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Puntos de Vista: primary eye care in migrant health
Migrant Clinicians Network

monograph series
MIGRANT CLINICIANS NETWORK

Puntos de Vista: Primary Eye Care in Migrant Health

Eye Care Needs Assessment

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What is Primary Eye Care?

The principal goal of primary eye care is to decrease the incidence of preventable eye disease and vision impairment. In addition, primary eye exams can reveal systemic disease such as diabetes and other blood vessel, neurologic, and endocrine disorders. Most eye diseases and injuries can be prevented by simple individual and community activities in the field of public health, injury prevention, and nutrition. An effective primary and preventive eye care program will prepare the community to recognize and prevent many eye problems. While many migrant health centers provide some level of curative eye care services, fewer have instituted a comprehensive primary eye care program that encompasses a significant amount of preventive eye care.

The Puntos de Vista Project: Background

In 1996, the Migrant Clinicians Network and its partners InFOCUS, the Interamerican College of Optometry and the Pennsylvania College of Optometry are piloting the use of a primary eye care project in migrant health settings. The *Puntos de Vista: Primary Eye Care Project* will provide education to migrant health providers about primary eye care and pilot the use of educational materials and an eye care kit at demonstration clinics. The eye care kit will include opthalmic antibiotics for eye care, a tool for assessment of refractive errors (the Focometer™) and low-cost spectacles that can be constructed on site and dispensed at a modest profit. The goal of this three-year project is to institutionalize primary eye care services as a part of health care in selected migrant health centers.

The Needs Assessment: Purpose

The primary eye care kit and educational materials seem suited for use in migrant health care facilities. A pilot project, such as Puntos de Vista, will demonstrate whether these innovations can in fact fit into the primary health care already provided to migrant workers through migrant health centers. The first step in this process, however, is to assess the need for eye-care and vision-screening services in the health centers. Is there a need for improved eye care services for migrant workers? Are eye care and vision problems prevalent? Do migrant health care providers see this as a need for their patients and as a service that they would like to provide?

Existing Documentation of Need for and Access to Vision Screening and Eye Care Among Migrant Farmworkers

Demonstration projects conducted by the Association of Schools and Colleges of Optometry (ASCO) from 1974

to 1988 showed a clear deficiency in eye care for migrant workers and an increased prevalence of eye and vision problems in comparison to the general population. As reported by Dr. Ian Berger, Director of InFOCUS, in an article entitled *Primary Eye Care as a Part of Comprehensive Health Care* in the July/ August 1991 edition of the *MCN Clinical Supplement*:

- Between 45-55 percent of several thousand farmworkers screened had never before seen an eye care practitioner.
- About 85 percent had not had a vision examination in the previous five years.
- Nearly 50 percent of workers and members of their families failed one or more of the screening criteria.
- Eye pathologies and systemic diseases were identified in about 15 percent of the patients seen. This pathology rate is higher than expected in the general population.
- A higher proportion of eye and vision problems was found than occurs in the general population.

Although children in farmworker families were found to have similar prevalence of visual refractive errors as in the general population, the extent of uncorrected vision problems was much higher. Although not from a scientific random sample of migrant farmworkers across the country, the findings are probably generalizable to a large extent to the general farmworker population. Available information indicates that vision and eye care problems are more prevalent in the migrant farmworkers than in the general population. Vision problems are a major health concern and a problem for people dependent on steady work for income and for whom reading can be a valuable tool for bettering their circumstances.

Perceived Need For Improved Vision Screening and Eye Care Technology by Migrant Health Care Providers

The question that remains is whether migrant health care providers consider vision and eye care as a pressing need and whether they feel willing and capable of addressing some of those needs at their facilities. To address this question, an assessment was developed to determine the perceived need for improved vision screening and eye care technology among those who would use it. If providers do not feel that this is a need among their clients, or they do not feel that they are the appropriate parties to address such a need, the project--no matter how innovative and easy to use--will not be used or incorporated into the core services of the clinic.

Methods

This assessment addressed the questions: Do migrant health clinicians perceive a need for improved vision screening and eye care in the populations they serve? Do migrant health clinicians believe that their clinics should and could provide improved vision screening and eye care services?

