"They [saw the] benefits and started to talk": Anne Coolen of VisionSpring on fitting into the supply chain, the mix of factors preventing uptake and leaning in to people's motivators

Ambika Samarthya-Howard

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Ambika Samarthya-Howard: Can you start by telling me more about your eyeglass work and the model that you're using in Ghana?

Anne Coolen: I'm the Global Vice President for Global Programs, so I oversee four pillars in my department

So I oversee four pillars in my department, which is monitoring information, research and learning, where I have a director who's in charge of that and then a whole department who's looking at data quality, but also do research and evidence site evaluations from RCTs [randomized control trials] to smaller impact surveys, all kinds of material, but it's also just the basic data getting into the systems. Then there is program implementation, which is all the support to our programs across the globe, whether it's the community health worker (CHW) program, the pharmacy program, or some of the country supports, like in Vietnam, India, and Africa. Then next to that, there's the quality assurance. I'm setting up the whole quality assurance for this growing organization because we want to make sure that each one of our clients has a similar client experience.

We've been working on SOPs [standard operating procedures] for each one of our channels to make sure that they take into account the client and how the client's insights on what they need to know in order to not only move out of a service provided with glasses, but also to increase their wearing habits afterwards. If people are clear on why they're getting their glasses and what kind

of potential initial side effects they might have – like small headaches and stuff – the better the chance that they will wear them in the future and not put them aside within three or four days because they're uncomfortable or they create headaches.

Ambika Samarthya-Howard: Can you tell me a little bit about how you mine the insights? Do the insights come from RCTs or from research with the communities?

Anne Coolen: It all starts from simple data. Let me just give you an example of Bangladesh.

We have our community health worker program, [which is] the oldest program that we have and what we've noticed, just by collecting data regularly, is that they do the screenings, and then after the screening, out of the 10 people who need glasses, only three and a half, so 35%, are actually leaving with glasses. A conversion rate of 70%, 80% or 90% would be normal depending on which channel.

We are trying to not only do the screenings, [but also to raise awareness so that] people who have a challenge with near vision also then see it as a necessity to get a solution for that, which is readily available on site. So what happens in that process between them knowing they have a challenge with near vision, them having the solution right there and then walking away not opting in for the solution? And so that's the first step where we get an analysis of basic data that gives us that first insight, "Hey, there's a problem."

Second, we can do surveys. We can do surveys based on the clients that are coming through and asking them questions [about] what happens. For this, we're going to work with Appleseed, who will do qualitative research.

Ambika Samarthya-Howard: I spoke with Appleseed ahead of these interviews as well about this research you're doing in Bangladesh.

Anne Coolen: Yes. That's the next step. We don't think it's necessarily a financial barrier because in Uganda, we've seen the same thing, but we've changed the cost from $6 to $3 – or something like that. Don't quote me on the numbers, I have the exact numbers if you want them. And we've seen an increase in uptake just by reducing the price. However, in Bangladesh, the price is so low and so affordable in our assumption, but in analyzing where we are in the market space, we do think that there's something else going on. And that's why qualitative research will help us gain further insights and then we can course correct by putting the process in place.

Ambika Samarthya-Howard: Is it your team that is doing that qualitative research?

Anne Coolen: Sometimes we work with our teams to do surveys. We are not currently equipped to run big qualitative research [projects], so we would outsource that to people like Appleseed.

 Let me use the Ghana example. We had assumptions around the pharmacy project. The data day-to-day looked very skewed because, of course, if you think it through further, the pilot has now been ongoing for two years. And pharmacists don't necessarily have the time or the interest to write everything down.

So we, as VisionSpring, are very interested to know whether this person that came in is a new client, has never worn glasses, and their age, and all that. Pharmacists were mainly writing down those people that they screened and needed glasses. And all [of the people who] they also screened but didn't need glasses, they didn't report them. So, the numbers were much lower than we would've expected. [Glasses] are so needed in the community, so why are people not buying glasses in our pharmacies?

