interventions and further understanding on how the health systems work.

 For example, the cost of delivering the readers that we're distributing now is maybe $1.50. When we look at the economic benefit for those who are receiving the readers, I think we are getting great stories. Like, for women who are doing beadwork, in terms of the increase in their productivity, and the fact that they're able to do more and sell more. One of the areas we're looking at is working with the tea pickers. Because tea picking is also near work, and because of loss of vision, some older populations are not able to continue to engage in that economic activity.

Ambika Samarthya-Howard: Can you talk a little bit about the partnerships you've developed, some of the insights you've had from those partnerships, some of the limitations, and how you've been using those partnerships in order to scale?

 **Peter McOdida:** In terms of healthcare services in Kenya, we have the national eye program which is coordinated by the Ministry of Health. So we are working very closely with the Ministry of Health at the national level in terms of policy, in terms of decisions around the devices that are being rolled out, in terms of issues around the inclusion of the devices in the UHC and essential list of health products. Also in terms of data for eye care services, monitoring and reporting.

For example, I mentioned vision care services including presbyopia is a specialist area as per Ministry of Health standards, where you only have a few eye specialists. We are working with the Ministry of Health to change the policy and task shifting in the management presbyopia to allow other health cadres and community members with minimum level training to screen and dispense reading classes in different settings in the villages. One of the areas that we are also looking at jointly with the Ministry of health is making readers an over-the-counter product, because as it is now, it has to be prescribed by a specialist. These policy shifts will help to increase take up and usage of glasses; and expand reach using a variety of models.

In Kenya, we have a devolved health system. Within the system, policy and standards are done by the Ministry of Health at the national level, and service delivery is done by the county governments. Within the county governments, we have what they call eye health coordinators, and they're the ones who are responsible for coordinating and monitoring the provision of eye care services in the county.

 Traditionally the provision of eye care services has been largely done by faith-based health facilities. So we want to make sure that these services are available within the public health sector, particularly when it comes to readers. Also, community health promoters are primarily attached to the public health facilities and we want to work with county health authorities to train the community health promoters that are looking after 100 households, so they can also be part of the last mile distribution for readers. That's the type of collaboration we're working on.

We also collaborate with other faith-based health services. Like I mentioned earlier, Christian Health Association of Kenya is a membership organization of Protestant health services. We also have the Kenya Conference of Catholic Bishops, which represents Catholic health services. We are also collaborating with them to make sure that within the work that we are doing with RestoringVision, we also include Catholic health facilities. [We want] to make sure that no one is left behind—that the service providers are not left behind in all the facilities in terms of training, but also in terms of distributing the readers through the Catholic and all of the other faith-based health facilities in Kenya.

 CHAK is a member of Kenya faith-based health services consortia, which brings together Protestant, Catholic, and Muslim health facilities. We are leveraging the membership to this forum to include almost all faith-based health facilities in Kenya in the distribution network for readers. The churches and the mosques become the points for screening, as well as the points for distribution to the last mile.

 We also have the Kenya Coalition for Clear Vision, which is part of the global network. We are bringing together all of the actors, and CHAK is playing an active role on behalf of the Africa Clear Sight Partnership program. We are hoping that by partnering with RestoringVision, we should be able to support all the other players to access readers, so they can distribute [them] to the last mile. Some of them are doing it as part of social impact investment. For example, we have DOT Glasses, which is doing it as a social impact investment. We also have two other organizations that are charging a fee. But what we are looking at doing, [along with] LIF [Livelihood Impact Fund] and RestoringVision, is what we call market shaping, in the sense that we help address the policy barriers, we facilitate access, and we also make sure that access is available to the last mile.

Ambika Samarthya-Howard: What makes a successful partnership?

 **Peter McOdida:** Number one, there must be a shared vision, and also a shared understanding of the need. What we have done with RestoringVision has been what I would call a co-creation process, in the sense that we work together as a team. When we design the program, we are co-creating it, not one partner saying, "I'm the donor, this is the work plan." No, we have worked together to identify the need. We work together to map out the high impact interventions that are needed, that can work for our settings. And we work together to make sure that we have clear metrics in terms of monitoring the outcomes of what we are doing, and also shared learning. We make sure we in-build learning. For me, the starting point is a co-creator program, and if possible, we have community voices inform the program design.

 We have the advantage as CHAK that we have a constituency—we have a membership organization of congregations. So we always engage with them to get their insights. “Here is a program we are co-creating, what are the policy implications? What are some of the operational challenges that may occur? What is the need? Are we addressing the need and are we doing it the right way?” It's a shared work plan, and when the goals are set, everybody has the same understanding. Respect is key, and recognition that, yes, as organizations we have different missions, but many times we share the same goal of bridging the gap for those populations who have limited access to readers or to eye care services.