Survey Method

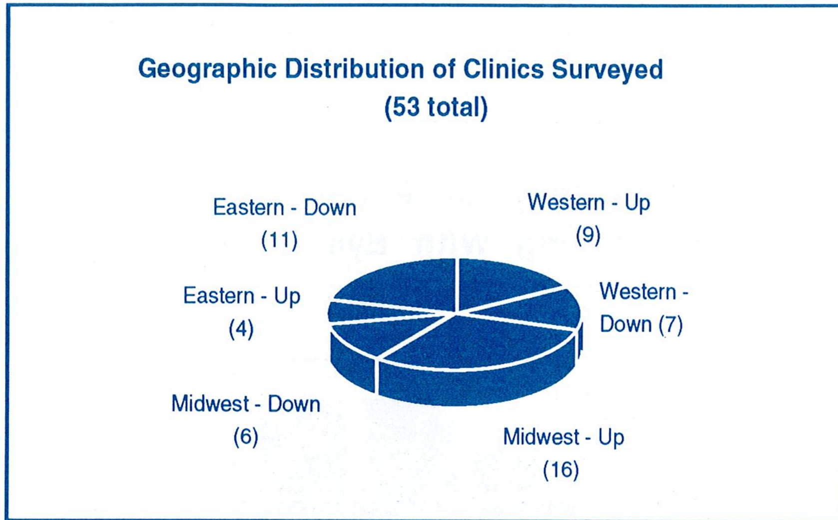
The Migrant Clinicians Network selected phone interviews as the most appropriate survey method for this needs assessment. Although not as in-depth as face-to-face interviews, phone interviews do allow questions and explanations that are not possible in written surveys. They are more cost-effective than face-to-face interviews when surveying people in a large geographic area (in this case, the continental U.S. and Puerto Rico); and they produce a higher response rate and are a faster information collection method than written surveys.

Survey Subjects, Sample Size and Selection

The survey was directed at clinicians in migrant health centers in the continental U.S. and Puerto Rico. Clinicians were defined as doctors, nurses (RN or LPN), nurse practitioners and physician assistants who regularly saw patients at that clinic site. In some cases, outreach workers or medical assistants added supplemental information to the interview. Clinicians were selected as the survey subjects because they actually saw patients and were aware of the most common presentations and problems. In addition, clinicians would be the most likely to actually use the primary eye care kit.

Clinics were randomly selected from the list of 329 funded Migrant Health Centers, which includes clinics in 37 states and Puerto Rico. A sample size of at least 53 clinics was chosen by the Migrant Clinicians Network, in order to include at least half of the migrant health centers (a total of 106). The callers identified

themselves and then asked to speak with a clinician who regularly saw patients. Calls were made taking into account time zone differences in order to facilitate responses. When a clinician could not be reached after three calls or did not return a message left on two consecutive days, that clinic was omitted from the sample and the next randomly selected clinic was called. This was the situation in approximately 20 percent of the clinics called; therefore the initial response rate was about 80 percent. The most common title of the person interviewed was nurse, primarily registered nurses. Approximately 30 percent of the respondents were not nurses, but doctors or other clinicians.



A total of 53 clinics were surveyed. Interviews were conducted with clinicians in 23 states and Puerto Rico. All three migrant streams were represented: 16 Western Stream (9 upstream, 7 downstream); 22 Midwestern Stream (16 upstream, 6 downstream); and 15 Eastern Stream (4 upstream, 11 downstream).

Survey Instrument Design

The survey instrument was designed to assess the providers' sense of the most common eye care and vision-related presentations at their clinic; how often they are faced with these problems; what kind of vision and eye care services they currently offer and to whom; how often patients request eye care services that are not available at their site; how they handle eye care and vision problems they cannot address on site; and their interest in providing additional vision and eye care services. The instrument was designed to be short (taking about 10 minutes to administer), and to be sensitive to clinicians busy schedules.

Results

The needs assessment yielded many interesting findings about migrant health care providers' perceived need for improved eye care and vision screening services for their clients. As expected, some clinicians seemed very interested in the possibilities of these new technologies, while others were too overwhelmed with current responsibilities to welcome potential additions to their duties. The results were varied, but showed several strong trends.

Most Common Vision or Eye-Care Problems Seen and Frequencies

By far the most common vision or eye care problems clinicians reported finding among their clients were basic refractive errors or a need for glasses. Thirty-eight of the 53 providers reported this as the most or one of the most frequent vision or eye care related problem they saw in the migrant farmworker population. (Other terms used to define this problems which were also counted in this category were: decreased vision, poor vision, visual acuity, poor eyesight, cannot read, headaches related to vision, acuity deficiency and myopia.) Several respondents were very concerned about this need and saw it as a major gap in the services they provided. Two East Coast interviewees talked about this as a problem they saw particularly at sites where the vast majority of clients were men, and primarily African American men. They expressed frustration at not being able to find funding to address these problems, and felt that much of the funding came to them in packages directed to maternal and child health or other categories. These two providers claimed that this was the *main* problem they saw at their sites. Many others volunteered that this was a pressing problem for workers in their areas.