So that's where we sat together with Abi and said, "Let's research this more because it makes logical sense for the pharmacy to be the key entry point for communities to access glasses. Similar to Europe, to the U.S. where they can just try the glasses on, buy them, and walk away with them. So why isn't it working the way we were hoping it would work?" And so Appleseed came in and did that research together with our team and they did all the interviews and then they came up with a lot of different findings. And the report is open, so you can have the report if you don't already.

What you see in the qualitative research is a piece on motivators. So what motivates people to come and buy glasses? And there's a piece on the barriers, what challenges or what barriers do people face [that keeps them from going] into the pharmacy? And once they're in the pharmacy, why don't they get the glasses? These are all different questions that are answered in the report. But in terms of the motivators, for example, one of the key motivators people have is that it needs to be a pain point. Being a pain point is the main motivator for people to actually go and seek a solution.

Ambika Samarthya-Howard: You're competing against a lot of more urgent health problems, right? As well as pricing problems. So I'm curious, when you're saying that it must become a pain point, I've heard almost no one mention that presbyopia has become a pain point because it prevents them from working or doing their job. So how does it become a pain point?

Anne Coolen: All of what you said is correct, but the thing is it's about what are the advantages to actually having [reading glasses]? And so moving from the main motivators to actually having the experience of having glasses on your face and seeing, "This actually really helps me during the day, or it helps me on my phone, or it helps me in my day-to-day, in my weaving, or in other places where I didn't think that it would also benefit me."

Ambika Samarthya-Howard: Before people have glasses, they don't know what they're missing out on. How do you show that to people before they have the glasses?

Anne Coolen: Exactly. You're [capturing] the right challenge and I'm honestly not sure that we have fully figured that one out.

There's evidence we can use, but it needs to speak to specific clients. For example, the evidence we have [showing] that it increases your productivity isn't helping the one farmer in one community somewhere. This is not something you are currently asking me for, but, for example, the Clear Vision workplace in the garment factories. If you hear the success stories there, it's like these people were all just doing it at their job. They were given glasses and they realized that they didn't lose their jobs anymore. So they [saw the] benefits and started to talk [about it] and then it spread by word of mouth. But you do need that base of actually having interacted [with] glasses, having good stories so that people can indeed understand that there is a real benefit from having glasses.

Ambika Samarthya-Howard: Is there anything else you wanted to share in terms of background?

Anne Coolen: The last thing is the fourth pillar, which is innovation. Some of the things that we're trying to develop, so pharmacies were [under] innovation for two years and now have moved to program implementation. But trying new models out, that's also under my department.

Ambika Samarthya-Howard: Can you tell me about some of the models and approaches that you're trying out and why you're trying them out?

Anne Coolen: So there's quite some innovation around demand generation this year specifically. Demand generation, that's where clients are coming to the center. After we've [gathered] all the evidence and all the other things, the bigger pieces, we are now talking about the actual client even before the client is a client. So when the client is a client we get them into the services they require. And so demand generation across the sector is very underdeveloped.

This time around, we're focusing on the results from the Appleseed study in the Ashanti Region in Ghana, we are focusing on the playbook and going to try and implement some of the key strategies that came out of there and see how that works and how it might potentially be of interest to other countries because we think that there might be a similar context in Nigeria where we also have pharmacies.

But even when I went to Bangladesh and discussed some of the initial research findings with the Bangladesh team, they also said it might be true in their context too. Then we can do a quick

check because it's not a blueprint, but we can quickly check, do some surveys and see if some of these same challenges or myths and misconceptions are also present in the Bangladeshi market, which then also might hamper people from actually walking up to the pharmacy and buying glasses.

 So that's part of the demand generation. [We are also interested in] where people go for a second pair. We are doing a survey around where people buy a second pair. Do they buy a second pair? After they've had access to a first pair, not free, but often subsidized, where do they go for the next, especially if some of our channels are moving, they are not fixed like the pharmacies. Where do they go for a second pair, if at all they are going? And if they're not going, why are they not going? What are the barriers that they face? Or are they just not interested in having glasses again?

