Swiss Red Cross

VISION 1ST PROGRAMME
Ghana Health Services Ghana Red Cross Society Swiss Red Cross

Conceptual framework for Swiss Red Cross supported eye care programme in Ghana

Vision First Equity Fund (VFEF) Increasing access to eye health services for the poor

ACCRA, GHANA
May 2005

For comments and questions please contact:

Country:	**Ghana**	**Switzerland**
Name:	**Seth Addae-Kyereme**	**Josef Kasper**
Function:	Country Representative	Programme Coordinator
Organisation:	Swiss Red Cross	Swiss Red Cross/ Int. Cooperation
Address:	3rd Floor Mobil House Liberia Rd. Accra P.O. Box 835, Accra	Rainmattstrasse 10 P.O. Box CH-3001 Berne
Phone:	++233-21-667226	++41 (0) 31 387 72 85
Fax:	++233-21-667226	++41 (0) 31 387 73 73
E-Mail:	srceye@nas.com.gh	josef.kasper@redcross.ch

Table of Content

Table of Content 2

Abbreviations 3

1.0 Introduction 4

2.0 Strategic Intention 4

3.0 Removing Barriers 5

Removing Financial Barriers 5

Removing Proximity Barriers 5

Removing Ignorance Barriers 5

Removing the Barriers of Fear 5

4.0 The Target Group 6

5.0 The Actors 7

Community Based Red Cross Volunteers 7

School Health Teachers 8

Level B. Nurse 8

Ophthalmic Nurse 8

Social Worker 8

Ghana Red Cross Regional Secretary 8

Implementation Team 8

6.0 Skills Development 9

7.0 Institutional Arrangements and Financial Mechanism 9

Developing District Based Institutions 9

District Hospital Contract 9

Approach for Reimbursing the Health Facilities 9

8.0 A Pilot Phase 10

9.0 Quality Management 10

Monitoring 10

Scheme Review 10

Programme Evaluation 10

Documentation 10

10.0 Annexes 12

Annex 1 Vision First Equity Fund Exemption Form 12

Annex 2 Vision First Equity Fund Confirmation Form 13

Annex 3 Exemption Screening Grid 14

Abbreviations

BAR	Brong Ahafo Region
CBRCV	Community Based Red Cross Volunteers
CBV	Community Based Volunteers
DDHS	District Director of Health Services
DO	District Organiser
ECS	Eye Care Service
GHS	Ghana Health Service
GRCS	Ghana Red Cross Society
GRCS RS	Ghana Red Cross Society Regional Secretary
HPDP	Health Promotion and Disease Prevention
IFRC	International Federation of Red Cross and Red Crescent Societies
IOLs	Intra Ocular Lenses
MOH	Ministry of Health
NGOs	Non Governmental Organisations
NR	Northern Region
ON	Ophthalmic Nurse
OTTP	Optical Technicians Training Programme
PSU	Programme Support Unit
RS	Regional Secretary
SHT	School Health Teachers
SRC	Swiss Red Cross
UWR	Upper West Region
VFEF	Vision First Equity Fund

1.0 Introduction

Evidence that the poor often benefit less from public spending is well established[1]. The inability of the poor and vulnerable to make use of the public services is driven by both supply and demand factors. Fortunately and unfortunately, the focus of most health policy interventions has been on reducing supply barriers. Delivery of essential services concentrates on improving the quality of staff skills, protocols of treatment, availability of suppliers and environment of health facilities. Yet while these interventions are important, they do not address many of the barriers to accessing health services faced by the patient especially, in a low-income setting[2]. Often, health services of a reasonable quality exist, but few use them. Just as important are the physical and financial accessibility of services, knowledge of what providers offer, education about how to best utilise self-and practitioner-provided services and cultural norms of treatment.

The Swiss Red Cross (SRC) with the Ministry of Health/Ghana Health Service (MOH/GHS) and Ghana Red Cross Society (GRCS) as partners have been supporting Eye Care Services (ECS) in the Upper West Region (UWR) since 1990 and in Brong-Ahafo Region (BAR) since 1995 and in the Northern Region (NR) since 2004. Eye units located in District hospitals have been renovated, equipped and staffed sufficiently to provide curative ECS. To promote curative services and address issues of preventable blindness the SRC finances training for Community-Based Red Cross Volunteers (CBRCV) in Health Promotion and Disease Prevention (HPDP). The SRC supports optical services through the facilitation of the Optical Technicians Training Programme (OTTP) and two optical workshops.