Another very common problem cited by clinicians was eye infections, almost always identified by them as conjunctivitis. Twenty-two of the 53

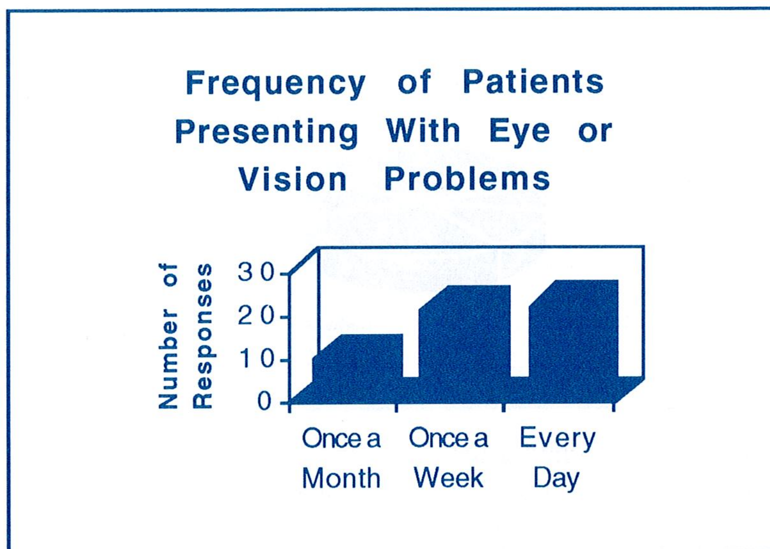
respondents cited this as the most or one of the most frequent vision or eye care problems presented at their clinic.

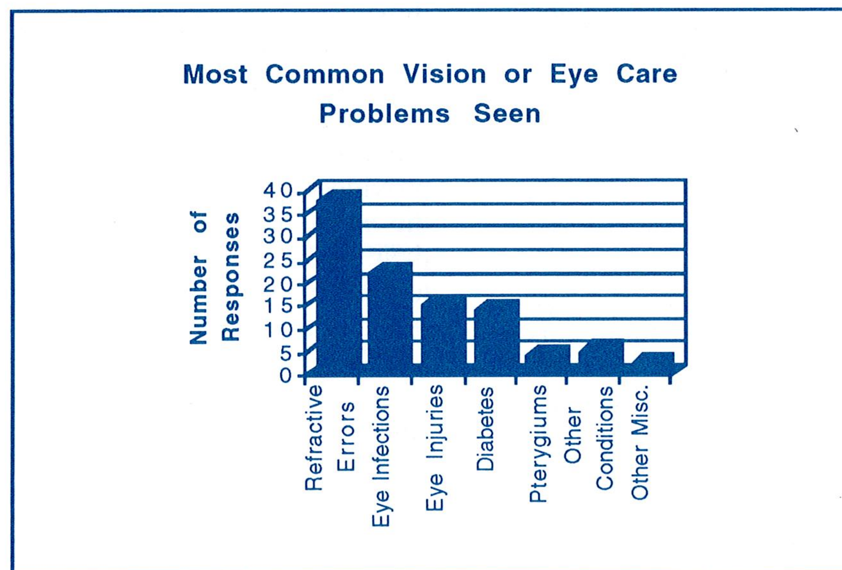
Third most common were eye injuries, almost exclusively specified as foreign bodies in the eye. Fifteen of the 53 respondents cited this as the most or one of the most frequent vision or eye care problems presented at their clinic.

Another common response was eye care for diabetic patients or diabetic retinopathy (cited by 14 of 53 respondents). Many clinicians expressed this as a concern in clinics where the majority of the patients were Hispanic. Refractive errors, conjunctivitis, foreign bodies and diabetes were the most common vision or eye care related problems seen by migrant clinicians interviewed. (Totals equaled more than 53 because some providers listed more than one most common problem.)

Other problems mentioned were: pterygiums (four responses); other eye conditions including glaucoma, cataracts, lazy eye and crossed eyes (five responses); broken glasses needing repair or replacement (one response); and sun exposure (one response).

Clinicians' responses as to the frequency of seeing these types of problems were fairly evenly distributed between "*sometimes*" (defined as once a month- 10 responses), "*frequently*" (defined as once a week- 21 responses) and "*every day*" (22 responses). Clinicians at migrant health centers across the country are seeing at least one patient with some kind of vision or eye care problem almost every day of operation.

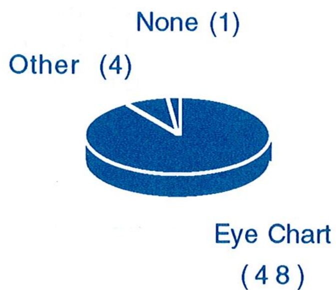




Vision Screening Currently Offered

The overwhelming majority of clinics surveyed (48 of 53 clinics surveyed) offer basic vision screening services in the form of the Snellen's eye chart or the E-chart. Only four clinics offered any more extensive services (including the Titmus test and occasional use of diagnostic equipment), and one clinic offered no vision screening services at all.

The eye chart test was administered primarily at routine physical examinations, especially children's exams (well-child exams- 34 responses; routine physicals/ annual exams- 27 responses; work, sports or Department of Motor Vehicle physicals- 6 responses). Some clinics screened all children who came in for any type of visit (3 responses), and one clinic screened all patients routinely. Other than physical examinations, the most common time patients were tested with the eye chart was when they were

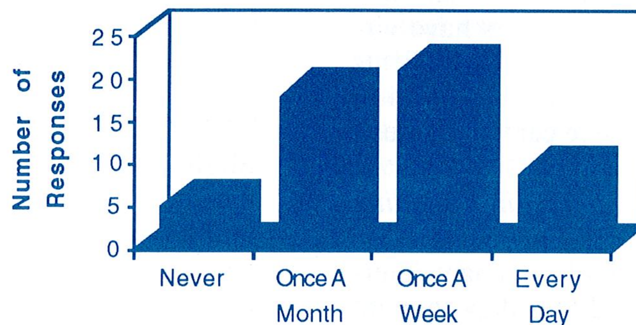


complaining of vision or eye problems or requested a test (19 responses). Other times clinics used this basic vision screening tool were with diabetic patients (two responses), at post-partum visits (one response), special off-site screenings (one response).