Thirdly, we do some of the work now [around client behavior]. We're trying to see in Uganda with the price changes, [how it impacts] the clients' behavior. We are also trying to see what the clients' behavior is and if that's indeed the only barrier or the main barrier that people in Uganda are facing. Or if there are other barriers that we could also remove or reduce.

Ambika Samarthya-Howard: I've heard a lot about your Bangladesh program, but I've heard less about your Uganda program. Can you tell me a little bit about it? Do you work with community health workers in Uganda instead of pharmacists?

 **Anne Coolen:** There's no pharmacy program in Uganda. We call the community health worker program the RGIL, Reading Glasses for Improved Livelihoods. Those are all some form of community health workers that are going into the community, organizing small camps and having people's vision screened. And then if they have presbyopia, they will get a reading glass on the spot. Otherwise, they'll be referred to a nearby institution.

 Uganda is our second biggest program, where we also work with BRAC [Bangladesh Rural Advancement Committee], who is our key partner. We have also [started working with] other partners, social marketing partners, like an organization called PACE [Programme for Accessible Health Communication and Education] who has a basket of goods with their community health workers and has now added reading glasses. We also have a program in Zambia with Live Well, which is a CARE [Cooperative for Assistance and Relief Everywhere, Inc] spin-off, and is now an autonomous organization with some technical support sometimes from CARE itself who also have community health workers that go into communities and prescribe reading glasses in the same way.

We now work with the Council of Churches in Zambia because the churches have, of course, a huge group of people gathering every time in the churches. And if you talk about reading glasses,

the churches are actually an appropriate place to use the word reading glasses because most of the time, it's near vision glasses that people require. And “reading” glasses are a bit misleading. But in the churches, people really do need their reading glasses. And so we work with the Council of Churches in Zambia, and now we've moved to Malawi and we also work with the Council of Churches in Malawi through their outreach workers.

Ambika Samarthya-Howard: Can you talk a little bit about how that partnership started? How did you approach faith leaders and get their buy-in?

Anne Coolen: I have people that will know more of the details on this, but for me, we started out in Zambia where we celebrated our successes of the Reading Glasses for Improved Livelihoods with Live Well. And the Council of Churches of Zambia had started to be interested because they saw that their members in the community were screened sometimes. They said, "We want to make this available for all our members." And so the Council of Churches of Zambia is really big. Again, I can give you the numbers afterwards. I'm not necessarily the best in terms of remembering all the numbers.

Ambika Samarthya-Howard: I was just wondering if you approached them or they approached you?

 **Anne Coolen:** It's a mix. I think they've seen the work. Live Well had been interacting with their constituents, their congregation. And they had seen the benefits. They have a huge network, they said, "We will be willing to do this too for the rest of our faith-based community." And so that's where it came from. They approached us and we made arrangements with them and signed a memorandum of understanding. We trained, I think today it is up to 400 of their community health workers and started [providing] services. [Community health workers] do the screenings, they go into the community, and then they also carry the glasses so that they can then sell the glasses.

Ambika Samarthya-Howard: The community health workers are also part of the church?

Anne Coolen: Yes, they're the outreach workers of the church in this case.

Ambika Samarthya-Howard: And you mentioned you are working with faith leaders in another country as well?

 **Anne Coolen:** In Malawi. It's the same church. The Council of Churches Malawi is the same leader. So they linked in with us and said, "Are you willing to also come to Malawi?" That's how we signed that one.

Ambika Samarthya-Howard: Could you talk a little bit more about how your partnership with PACE, around social media marketing, started? I'm not familiar with that part of the project.

 **Anne Coolen:** Sure. So I don't know if you know organizations like PSI [Population Services International], but PACE is a spin-off, like a localization of PSI. They have different baskets of goods and different programs, some of them are directly with government and government health workers, but they also have their own network of community health workers. The community health workers from the Ugandan government are not allowed to sell anything. So that was more difficult.