Ambika Samarthya-Howard: What have been some of the challenges with partnerships?

Peter McOdida: Given my background of being exposed to partners from Northern and Southern organizations, I think we are moving well. From my past experience in terms of North-South collaboration, I think the challenge is when there's an imbalanced relationship. But I've not seen that indication in terms of what we are doing with RestoringVision at the moment.

Ambika Samarthya-Howard: What are the policies you're trying to change, and how are you going about changing that?

 **Peter McOdida:** If you are going to change any policy, the starting point is, what data do you have? Generate the evidence to show that, yes, this is the policy we have at the moment, but if we did things this other way, if we change the policy, this will be the new outcome. Or, say, a policy was developed at a stage when we didn't have enough data around the issue. Then how do you work with the national government? Or there's a new expert recommendation from WHO [World Health Organization], for example. How do you make sure that expert recommendation is clearly understood by the national authorities so that everybody's on board?

There are two policy barriers that we have. Number one is, should readers be classified as a prescription product that can only be prescribed by clinicians? What if you used the community health promoters, or other nursing cadres, to dispense the readers? You need to compare the performance of maybe the specialist vis-a-vis the health promoters on the specificity of the screening tool. If it shows that there is no difference between the specificity of the screening for community health care workers or the community health promoters, then you have that data. And even as you do that, you work jointly with the Ministry of Health. So that data can be used to inform policy change to say, now readers can be dispensed by community health promoters, but they can also be over-the-counter devices, as opposed to being devices that require a prescription or available only in specialist clinics.

Ambika Samarthya-Howard: That's a very clear policy that you're trying to shift. Can you tell me what your process is, who you're working with, and how you're going to try to shift it?

 **Peter McOdida:** In this work we are collaborating with the national government, the head of the eye health unit, which controls the technical working group at the national level, but also the development of various policies and standards for eye care. During the launch of the Africa Clear Sight Partnership program in Kenya, the head of the eye health unit was the chief guest for that event. So, one, we are making sure that there's buy-in at the highest level within the department. Number two, we are actively part of the various technical working groups, but we are also making sure in some of the evaluations that are happening, the Ministry of Health is part of it. In fact, the policy makers also become some of the co-PIs [principal investigators], so that they can own it.

 It is extremely important that we involve them from day one, because they're the ones who will be working on the policy change. In generating the evidence that informs the policy, they should be part of it, and they should also be able to understand what they're doing. The community health promoters already have a job description, which may not include, say, dispensing of reading glasses. So you need to make sure that that is added. Also, if they're training, their training may not include screening for eye services or eye conditions. If it's not there, then you have to include that. It has to involve a large number of people, and also different departments within the Ministry of Health: those who are doing the trainings, those who are doing the standards, but most importantly, those who are providing the policy direction to the public health sector.

Ambika Samarthya-Howard: I'd love to hear a little bit about the economics of all of this, in terms of price point for both glasses and delivery methods, and even incentives for community health workers.

 **Peter McOdida:** Like I said earlier, the readers are at approximately $1.50. By and large, that should be the right price. But one of the things that we are discussing with our health facilities is that there's a cost related to outreaches and distribution. And staff time that will be involved in dispersing the readers. So we should be able to cost this [out]. What they're suggesting to us is that the price will be like $2 if we [account for] all of the costs of distribution and logistics.

Ambika Samarthya-Howard: Do you think that there's a big difference between $1.50 and $2?

Peter McOdida: In terms of Kenyan currency yes, and also in terms of populations served by our programs, largely poor and with greatest need.

Ambika Samarthya-Howard: Do you feel like people would pay for it? I know you're giving them out for free right now, but as an economist, I would love to know what you think should be the best market model for this.

 **Peter McOdida:** My take is that people would pay for it, and we are hearing from the people who are receiving them that they are determined to buy the second pair themselves. And they would be willing to spend between $2 and $2.50 maximum, in the rural areas. In the urban centers, people are already buying readers at anywhere between $10 and $15.

Ambika Samarthya-Howard: Do you feel that we should be providing financial incentives for community health workers?

 **Peter McOdida:** Yes. I want to emphasize that it's going to be important for us to do that. For example, I'm giving it to the community health worker at $1.50. Is it possible for me to allow the community health worker to put a markup, like zero point something dollars, to help them cover the cost? That should be considered, yes.