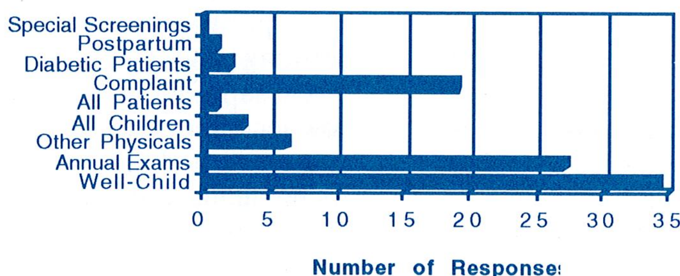
Almost all migrant health centers seem to be using a basic eye chart screening tool routinely as part of the preventive services offered. The primary targets of this basic screening are children.

Patients Seeking Eye Care and Vision Screening at Migrant Health Centers

In order to get some picture of the perceived need of migrant farmworkers themselves for vision and eye care services, providers were asked how often patients came to their clinic sites specifically asking for these types of services. They were also asked how they handled such requests. The majority of clinicians reported that patients came into the clinic asking specifically about eye care or vision problems once a week ("frequently-" 21 responses) to once a month ("sometimes-" 18 responses). Only a few clinics reported that patients never (five responses) came in asking about vision screening, glasses or eye care or that they had these questions daily (nine responses). These results indicate that, although it is not uncommon for patients to come to migrant health centers asking about vision screening, glasses or eye care, more of these problems are identified by clinicians when patients are at the clinic for another reason.



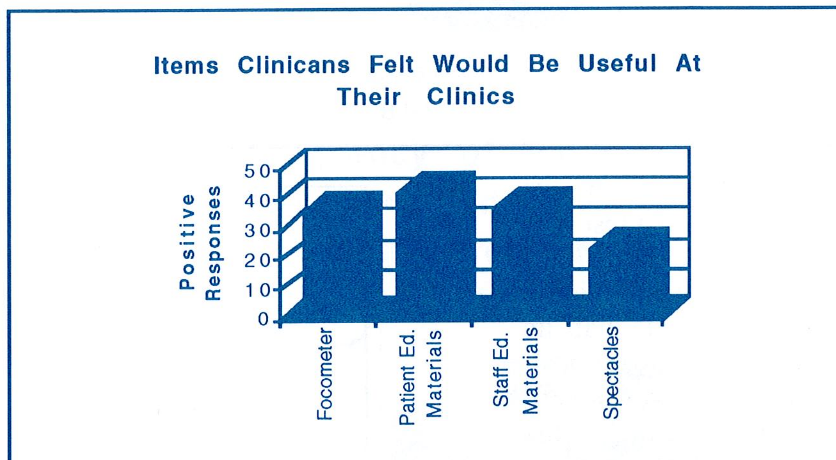
Almost all of the clinicians surveyed (46 responses of 53 surveyed) stated that their clinic policy was to refer patients needing vision screening or eyeglass prescriptions, or more involved eye care to other sources for care. Of these, three specifically stated that they used a voucher system with local optometrists or opthamologists, enabling them to offer a limited number of discounted visits and eyeglasses to their clients. Many stated that they would refer patients if they were able to pay a private provider, if they had insurance, or if a local provider took Medicare or Medicaid and



the patient received one of those aid sources. Some mentioned referring patients to the local Lions Club chapter for used eyeglasses. Other referral sources mentioned were other clinics, including health departments, university medical schools, and school nurses or clinics. One clinic tried to find used glasses on their own for patients. Another stated that they were simply unable to help clients with these needs. Three sites reported that they had an optometrist or opthamologist who held clinics at their sites on a regular but infrequent basis. These results indicate that most migrant health centers have virtually no way to help their clients who need extensive vision screening or eye care or glasses.

Clinicians' Interest in Providing Vision and Eye Care Services

The majority of clinicians interviewed stated that they thought their clinic would be interested in doing vision screening (50 responses of 53 surveyed). When asked which components of more extensive eye care services they felt would be useful at their clinics, the most popular addition was patient educational materials on eye care and vision screening (42 positive responses of 53 surveyed). Seventy-nine percent of the clinicians said that educational materials for patients on eye care and vision screening would be useful at their site. Of all of the items potentially available to the health centers, patient educational materials would require the least change from the typical standard services and routines at a clinic. Clinicians indicated that they "could always use" more patient educational materials. Four clinicians stated specifically that they especially needed educational materials in Spanish. Many of the interviewees answered this question nonchalantly, implying that they would not refuse extra resources that did not require a time commitment from them.