Ambika Samarthya-Howard: That's a Ugandan regulatory rule that they're not able to sell anything?

Anne Coolen: Yes. So BRAC isn't covering the whole country with community health workers and with our program. And once we had success with BRAC, we thought, "Let's see if we can expand this program." We did some stakeholder mapping, looking at who is in the country. Who has community health workers? Which organizations could potentially be interested in this?

 And PACE came up. So over a period of time, we've been interacting with them, having meetings with them, and we decided that this was indeed a value add for both parties. Therefore, we went ahead and ran a pilot to see if it works. The first results were quite positive, and therefore, we continue to work on this partnership with PACE, which now is using – not community health workers – more like commercial health workers who are allowed to sell a little. The social marketing agents are also now doing glasses screening and they're also handing out or selling the reading glasses.

Ambika Samarthya-Howard: So what does PACE actually do?

 **Anne Coolen:** PACE has multiple areas, but largely they have a basket of goods that they're trying. They have the pill, they have some of those kinds of commodities that they distribute into the community either through social marketing agents or through government and community health workers. So they implement part of the community health workers strategy from the Ministry of Health by [distributing] products. Those are the key things.

Ambika Samarthya-Howard: What did you do with PACE in Uganda specifically? Was it specifically working with their community health workers to add glasses into their basket of goods? What is it that they contribute through their partnership that BRAC and you weren't able to do without them?

Anne Coolen: They had a different reach than BRAC, [access in] a different regional area. [It's the] same thing as with BRAC, it's just that we train them and then they can then screen people and provide glasses. BRAC wasn't covering the whole country.

The slight difference is around their specific models, if that makes sense. They have the same type of community health workers that are going around, but they're a little bit differently structured. They are more like social marketing agents. But if you want more details, I'm happy to connect you with the RGIL [Reading Glasses for Improved Livelihoods] lead who can go into more details on each one of these partners that we have.

They have 11,000 plus community health volunteers, but they give out the products for free and they make sure that the community health workers have those products. But on the other hand, it's the medical detailers that sell a basket of goods to health facilities and health centers and pharmacies, and that's where they are working with us.

Ambika Samarthya-Howard: That makes sense. Let's talk a little bit about what's working and what's not. Across these pilots in Zambia, Malawi, Uganda, and in Bangladesh, what are you seeing as some of your biggest successes and insights?

Anne Coolen: I think the biggest success is the reach, the number of people you can actually reach to screen. You can really see that we're reaching over a million people with this program by screening them.

Ambika Samarthya-Howard: Do you have any advice for other places that are trying to increase their reach?

Anne Coolen: I would definitely say that we should use existing systems. Reading glasses alone are not a viable way of doing it. It needs to be an add-on to an existing structure, so whether there's an existing supply chain, in terms of having community health workers, whether it's medical detailers, and it can even be other types of products, even private professionals that have baskets of goods, if that's what they want to add to their basket. But it can't work as a standalone product on this scale. If you want to scale it up, it should be part of a bigger basket of goods.

Ambika Samarthya-Howard: What do you think specifically in terms of community health workers? What have you seen to be the most effective?

Anne Coolen: I think what the advantage of community health workers is that they understand some of the cultural hesitations. The myths and misconceptions. So if we train them

well, they're able to talk to their people and they're often trusted by the people. Some of the myths and misconceptions are that your eyeballs are sinking into your eyes or that the community thinks that you can't marry off a girl that has glasses.

There's multiple things that have come up as challenges in terms of reading glasses. If you have community health workers, they're able to localize it with the knowledge that we've given them. They can have that conversation and make sure that some of the barriers that are overcomeable can be overcome.

Ambika Samarthya-Howard: What have you seen to be most effective in terms of how to train community health workers around eyeglasses?