Having implemented eye care services over the years, the programme commissioned an evaluation in 2003 to assess the contribution of the SRC to eye care in Ghana between 2001 to 2003; identifying barriers, shortfalls and challenges in project implementation, and make recommendations for change. Among others, one of the specific objectives was to review the types of subsidies and the practices for making eye care services available and accessible to the poor[3]. “The evidence shows that the support goes to subsidise the facilities and is not transferred to the patients…” The design of the revenue support of SRC support could therefore be revised to improve ways of targeting … the poor and vulnerable groups”[4]. Unfortunately, the report failed to describe who the poor and vulnerable is. This therefore makes any form of intervention difficult as the target group or problem area was not clearly defined during the evaluation.

In response to the recommendations made in the report coupled with various programme reviews and monitoring exercises by SRC, the SRC called for the elaboration of a conceptual framework to guide its commitment to improve upon access to eye health service for the poor[5] through community level (both demand and supply sides) interventions in two pilot districts; Jirapa and Bole in Upper West and Northern Regions respectively from 2005 to 2007.

2.0 Strategic Intention

The SRC over the years has equipped eye care units in 18 hospitals that provide a reputable service across both the UW and BAR in Ghana. Having done that, the SRC wishes to guarantee that people from the poorest sections of Ghanaian society benefit demonstrably from the services they offer. The SRC will focus on improving access to quality eye care for the poor. This is influenced by the Mission “to improve the lives of vulnerable people by mobilising the power of humanity”[6] as well as the SRC strategic intention “…improving access to quality eye care by those living in absolute poverty…”[7] The strategy will gear towards putting in place systems and structures to provide solutions to barriers such as lack of knowledge on health care

[1] Demery 2000; Makinen et al. 2000 quoted in Ensor and Cooper 2004
[2] Ensor and Cooper (2004) Overcoming barriers to health services access: influencing the demand side
[3] Addai E. et al. (2003), Evaluation of Swiss Red Cross Support for Eye Care 2001-2003.
[4] Addai et al 2003
[5] In accordance with pre-determined criteria
[6] IFRC Mission (1999), Strategy 2010.
[7] SRC, Country Strategy for Ghana: 2004-2013, September 2004

choices/providers, indirect consumer costs (distance cost), attitudes and norms and above all cost of services. The predominant emphasis will be on District based ECS where the professional eye health staff shall be prepared to fulfil the roles required of them by Vision First Programme towards eye care. The underlying causes of the barriers for the poor to the uptake of health services shall be identified, understood and alleviated as much as possible.

3.0 Removing Barriers

3.1 Removing Financial Barriers

I. **General Subsidy** – As a general subsidy, the SRC shall absorb the cost of vital inputs to cataract surgery i.e. IOLs, Sutures and Viscoelastics. This subsidy shall be extended to all patients reporting to the eye clinics. The patient then pays for his/her feeding, accommodation and other hospital charges.

II. **Vision First Equity Fund Subsidy** – SRC shall assist patients who fall within the target group to further meet the cost of service i.e. in addition to the general subsidy determined above, the SRC shall provide further support to these patients. The level of need shall determine the level of relief/support. Support therefore shall range between other clinical costs (i.e. after the general subsidy) to accommodation, feeding and transportation.

III. **Eye Camps** – SRC shall fund eye camps to reduce the existing large backlog of cataract cases. This exercise shall in a one-off activity, cover large numbers of cataract patients who will be identified to undergo free surgery in a camp setting. The usual time period for this activity shall range between 1 to 2 weeks. In the meantime the SRC shall research into more effective ways of providing such services. Extended surgical outreach[8] stands to be a sure substitute to eye camp[9].

3.2 Removing Proximity Barriers

SRC shall fund surgical outreach programmes. The Ophthalmologist shall be supported to undertake surgical outreach to carry out surgery on identified patients at the District clinics. The Ophthalmic nurses shall also be supported with transport and fuel and outreach allowances to undertake medical outreach to both communities and schools.