Slightly fewer clinicians interviewed (37 responses) stated that their sites would benefit from educational materials for clinic staff; though, here again, most stated that more educational materials for staff "could never hurt." Three of those interviewed who were especially interested in and excited by the idea of the Focometer™ linked staff educational materials to the instrument and replied that they would definitely need more education in order to put this technology to use. Two clinicians said that they were particularly interested in trainings that provided continuing education credits.

Interest was also relatively high for the Focometer™ (described as "a new technology in vision screening: an inexpensive, simple, hand-held diagnostic tool to use on- or off-site-" 36 responses), with 68 percent of clinicians resonding positively, slightly fewer than for educational materials. Two clinicians said that they were worried about added duties and stated that they would not be able to use such equipment without added staff, especially outreach staff.

Slightly more than half of the clinicians interviewed (23 positive responses) stated that "easy-to-fit and inexpensive eye glasses that you could assemble and sell on site" would be something that would be useful at their clinic site. Although it was not a surveyed item, at least 13 percent (at least 7 of the 53 clinicians interviewed) voiced concerns about the legality of staff other than medical doctors or specialists making an eyeglass prescription and distributing eye glasses without an MD's involvement. Others were concerned about the space such equipment would take up and the staff time it would require.

This question brought to light defining issues in the responsiveness of clinicians toward new technology and approaches to eye care and vision screening. As the items in the kit increased in required duties and strayed from the familiar role that clinics and clinicians currently played,

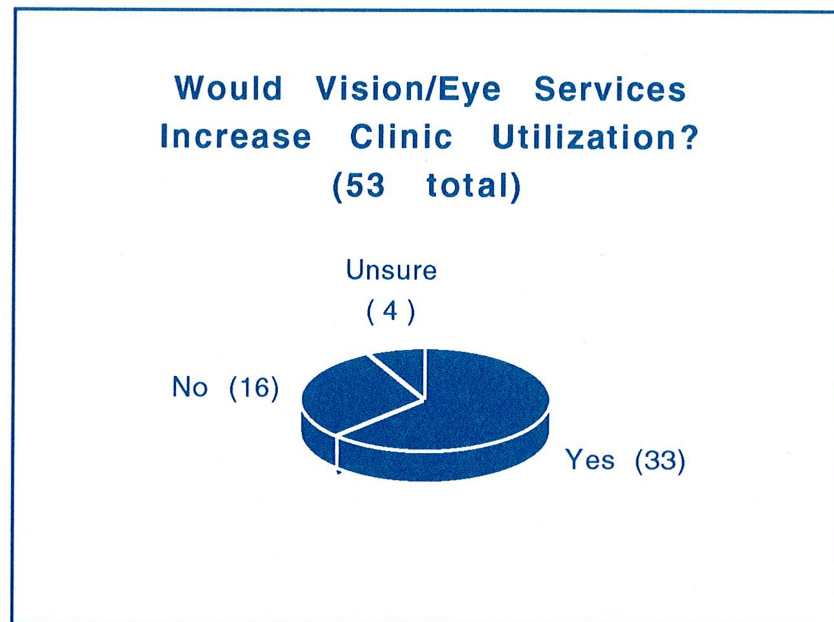
responses became more hesitant. As a general rule, those clinicians who were most pressed for time at the time of the interview were most concerned about the added staff time training and use of the eye care kits would entail. They felt their clinics were already too busy and understaffed to provide the range of services they currently offered.

A second trend was that those clinicians who seemed more in touch with their clientele were more interested in these new approaches and expanded services. Although this data was not systematically collected, it appeared that those clinicians who had done outreach work with migrant farmworkers, including mobile clinics or camp visits, and those who stated that they had several years of experience with migrant health were more likely to be very excited about the possibility of offering expanded and improved services. They were more likely to frame their responses in terms of meeting unmet needs than in how to change their current systems to accommodate another service.

Expanded Eye Care and Vision Screening Services as a Draw to Migrant Health Centers

The final question asked was whether offering vision screening services and low-cost eye glasses would cause more people to visit the clinic. Thirty three of the 53 respondents answered "yes" to this question; 16 said "no;" and four were unsure. Those who responded positively referred to the informal communication network among migrant farmworkers which would facilitate the spread of the information that eye glasses were available at the health center. They felt that once this information was known, those who previously were aware that they could not meet their vision needs at the health center would now come in. One woman stated that they would be able to see more people by taking this technology out and using it at camp visits.

Those who answered "no" were generally not disapproving of the idea of the eye care kits, but felt that their clientele already came to them for all of their health needs. As one nurse stated, "It may not cause more people to come in, but it would improve the services that we offer."