 **Anne Coolen:** There's two things. I think you don't need a week of training for reading [glasses]. We're still talking near vision. If you talk about distance vision, it becomes a whole different discussion and you need a medical person for that.

In terms of reading glasses, you don't need a lot of technical knowledge. It's actually quite easy to do. The training for doing the screening is the equivalent of an hour, we could all be trained. The thing which is most effective, I think, in training is this interaction with the clients, [training on] client-centered communication. How do you receive a client? How do you see that clients [might be] facing some insecurities? Are they able to ask their questions? Are we giving them all the information they require?

In terms of the value add of the products, it's almost a commercial strategy in terms of being able to talk to the clients. For them to understand what the added value is. In terms of training, what I think is more valuable is the role plays. You have a hesitant client, how do you go about it? Do you just leave that person or are you able to explore a bit further? Do you have the confidence yourself to have the answers to their hesitations? And some of that interaction between the client and the community health workers is, I think, of more [importance] than a long training on how to do vision screening. I don't think we should even necessarily have to do any distance vision or for trying to do all of that. The key thing is to do the near vision screening well and help people with the composition.

 I think role plays are essential to the training, and therefore, an online training wouldn't be my preference. I would like it to be a cascaded train of trainers and then have the trainer train our community health workers for a day. [First, they can] try it out on each other, act out difficult clients, some of the hesitations clients come up with. And in the second phase, which we're now developing, will have short video send-outs to our community health workers or our pharmacists, because both of them can actually be addressed similarly. It's like sending them out a small video, "Remember this…," or a one-minute video on how to overcome a client that is challenged by, name

any of the barriers that the client might be facing. All of the challenges that might come up, you send some small videos saying, "Yes, you can see this, or you can interact like this."

Ambika Samarthya-Howard: Can you tell me a little bit about supervision? After they get trained, how did they continuously get supervised?

Anne Coolen: So again, there are some different models going around. We're now trying to streamline that. In terms of trying to set up quality standards and then making sure that they have supportive supervision models, I think that's my to-go-to model. I feel it's one of the strongest models in terms of making sure that there is some level of actual quality assurance that we can guarantee.

When I came to VisionSpring, now almost two years ago, we started this department. I first had to scan everything that was available, the things that we were doing and seeing how to bring it all together. I saw that there's some level of quality assurance and supportive supervision in the India program, which is our biggest program, but there's not much standardized anywhere else. So we started working on identifying the minimum standards that we want to ensure for each of our different models. For example, RGIL, these are the steps that we're expecting to be in place, pharmacy, these are the things we want to see when we get to the site. So you train people on that. The training needs to be interactive and needs to have some of the other social confidence as I just explained.

 And then thirdly, you will need to have a level of supportive supervision put in place whereby you say, for example, if we do a million screenings in Bangladesh, at least 1%, for example, need to be able to be supervised on a regular basis. Supportive supervision, in my expectation, is internal. It's the program leads and people like myself. The tool is easy to use and can actually even be easily keyed in on a handheld device, like a telephone. The idea of supportive supervision is not to be an act of policing. It's like, "Hey, what is the standard? What should the standard be? Are we adhering to the standard? For example, for dignity of choice, do we have three types of glasses available for our clients [to choose from]? Is there only one black pair of readers available?" If so, there's no dignity of choice. We're not going to punish anyone if there's only one type available, but we will try and find a solution after we finish with the supportive supervision.

Another piece, which is a regular one that I encounter but might not be seen as important, but to me, it's the crisis, is the sign-off by clients that they understand what they've signed up for. The client agrees that the data is being used, that they're signing up for the service and that the data will be aggregated somewhere else. So if they agree to that, in order for them to sign it when they go through our services, we need to make sure that we do that well. If we don't do this well, then there's no point of actually making people sign. So we need to say, "These three bullet [points], this is what you're signing up for. Please sign here," instead of just putting their [name] on a paper saying, "You've signed."

Ambika Samarthya-Howard: You're talking about privacy and sharing of data, right? Could you give me an example of one bullet point?