3.3 Removing Ignorance Barriers

The SRC shall fund the training of community based volunteers to create awareness of the eye health services in their respective communities or their catchment areas and encourage eye patients to access the facilities. The volunteers shall be provided with education materials (i.e. flip charts, Snellen charts etc.) to guide them in undertaking disease prevention and health promotion exercises in their communities. These shall be done on house-to-house and community basis. The ophthalmic nurses shall also play a significant role in this education and information giving exercise during their community outreach activities.

3.4 Removing the Barriers of Fear

Being one of the significant barriers to uptake of eye health services, the SRC shall support the training of community-based volunteers in basic counselling. The trained volunteers shall be encouraged to undertake one on one or group counselling in their respective communities to allay the fears of the patients about surgery.

---

[8] Accumulation of a number of patients through routine hospital and outreach activities with surgery performed over a period of time by the visiting surgical team. In this case no additional cost is incurred in the identification of patients and uptake outcomes are readily known.

[9] Identifying high number of patients within a short period through efforts of a visiting team with surgery performed over a period by the visiting surgical team. High costs are incurred on the identification process and personnel. Expected outcome is also not guaranteed.

4.0 The Target Group

Arriving at the target group for the fund shall be influenced by the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief which indicates that “the humanitarian imperative comes first and aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind; aid priorities are calculated on the basis of the need alone”. Taking inspiration from the above and coupled with the difficulties in relation to identifying the poor especially in a population which is relatively uniformly poor[10], the most appropriate way to identify the poor is through direct targeting[11].

To arrive at who is eligible for exemption of user fees, an exemption screening grid[12] was developed. The process of determining the grid involved consultations with relevant bodies such as District Assemblies and health institutions to garner desk top information on systems that are put in place to cushion patients who cannot afford health expenses and circumstances that demand giving assistance to such patients. In addition, communities’ perspectives and/or concept of the poor were also acquired.

No. of Priority	***Condition/Criteria***	***Indicators***
1	Bilateral Blind on Waiting List	Patients who are cataract blind in both eye and have being on the waiting list without under going surgery for no apparent reason.
2	Bilateral Blind (New Cases)	Newly identified blind in both eyes but not on the waiting list
3	Unilateral Blind on Waiting List	Patients who are cataract blind in one eye and have being on the waiting list in the hospital without under going surgery for no apparent reason.
4	Socio Economic Factors	Screening grid[13].

Although persons who fall within the above four criteria shall have access to the fund, priority shall be given to patients according to exigency of need. Those who fall within the first priority number of the criteria shall qualify for the Vision First Equity Fund (VFEF) first, follow in that chronological order. Patients in the first priority are blind in both eyes. The condition normally starts from one eye and get to the second. To have waited for the second eye to go blind and be on the waiting list, especially after accepting uptake of surgery (no other barriers) but are limited by cost as barrier is a good indication of hardship. They therefore need urgent attention by providing them sight at least in one eye. The second priority is patients’ blind in both eyes who may either have or not have information about the service and are limited by cost of service. Accordingly, bilateral blind identified by volunteers from the communities shall be granted the second priority to qualify for the fund. Patients with priority number three (3) have at least sight in one eye. Probably through the effort of the volunteers, they have information about the service and wish to gain sight in the second eye but due to financial constraints have been on the waiting list. This category of patients will qualify for exemption after giving priority to the first and second priority groups. Lastly, priority shall be given to those who will be identified by the volunteers using the exemption-screening grid in the annex three (3).