Problems With/ Limitations Of the Survey

In addition to the inherent limitations of phone surveys detailed above, other minor problems presented themselves as the assessment tool was implemented. As expected, one limitation was the amount of time clinicians felt they had to answer a phone survey. This problem turned out to be relatively minor, however, given the approximately 80 percent response rate that was attained. Most of the clinicians surveyed were interested and helpful.

Two potential confounding factors of the results of the question concerning how often patients come to the clinics specifically requesting vision and services and eye glasses were: (1) That clinicians may not be aware of how many requests for such services actually are made, since in many cases receptionists, medical assistants, or outreach workers may screen out these requests, letting clients know that those services are not available on site; and (2) that migrant farmworkers may not come to migrant health centers looking for vision screening and glasses because they are aware that these needs cannot be met at these clinics.

A problem in the survey itself was in the question, "Would

your clinic be interested in doing vision screening?" (question number four). This was slightly confusing and yielded uncertain results because most clinics felt that they already did offer some vision screening services in the form of basic eye charts. Another concern was clinicians feeling hesitant to speak for the entire clinic and especially administration. These fears were ultimately overcome by interviewers' assurance that this was simply a survey to assess interest and was in no way a commitment to accept training or equipment.

IV. Conclusions

Several important trends were identified in this needs assessment. ***The basic finding was that the majority of health care providers interviewed were interested in new technology that would improve the services offered at migrant health centers.*** Many clinicians, however, had reservations about legal issues and especially staff time needed to administer expanded services. This points to a few important conclusions for the Migrant Clinicians Network and the Puntos de Vista project:

(1) Education for migrant health clinicians about the Focometer™ and the eye care kits should initially focus on the issues of who can be trained to use the kits, how much training is required, and legal issues surrounding prescribing and issuing eye glasses. In addition, if primary eye care is to be institutionalized into all migrant health clinics, clinicians must also recognize the importance adding these elements to the basic services they provide. Education on the importance of primary eye care and how it fits into primary health care services will need to be made available for clinicians and clinic administrators.

(2) As the project continues, it will be important to target initially those clinics and specific clinicians who have a demonstrated commitment to improving services for and the lives of migrant farmworkers. Those who expressed this type of commitment were overwhelmingly approving of the project and excited about the possibility of obtaining the equipment for use at their sites. This kind of health care clearly did not fit the standard medical model of other clinicians, who were generally only completely approving of the idea of more patient educational materials. Because behavioral research clearly shows that written educational materials alone effect little or no change for most health conditions in most populations, it is this group of less enthusiastic clinicians for whom the education on the role of eye care and vision screening in primary health care will be particularly important. It should be noted, however, that most clinicians interviewed were interested and receptive. Those who approached the entire subject with skepticism were very few.

Of major importance is evidence gathered concerning how clinics currently deal with eye care and vision needs among their patients. That only six percent of the clinics called could offer any type of assistance (including vouchers or a visiting optometrist) to patients needing glasses is a clear statement of the need for a new approach to vision and eye care in migrant healthcare delivery. Patients were almost always referred to other providers according to their ability to pay and their insurance status. Knowledge of the socio-economic status of migrant farmworkers and the number of uninsured persons in all lower socio-economic groups in this country leads to the conclusion that most of the vision needs in this population are simply not being met, and lends support for projects like Puntos de Vista that try different approaches to meeting this need. If successful, one outcome of the Puntos de Vista project will be to train primary care/family physicians to treat on site a number of eye problems that it appears are currently being referred out to specialized care.

Finally, it appears from this survey that few migrant health centers are conducting large-scale screenings for eye and vision problems. Most problems are currently identified when patients are at the clinics for other reasons. The Puntos de Vista project could open the door for the opposite to occur: patients may be drawn to migrant health facilities for eye care and vision screenings and this may become a vehicle for identification of other health problems in this population.

Getting Started

If your health center is interested in starting or expanding a primary eye care program, you can start by:

1. Completing the Clinic Self Evaluation checklist below. This will give your staff a context within which to begin planning.

2. Calling Migrant Clinicians Network at (512)327-2017 for information, input, and technical assistance.

3. Requesting the *Primary Eye Care Manual* that MCN has prepared for health centers in the process of creating a primary eye care project. The charts on the following pages are excerpted from the manual. The *Primary Eye Care Services Grid* gives an overview of the potential components of a primary eye care program. The next chart gives a summary of Activities Needed to Implement Primary Eye Care Services. The Primary Eye Care Flow Chart presents a picture of the tasks an outreach worker might perform in a primary eye care program.