Anne Coolen: It says, "I hereby agree that my data will be used. I hereby agree that my data can be published. I understand that by going through this service," something like that. It's a consent form. And so it's not only [important] that they sign it, but for me, it's important that they also understand what they've signed up for.

 And sometimes in the speed of things, that gets lost. And so going through supportive supervision and seeing something like that happen, you can correct it. Again, it's not policing because the next place after supportive supervision, you go for internal audit, which is like an internal party, and then you have an external audit. We're nowhere near internal and external audits, but we do want [to expand beyond] India this year, to get supportive supervision for each one of our channels. So a percentage of our services should be observed by people in the organization that are not the people doing it.

Ambika Samarthya-Howard: That makes sense. I'm going to shift a bit to talk about pharmacies. I've heard that it's hard to get pharmacies to feel confident that they can and should be screening and giving out eyeglasses. How have you dealt with that?

 **Anne Coolen:** That's a good question. I think with pharmacies, we have really tried to do near vision and distance vision screening and referrals. And so we've trained most of them in a one-day course or sometimes in a two-day course. To be honest, if you look at the results from the Appleseed study, it's clear that none of these pharmacists are doing the same thing. They all did that process differently.

So that also shows that it might actually be too complex. Plus the pharmacies, we shouldn't forget, they're a business. They're not a social venture, they don't have time. Some of these pharmacies have constant client flow. They don't have time to spend 15 minutes on a client to do distance vision, near vision, or look at their eyes. What they want is to sell a product.

So we, as an eye care community, need to see how that fits within what we offer as a value proposition for our glasses and need to see what we really want to do. We should just be focusing on readers and getting readers on faces. Is this as straightforward as the clients walking into the pharmacy and putting on their glasses? No, it isn't. I think on the continent, and even in some of the other continents, there's still this barrier, fears, myths, misbeliefs, and even the idea of price that it's a luxury product. Even if the glasses stand on the counter, they won't try them on. They're afraid that it'll be too expensive. Somebody thought it was 300 [cedis] while it's 35 cedis. So there's a lot of misconceptions.

 The real opportunity lies in not focusing on doing all these kinds of technical screenings, but getting this pharmacy to be comfortable saying, "Hey, I see that you can't read the bottle that you've just been prescribed. Here, try on a reader to see if it makes it easier for you to read the prescription on the bottle." If we want to do it well for pharmacies to be comfortable, those are the things we should be focusing on.

 Pharmacies are not used to proactively selling. Most clients walk in with a prescription and they're actually buying what they've been prescribed. There doesn't need to be a sales technique for the pharmacist to sell it because they already came to get that product. So for pharmacists to be comfortable starting to cross-sell, starting to announce, or to make more efforts to [sell] glasses, it also needs to be something that is being thought of. It doesn't come natural to everyone to be a salesperson, right? And for glasses, it requires a little bit more engagement with the client before they even try these glasses on or replace their glasses, "They're only 35 cedis. It will really help you to read the prescription you just brought me," or something like that.

Ambika Samarthya-Howard: Are there any examples of things that you have seen that have helped or supported pharmacies to feel that comfortable about testing?

 **Anne Coolen:** No, we cut out most of the testing. The only testing we now do is near vision screening. We don't do distance vision screening anymore. So the near vision screening is only small leaflets that you put in front of the person, put glasses on them and see if they can see better with the glasses on, which most often is the case. It's only from the age of around 40 onwards and you can guess by the age of the client which power they need. Then they can try it on and you can go one higher or one lower to see if that's a fit. But overall, you don't have to do much real testing.

Ambika Samarthya-Howard: Do you feel like there's anything you're doing in your approach with those pharmacies that have made a difference?

 **Anne Coolen:** We've started to give different trainings around this cross-selling. That's one. And we're seeing that some of our key pharmacies are actually seeing much more uptake of glasses, but this is something we have built on even further with the playbook that we have developed together with Appleseed that we're going to launch soon. We actually even work further to make it easier for pharmacists to do some of those things.