Ambika Samarthya-Howard: Your organization, CHAK, has been doing so much health work across non-communicable diseases—malaria and everything else. How have you found this to be different?

Peter McOdida: With this, the impact is instant. You see the results immediately, because [if you] give a lady who is struggling to read the Bible reading glasses, she is able to read [right away]. You see how they're dancing. It's an immediate solution. Just $1.50 and you recover your sight immediately and you go back to being productive. It's not just a health intervention, it's an economic and livelihood intervention. That's the difference between this and what we've been doing in the past, because in the past there is improving the quality of life, but this one is not just

about the quality of life but also making sure that people go to work. We are also fighting poverty, because a lot of people will move out of poverty because of access to glasses for near vision.

Ambika Samarthya-Howard: I'd love to hear some of the things you're doing to increase awareness that have worked. Do you also feel that some people don't want to buy them because of stigmas? What's the misinformation around it?

Peter McOdida: We are looking at awareness at two levels. [The first is] healthcare worker awareness. Is eye screening or screening for presbyopia a part of the routine services? Because people come in with many eye related problems. The traditional thought is that loss of vision is a normal thing. So they don't see it as a problem. That's one area that we need to work on, and also making people aware that correcting that problem is as [easy] as a pair of reading glasses.

The other broad awareness is linked to policy. There are lots of people involved in budgeting for healthcare services, eye care services, or presbyopia, as part of the national insurance scheme. How do you get it there, so that the next pair of glasses will be covered through the national health insurance, as opposed to people paying out of pocket?

Ambika Samarthya-Howard: When it comes to awareness, what method do you think works best?

Peter McOdida: We have above the line and below the line media. Above the line are radio spots and things like that. But we are also looking at congregational settings. So, increasing word of mouth and education when people come to your facilities. Taking advantage of a learning environment like schools to create that awareness about presbyopia. But if you have to push uptake of services, once you have the readers, I think it may be good to go through the above line: radio, talk shows. Talk shows in particular are more effective on radio.

It has to become a campaign. We need to align, for example, if we have an annual event related to eye care, how do you have a campaign during that month, so that we have activities, aggressive media engagement in terms of making sure people go to the radio stations, talk about eye services or presbyopia, and talk about the solution and how easy it is to reverse. If it's a campaign, I go through the mass media, radio and TV. But for our setting, radio has the widest reach. So I'd rather go to the radio stations. But in between, you can have interviews with the TV stations involving the Ministry of Health, as well as other implementing partners where they're talking about why presbyopia is important, how to access corrective services for presbyopia, and what is available.

It works better if you call in the experts. An advert doesn't work very well, but when they hear it from experts it is easy for them to take it in, and also make sure that they follow the recommendations or the information is taken to be valid. Billboards may not work much. I would not recommend billboards. It's not long-term, they're only in urban centers, and it's also very expensive. [What works best is to] have experts going to local radio stations and talking about this. Also local TV stations once in a while. It has to be an intensive campaign, maybe over a period of one month, where you saturate the media with information about eye care. And it also has to be backed with the availability of services or readers. [You don't want them to] go to the health facility and be told we don't have readers. So we also need to make sure that we have the readers at that point, either within the health facilities or when our people do outreach.

Ambika Samarthya-Howard: I would love to hear a little bit about what you're looking forward to in the next few months, in the next year.

 **Peter McOdida:** We are working with the Ministry on a few policy changes. We are going to test the use of community health promoters, working within the community, but also using the congregations or the mosques to dispense glasses, so I can see what the uptake is going to look like for the next six months.

The other broader goal is within the global initiative, we are hoping that of the approximately 30% of Kenyans who need readers, we can reach almost 80% of them within the next five years. But we have to do market shaping in terms of making sure that we change the policy, we increase awareness, expand availability of readers, and also check on price. Make sure that even when it comes to buying a reader, the prices will be within reach of the majority of Kenyans who are in need. So we'll be learning in the next few months, when we go to scale, what that scale will look like. Success for us would mean 80% of Kenyans who need readers have readers.

 Like I said, this is a co-creation. The partnership that we have with LIF and with RestoringVision is co-creating everything. And learning. We'll be testing different models: one is a free model and another model will be for a fee, so they can compare. We are also partnering with the University of Chicago on an economic evaluation. We have two PhD students who visited with us. They're [preparing] an economic evaluation of this activity. When we talk about solutions that work, we need to generate evidence. It may also inform how to roll out other WHO recommendations and expert recommendations around eye care. This is an evidence-based intervention.

Ambika Samarthya-Howard: Thank you so much.

ICON LEGEND

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.*