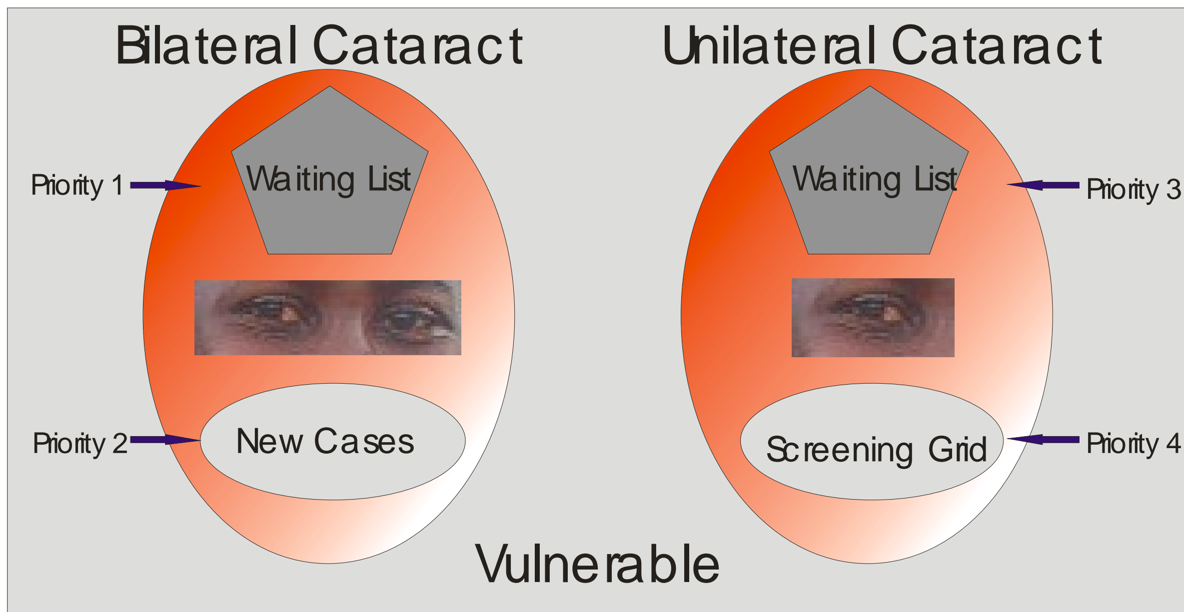
[10] Bart Jacobs 2004, Improving Access to Health Care for the Poorest: Insight from an Innovative Equity Fund Scheme in Kirivong Operational Health District in Cambodia

[11] Pre –determined criteria to direct the identification of beneficiaries

[12] See annex 3 for the exemption screening grid

[13] See annex 3 for the exemption screening grid

Below is graphical presentation of the priority groups for the VFEF members.



The exemption-screening grid (see annex 3) was developed based on easily verifiable poverty indicators identified in a survey undertaken in two communities based on socio economic characteristics. Each characteristic will be scored, with scores closest to zero representing financial hardship. A score of less than 15 was the cut off point under which exemption will be granted. All information with regard to a person's socio economic characteristic shall be kept confidential. There is assumption that all people identified with the pre-set criteria coupled with the self-interest of the identifiers may have some error of margin. To minimise this error, there will be the need to collaborate with social workers in the hospitals to cross check the validity of the information provided by the volunteers.

5.0 The Actors

5.1 Community Based Red Cross Volunteers

The volunteers shall be recruited, trained and assigned a number of roles and responsibilities in relation to the target group.

- The volunteers shall be responsible for identifying the poor in accordance with the pre-set criteria.
- The volunteers shall fill a VFEF exemption form[14] for each identified person to be presented by the patient upon calling at the hospital as being eligible for the VFEF. Patients who shall qualify for the fund through the use of the screening grid shall have their approval forms attached to the grid
- Volunteers will lead to the hospitals persons who have no carers
- The volunteers will also provide counselling, house-to-house education, post operative care and serve as the link between community and the health facility.
- If there is some doubt about the particulars of the patients on the forms or exemption screening grid, the volunteer shall lead the social worker to the community to undertake further investigation on the information provided on the VFEF exemption form (see annex 1) or exemption screening grid (see annex 3).

[14] See annex 1 for the sample of the form

5.2 School Health Teachers (SHTs)

The SHT shall similarly be trained to perform basic screening exercises on school children to stem and/or to detect childhood blindness within a reasonable time for corrective measures to be effected. They shall also be oriented on the set poverty criteria and how to apply it among school children who require services.

5.3 Level B Nurse

The Level B staff shall also be orientated on the entire programme process and their role and responsibilities. They shall be trained to treat minor eye ailments as conjunctivitis and also to identify major cases for referral to the District clinics. Interventions at that level guarantee significant reduction in costs i.e. transportation and facility charges.