 But in the end, to be honest, the simplest solution to get more glasses on faces in the pharmacy and making the pharmacist comfortable is to make sure that they sell more because

then they start seeing the value of the product. If they only sell one reader a month, I can jump high or low, but they won't start seeing the advantage of selling glasses. If they start selling 30 a month, which all our pharmacies are now doing, the $30 of just pure profits is actually adding value to their pharmacy business case.

Ambika Samarthya-Howard: I appreciate what you're saying in terms of the training, but it seems like a very long-term behavior change and work approach.

Anne Coolen: I wish there was one quick solution. I think human behavior and some of the barriers are just complex long-term things. It takes a while before we get to a level where we see a tipping point in which the market drives itself, in which we have private providers coming in with all kinds of options for reading glasses because people are now, in Europe, in the U.S., actually taking up reading glasses just by going to the supermarket. So I do think it does take time to change people's behavior. But once you reach a certain level within the community, it might actually be much easier.

Ambika Samarthya-Howard: What are you testing out in the next six to seven months?

Anne Coolen: So definitely the playbook with Appleseed, which is going to use some of these techniques that we've learned based on the barriers that we've identified and the motivators. And then roll out the demand generation campaign in Ashanti Region in Ghana. Then, of course, we do this research around the conversion rates of glasses in Bangladesh, which you've already heard about. So how do we get more people to actually take up glasses when they need them, when they have already been screened. Those are two of our biggest projects to get more into this space.

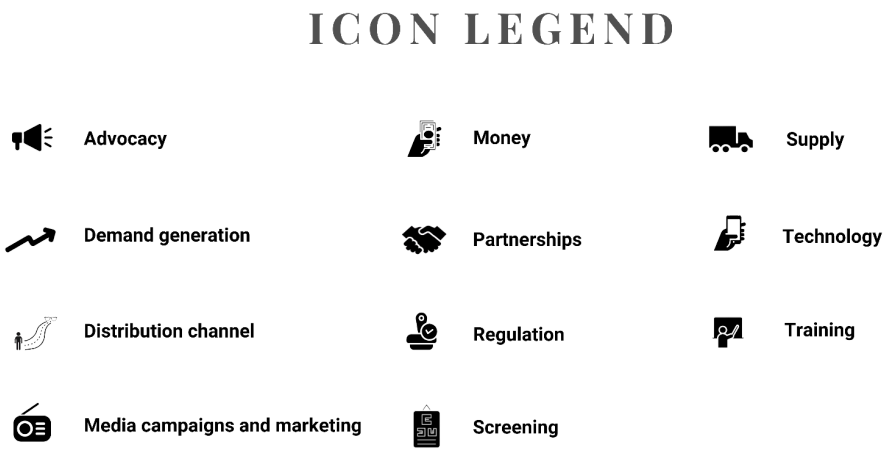
Ambika Samarthya-Howard: What is the timeline of the work in Bangladesh with Appleseed?

Anne Coolen: They'll do the pre-work now, in April. By the end of May, they will do two or three weeks of field research with our teams, and do qualitative data collection. And then we hope by September that we have a playbook ready that we can roll out that influences this conversion rate, moving it from 35% to maybe 60%, hopefully.

Ambika Samarthya-Howard: And so they're going to ask people who choose not to buy glasses why they said no?

Anne Coolen: It's a bit more comprehensive than just doing a survey. They will do some quite extensive qualitative interviews. And they keep on asking questions that are not always directly linked to glasses, [but helps] to fully understand the multitude of reasons why things happen, because there are sometimes reasons that are not as obvious or people are not even conscious of. So they're more comprehensive than just saying, "Why did you just say no to the glasses?" And they have their own techniques for interviewing that they use to actually get the answers.

Ambika Samarthya-Howard: Thank you, I really appreciate you talking with me.



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** This interview has been edited and condensed.*