Clinic Self Evaluation for the Provision of Primary Eye Care Services

Service Categories	Services currently provided	Services that your clinic would like to implement
Vision Screening		
Outreach screening	____	____
Screening in clinic	____	____
Screening for disease/injury		
Outreach screening	____	____
Screening in clinic	____	____
Prevention education:		
Written materials provided	____	____
One-on-one in outreach setting	____	____
One-on-one in clinic setting	____	____
Group presentations	____	____
Treatment of disease/injury		
Outreach workers give basic treatment	____	____
General health practitioner provides in clinic	____	____
Ophthalmologist on staff	____	____
Prescriptions for visual correction		
Ophthalmologist on staff	____	____
Linkages with local Ophthalmologists for referral	____	____
Provision of glasses		
Glasses for sale by outreach team or clinic	____	____
Linkages available in local community for low cost glasses	____	____

Primary Eye Care Service Grid

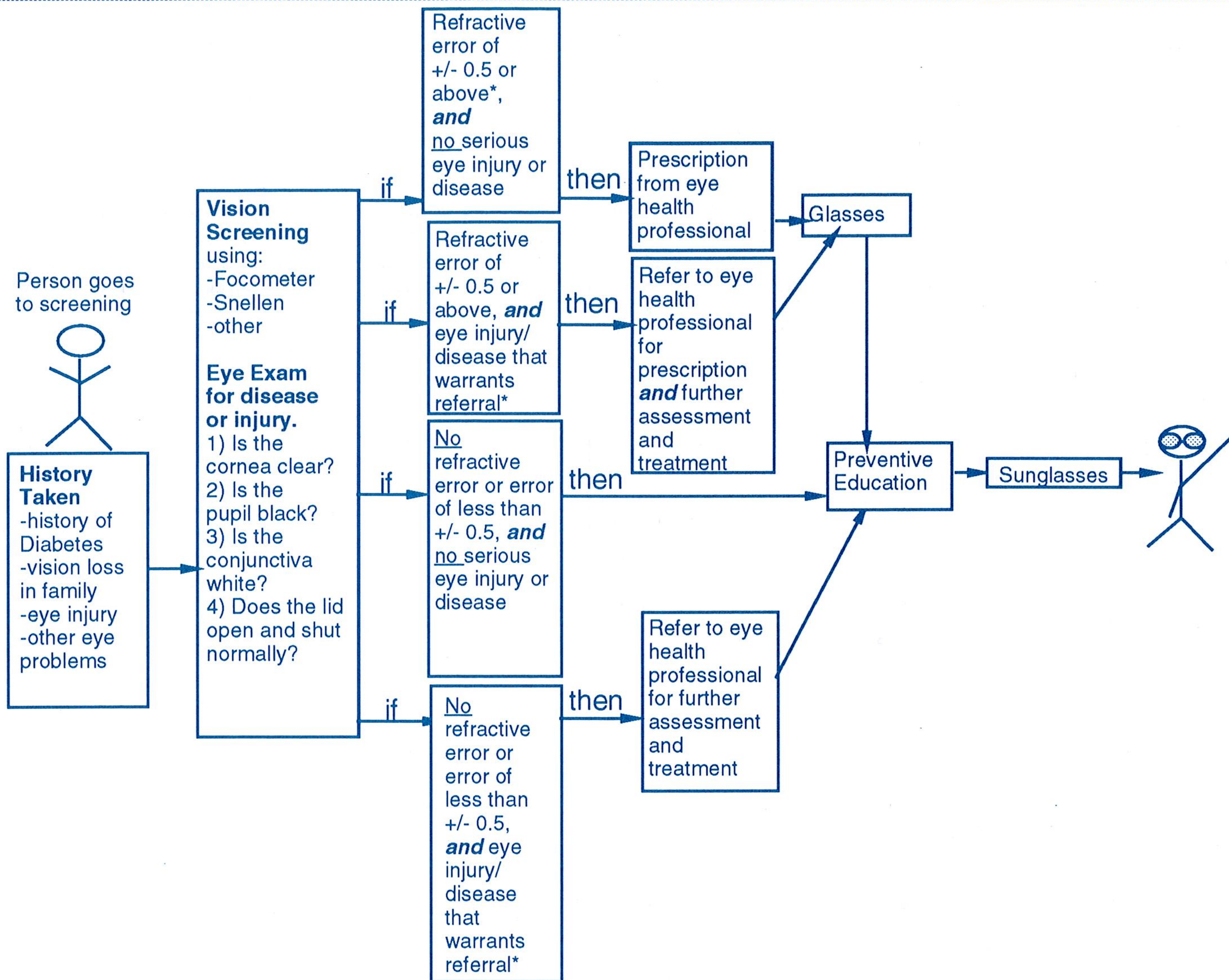
Service level	Screening		Education	Treatment of disease or injury	Prescriptions for visual correction	Provision of glasses
	Vision	Disease/Injury				
Outreach	Vision screening can be done in the outreach setting in a variety of ways: health fairs, one-on-one visits, or arranged group screenings. A variety of tools can be used for screening including the Snellen Chart and the Focometer.	Outreach workers can screen for a variety of eye problems. Any screening for eye problems should be based in the following four questions: 1. Is the cornea clear? 2. Is the pupil black? 3. Is the conjunctiva white? 4. Can the lid open and close normally?	Outreach workers have numerous occasions to provide effective preventive education messages. Education can occur in the following situations: one-on-one during screenings or in other situations; in a more formal group setting; or through educational materials left in the community. Education messages should stress injury prevention, UV protection, hygiene, and nutrition.	Outreach workers can dispense basic treatment for simple diseases or injuries provided that they are properly trained. Examples of the activities that outreach workers can do include: --Protection of an injured eye until the person can get to a clinic. --Removal of foreign bodies that are not embedded. --Cleaning of an infected eye.	Outreach workers can determine that a person has a refractive error using the Focometer.™ Once it has been determined that a person has a refractive error, a prescription must be obtained from an eye health professional. In some cases, eye health professionals can be made a part of the outreach team for selected screening times.	Once a prescription has been obtained, then outreach workers can dispense glasses. Outreach teams have the opportunity to sell low-cost glasses made specifically for the individual's prescription. The money from the sale of glasses can be put back into the project for other services.
Clinic	Vision screening can be done when people come in for eye or other problems. This is most commonly done for children during routine examinations.	Screening for eye disease or injury can be done when people come in for eye or other problems. Screening for disease or injury can also detect other systemic diseases such as diabetes.	Education can occur in clinics through educational materials either given to the patient or displayed in the clinic as well as during one-on-one discussions during the course of patient evaluations.	General health practitioners can treat some eye diseases including eye infections, dry eye, and some injuries. Some clinics may have an ophthalmologist on staff.	While MDs can legally prescribe glasses, it is generally recommended that prescriptions be obtained from eye health professionals. Some clinics may have an eye health professional on staff.	Clinics can dispense glasses once a prescription has been obtained. Clinics have the opportunity to sell low-cost glasses made specifically for the individual's prescription. The money from the sale of glasses can be put back into the project for other services.
Referral	Screening is generally not done on a referral basis. However, if an individual complains of a specific problem, he/she may be referred for further screening.	Screening is generally not done on a referral basis. However, if an individual complains of a specific problem, he/she may be referred for further screening.	Clients may be referred to other social service activities such as health fairs or migrant education events for further education on eye health.	Serious cases should be referred to an ophthalmologist if one is not available on staff.	Linkages should be made with local eye health professionals to obtain prescriptions if needed.	If a clinic or outreach staff does not want to provide glasses, referrals need to be made to local optometrists.