5.4 Ophthalmic Nurse (ON)

The ONs shall be oriented on the set criteria and all the procedures and systems put in place to ensure effective and efficient implementation of the scheme. The ONs will undertake outreach to communities to provide clinical activities and support the level B staff and volunteers.

5.5 Social Worker

The patient upon calling at the hospital with the VFEF exemption form[15] from either the level B staff, school teacher or volunteer, will be referred to the Social Worker within the hospital. The health centre social worker will then confirm the approval by further assessing the socio-economic status of the identified person using their professional skills in consultation with the set criteria.

5.6 GRCS Regional Secretary

The GRCS RS shall represent the Red Cross in the Regions in all aspects of the implementation of the scheme. All administrative and management requirements shall be met by the RS before the meeting of the implementation team. He/she may take all ad hoc decisions based on specific direction provided by the Programme and report accordingly during the Implementation Team meetings. The RS shall be expected to be in close contact with all the actors of the programme. The offices of the GRCS will keep originals of all documents in relation to the scheme. This will serve as reference documents for financial audit and project evaluation exercise.

5.7 Implementation Team

A district based Implementation Team would be formed in the two pilot districts to serve as oversight committee of the fund. This would consist of representatives from the GRCS, GHS and SRC. The team members shall be the District Director of Health Service (DDHS) for GHS, Programme Coordinator for Social Development for the SRC, GRCS RS for GRCS, ON, Social Worker for the facility and District Representative of Ghana Society for the Blind. The DO shall represent the volunteers at District level. The team shall have quarterly meetings.

The team shall be responsible for assessing the implementation processes and contribute to change; make sure that all laid down processes and procedures are adhered to by all actors; ensure that all actors hold on to the minimum standards of service delivery and certify for the reimbursement of the money spent on patients by the hospitals. It shall be necessary to pay working visits to randomly selected beneficiaries to assess the impact of the surgery on their socio-economic status. Minutes of meetings shall be documented and disseminated.

[15] See annex 1 for the sample of the form

6.0 Skills Development

Capacity strengthening will be an integral part and critical to the success of the strategy. This will begin in the pilot phase and cut across all levels of programme implementation. Skills of professional health personnel including Level B staff and ONs, will be strengthened through specific training interventions focusing on welfare, counselling, management and supervision, technical health issues, HPDP, presentation and training skills.

Volunteers and schoolteachers' capacity in community mobilisation using Participatory Rural Appraisal (PRA) tools, Health Promotion and Disease Prevention (HPDP) skills, welfare and counselling and Post Operative Care will be strengthened. They shall also be taken through the predetermined criteria and their application process and how to fill all related documents.

7.0 Institutional Arrangements and Financing Mechanisms

7.1 Developing District-Based Institutions

The synergistic outcomes, which will accrue by utilising the comparative advantages of the GHS in curative care and the GRCS in community mobilisation through the deployment and management of community volunteers (preventative eye care), can be maximised through District based ECS. To meet this challenge, professional District level eye health staff within GHS will be prepared to deliver pro-poor curative care. The GRCS will be prepared to fulfil management, supervision and monitoring roles.

7.2 District Hospital's Contract

A formal agreement shall be required with the curative eye care providers at Hospital level if they are to take on more responsibility for increased and improved service levels. The need for the agreement is also to reduce the tendency to favour treatment for patients who can pay. In doing that, service providers will be expected to care for patients identified as poor and referred to the health centers. SRC will reimburse the service providers for services provided to the eligible person.

The following issues would be considered, harmonised and embodied in the agreements:

- Responsibility for SRC resource allocation decisions within the service. This is in relation to accountability of funds released for the programme. Who, to whom and when should such accounts be made.
- Who the poor are, how they are to be identified and how their care can be subsidized without disrupting the wider health care systems and in a way that the direct beneficiary can be clearly identified.
- Responsibility for pre and post operative care agreed.
- Monitoring, supervisory and reporting guidelines.
- The minimum standards for service delivery and the bases for reimbursement.
- Non-discrimination: health center staff will not discriminate people according to their socio-economic status or ability to pay. Discrimination includes non-willingness to provide services or being unfriendly.
- Number of surgery to be performed
- General Terms: duration, abrogation, dispute, and amendments of contracts.

