**Supplementary Table A: Survey questions ascertaining vision impairment and other factors**

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| **Vision impairment** | Is there anyone in this house who is totally blind or has significant difficulty seeing? (Y/N) |
| **Onset and duration of vision loss** | **IF YES,**<br>When did the vision problem start? _____(days/weeks/years)<br>How did the vision problem start? _____ |
| **Care seeking practices** | Has the [affected] family member sought any care for their eye problem? (Y/N)<br>**IF YES,**<br>• Where did they first seek care for this eye problem ? _____<br>• Where did they next seek care for this eye problem? (ask as needed) _____<br>**If formal medical care was NOT sought FIRST [as a source of care]**<br>What was the main reason why the [affected] family member did not go to the hospital first ? _____ |
| **Treatment and Barriers to care** | Has the [affected] family member received any treatment for their eye problem? (Y/N)<br>**IF YES,**<br>• Did the doctor tell him/her what was wrong with their eye ? (Y/N)<br>• IF YES, What did the doctor say was wrong with their eye? _____<br>• What treatment did the family member receive at the hospital ? _____<br>Did the [affected] family member receive any eye operation? (Y/N)<br>**IF NO,** Why was their eye not operated ?( Select all that apply)<br>• No Need<br>• No Money<br>• No transportation<br>• No time<br>• Facility, Personnel or Equipment not available<br>• Person prefers traditional treatment or payer<br>• Surgery planned but not yet received<br>• Person avoided due to fear, mistrust, previous experience |
| **Functional limitations and Economic hardships** | Has this eye problem affected your family member's daily life? (Y/N)<br>**IF YES,** How has it affected their daily life ? (select all apply)<br>• They have difficulty speaking or communicating<br>• The person needs help dressing, eating or toileting<br>• They have trouble interacting with others, shopping, traveling<br>• They have trouble going to school<br>• They have trouble working/ working in the home<br>• They have difficulty standing or walking<br>• They have difficulty picking things up or using their arms/hands<br>• They have weakness, shortness of breath, or fatigue<br>• They have trouble understanding or remembering things<br>• They feel ashamed or depressed<br>• Unknown/Unsure<br>• Is there any other way this problem has affected their life ? (specify) _____<br>How has this problem affected your family? (select all that apply)<br>• Nothing has changed<br>• The family earns less money<br>• The family has spent assets/savings or borrowed money<br>• It is harder to afford necessities like food and rennet<br>• Another person must help care for the person with the problem<br>• Unknown/Unsure<br>• Is there any other way this problem has affected your family ? (specify) _____ |
| **Belief that certain types of blindness are surgically reversible** | Do you believe certain types of blindness can be treated with an operation ? (Y/N) |