Activities Needed to Implement Primary Eye Care Services

These activities are only relevant if the clinic does not currently offer the service. Activities are listed in order of implementation and level of services. For instance, to provide treatment, some clinics may not want to hire a eye health professional, therefore step 5 should be ignored.

	Screening		Education	Treatment of Disease or Injury	Prescriptions for Visual Correction	Provision of Glasses
	Vision	Disease/ Injuries				
What the Health Center needs to do to implement activity	1. Obtain vision screening tools. 2. Train staff (outreach and/or clinical staff) to do effective vision screening. 3. Establish screening protocol 4. If done in an outreach setting, then the Health Center needs to arrange a time for outreach workers to conduct screening. 5. The clinic needs to create mechanisms that make it easier to bring in referral cases.	1. Train staff (outreach and/or clinical staff) to do effective vision screening. 2. If done in an outreach setting, then the Health Center needs to arrange a time for outreach workers to conduct screening. 3. Establish screening protocol	1. Obtain eye care health education materials. 2. Train (if not already proficient) outreach and/or clinic staff to be able to convey eye care prevention messages. 3. Establish protocol for when and how to provide health education.	1. Obtain treatment supplies (i.e. antibiotic ointment). 2. Train outreach staff to treat basic eye problems. 3. Ensure that general health practitioners are proficient in eye care. 4. If the clinic does not have an eye health professional, linkages should be made with local ophthalmologists to provide care for severe cases. 5. If a high level of service is feasible, then the clinic can look into hiring an eye care professional.	There are three possibilities to obtain prescription services: A. Linkages can be made for referral to local ophthalmologists. B. Local ophthalmologists can be part of the outreach team. C. An ophthalmologist can be hired by the health center	There are two possibilities for the provision of prescription glasses. A. Health centers can purchase easy-to-assemble glasses from a company such as Morrison International and then either sell the glasses or provide them free-of-charge depending on the budget. B. Linkages can be made with local optometrists to provide low cost glasses.
What MCN can provide the health center for assistance	1. Assist with supply linkages for vision screening tools and when a clinic is an MCN demonstration site, provide the tools free of charge. 2. Train clinic and outreach staff on basic screening tools as well as how to establish an outreach program. 3. Provide sample screening protocol.	1. Provide training to clinic and outreach staff on how to recognize, treat, and prevent basic eye diseases/injuries. 2. Provide sample protocols.	1. Supply health education materials. 2. Train staff on health education techniques for eye care. 3. Provide sample protocol.	1. Assist with supply linkages. 2. Train outreach staff on how to treat basic eye problems. 3. Supply general practitioners with additional eye health information.		1. Assist with supply linkages. 2. If a health center is an MCN demonstration site, MCN will provide an initial supply of glasses for sale in addition to a supply of free sunglasses for use as an incentive.

PRIMARY EYE CARE SCREENING FLOW CHART



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