7.3 Approach for reimbursing the health facilities

The District hospitals will keep all forms, referral letters of the people to whom they provided services. During the quarterly implementation team meeting, cases in relation to reimbursement shall be discussed and decisions taken accordingly. The implementation team shall expedite action on reimbursing the health centers for the services provided by the health centres.

8.0 A Pilot Phase

SRC will support a pilot phase (2005-2007) of the strategy in two Districts, Jirapa and Bole Districts in UW and NR respectively, during which the provisions aforementioned shall be tested. It should be noted that, the intervention is being piloted in the two District hospitals. However, persons who call at these health centres irrespective of their origin or residential location and meet any of the priority criteria shall benefit from the VFEF. The selection of the Districts was based on poverty statistics and the prevalence of eye related diseases. Indicators used in selecting the Districts include level of access to health and social services, low level of consumption through lack of access to income and social capital and land, market opportunities and other health related indicators. The selected Districts fall within the most deprived Districts in their respective Region according to the MoH and GHS[16].

9.0 Quality Management

9.1 Monitoring

Monitoring of both the process and the approach will form an integral part of the programme implementation from the pilot phase through scaling up, consolidation and exit. Participatory approaches and methodologies will be the main tools for the monitoring process. The monitoring process will involve all actors at different levels. The rational for the monitoring is to improve the programme implementation process by ensuring that activities are on schedule and the processes are appropriate to facilitate the achievement of the objectives.

9.2 Scheme Review

There will be regular quarterly participatory reviews of the programme. The focus will be on looking at the impact and process of programme implementation as well as matching input with output. This implies identifying and setting indicators during the initial phase of programme implementation and using them as a baseline for assessing impact in the future. Indicators will be set for the different levels. However, the indicators for the various activities will be integrated to give a holistic direction to the programme during scaling up phase. The SRC will initiate the monitoring and review process. Feedback from the exercise will be used to improve programme delivery.

9.3 Programme Evaluation

There shall be an end of programme (end of pilot phase 2007) evaluation of the concept. Participatory evaluation processes shall be employed in the exercise. Methods such as the use of participatory tools (Focus Group Discussions (FGD), community mapping, wealth ranking) and any other tool that may evolve during the exercise shall be employed in the evaluation exercise. There shall be a review of existing documents and interviews through the use of checklists and questionnaires (open and close ended). The following indicators may guide the evaluation team; achievement of set target; assessment of selection criteria set for identifying the target group (cost effectiveness, efficiency and effectiveness of the strategy towards increasing access to eye health service for the poor); impact on lifestyle of end users (before as against after); the actors view about the whole process; willingness of the identified poor in accessing the health service and capacity assessment of the service providers. The outcome of the evaluation shall guide future programme design and direction.

9.4 Documentation

Reporting on programme activities will be one of the vehicles for communicating and sharing programme information among stakeholders. It will reflect on actual implementation activities drawing on interesting stories, experiences and lessons learnt. The SRC and partners would also document the process, capturing how the work was done, what worked and what did not and their

[16] Health Sector Response to Ghana Poverty Reduction Strategy (GPRS) 2004.

implication on the programme success. Challenges during the period will also be highlighted. This is to facilitate the decision-making process and direct future programme design. There will be regular monthly reports from the CBVs and quarterly reports from the service providers on activities undertaken during the programme implementation period.

A special reporting format will be developed for all the actors to record activities undertaken at their respective programme level, which will be collated by SRC at the end of every quarter.

10.0 ANNEXES

Annex 1

VISION FIRST EQUITY FUND EXEMPTION FORM

Name of Applicant: …………………………………….

Name of Community:……………………………………

Name of District:………………………………………..

Name of Hospital:…………………………………………………………………………………………..

Date of Birth: ……………………..Age:……………………. Place of Birth……………………………….

Gender:………………………

Diagnosis:………………………………………………………………………………………………...

What specific assistance does the patient need:…………………………………………………

Which of the criteria does the patient meet:……………………………………………………………..

What is the Patient/Family/Parents contributing:………………………………………………………..

FOR THE MEDICAL TREATMENT: THE HOSPITAL SHALL BE REIMBURSED from the VFEF for rendering service to the patient with the following cost:

1. Reimburse the cost of surgery which is: ……………………………………
2. Reimburse the cost of the ward/bed fee which is…………………………
3. Reimburse the cost of the consultation fee which is………………………
4. Reimburse the cost of drugs which is………………………………………
5. ……………………………………………………………………………..
6. ……………………………………………………………………………..

The Patient/Family/Parents is responsible for the cost/provision of the following:

1. Cost of transport to and from the Hospital: …………………………………………..
2. Food while at the Hospital:………………………………………………………..
3. Cost of glasses when required…………………………………………………………
4. ……………………………………………………………………………………………
5. ……………………………………………………………………………………………

Recommended by Volunteer/Hosp. Social Worker/Other: ______________________

Date: ________________ Patients Thump/Sign ______________________

Annex 2

VISION 1ST PROGRAMME
Ghana Health Services Ghana Red Cross Society Swiss Red Cross

VISION FIRST EQUITY FUND CONFIRMATION FORM

HOSPITAL NAME ____

TO PATIENTS:

For treatment of your eye condition, you need to be at the hospital/clinic to see the Doctor/Nurse on …………………………Your expected stay at the hospital will probably be……..…………….days

TO HOSPITAL ADMINISTRATORS:

This patient has been referred to your hospital for treatment of his/her eye condition. Please treat him/her with the same respect and efficiency that you would want. Also please note the costs that are to be paid for by the VFEF on the membership form and make the appropriate arrangements by billing her/him against the fund.

TO EYE DOCTORS:

The bearer of this coupon has been referred to you for treatment. Please fill in as well as stamp the bottom of this Coupon and return it to your Administration for onward transmission to VFEF Implementation team to pass on to the Donor of the Fund. Thank you.

____________________	____________________	____________________
Type of eye Surgery	Date	Sign/Thump

____

Sign (RS GRCS)

Annex 3

Exemption Screening Grid

Name of Patient:……………………………… Name of Community:……………………….

Scoring (please circle the appropriate score, indicate the score in the total box next to the score box. Sum all the scores and record the total score in the total score box)

1. Occupation				**6. Farm Animals**				
	Job	**Score**	Total		**Poultry**	**Mammals**	**Scores**	Total
	No	1			0	0	1	
	Sub farm	1			1 to 9	0	1	
	Brewing	2			1 to 9	1 or 2	2	
	Comm. farm	3			1 to 9	3 or 4	3	
	Civil service	4			1 to 9	5 and more	4	
					>9	0 or 1	4	
					>9	2 and more	5	
2. Daily Income	**Amt**	**Score**		**7. House features**	**Walls**	**Score**		
	0	1			Mud	1		
	¢0 - 4000	1			Bricks	2		
	¢4000-5000	2			Cement block	3		
	¢5000-10000	3						
	¢10000-25000	4		**8. House features**	**Roof**	**Score**		
	¢30000	5			Thatched	1		
					Mud roof	2		
3. Spouse	**Response**	**Score**			Iron sheet	3		
	No	1						
	Yes	2						
4. Occupation of spouse	**Job**	**Score**		**9. Period of condition**	**Time**	**Score**		
	No job	1			4 to 5yrs	1		
	Sub farm	1			3 to 4yrs	1		
	Brewing	2			2 to 3yrs	3		
	Comm. farm	3			1 to 2yrs	4		
	Civil service	4			< 1yr	4		
5. Why no access to eye care service	**Reason**	**Score**		**10. Knowledge of service**	**Knowledge**	**Score**		
	Cost of service	1			No	1		
	No carer	1			Yes	2		
	Distance to facility	2						
	Fear	3						
	Ignorance	4						
Total score								

Note: A score of a maximum of 15 was the cut off point under which exemption will be granted. If greater than 15 and the patients still need assistance, explain reason for application to exemption and reasons for granting full or partial exemption.

Sign:________________________ Date: / / 0

Name of Volunteer/Others:……………………………………..