June 18, 2015 - RSAC Unit Priorities

Africa is a priority over Iraq for large, permanent https://rinj.org/RSAC units. We are still evaluating the make or buy decision and have some good options in Canada. We have a supplier in Washington state with considerable experience and know-how. Turn-around time is very quick as we know exactly what we need.

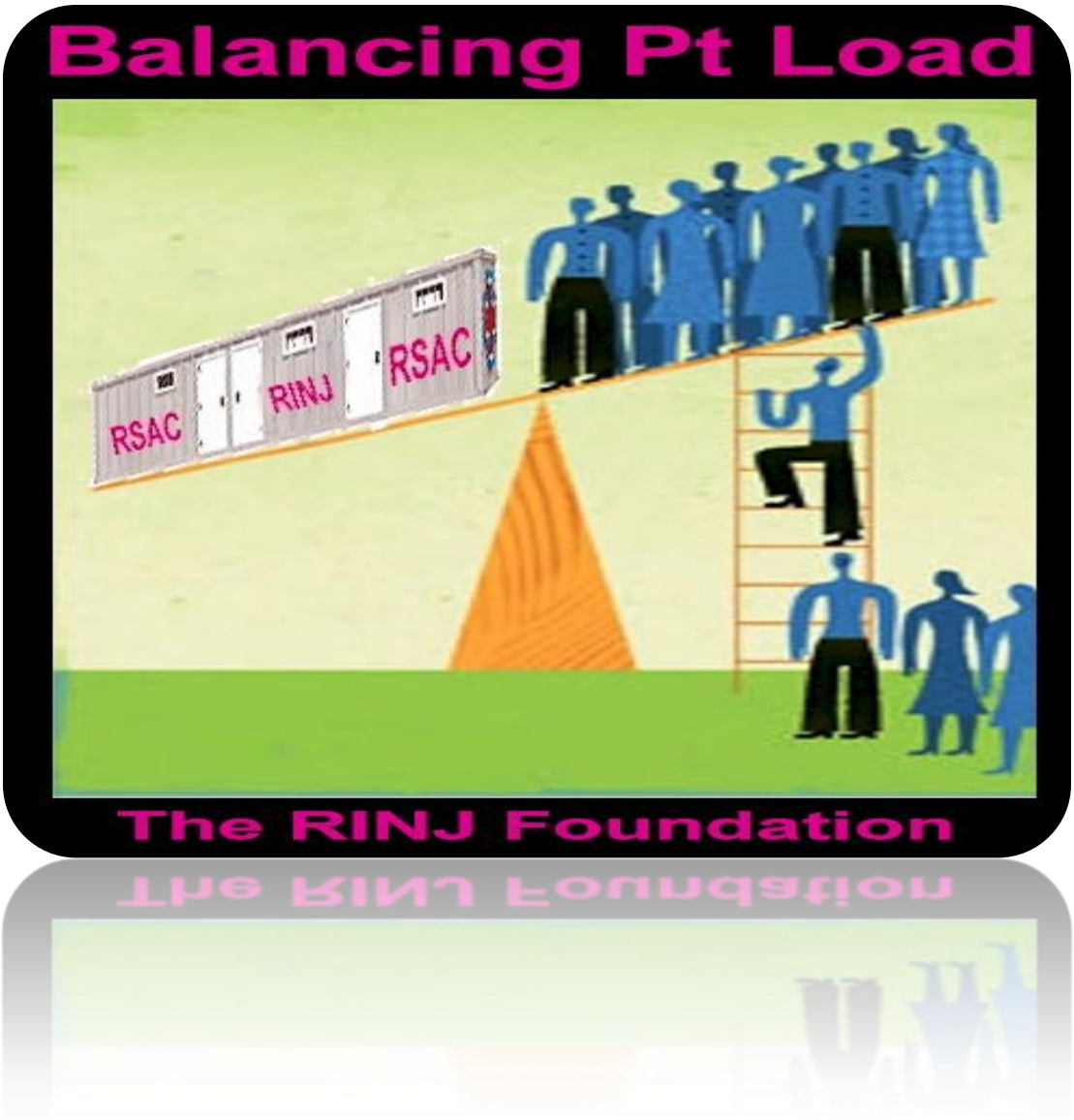
The type of units we build for Africa will also be sent to Kurdistan once the small mobile 20ft units have established patient loads. The problem with Kurdistan is that it currently is so fluid and unstable. It's potentially explosive. We are talking to the Canadians with the CAF advisory team near Erbil. They say the same thing.

So Dohuk, Iraq yes, if it stays in the hands of the Kurds otherwise further southeast and to the northwest. I hope to be sending one or two mobile 20ft. RSAC units to travel between camps on a 5-day rotation in the last quarter of this year. I want to continue downsizing in Mosul and get some staff out. That is sensitive. I don't want to send only fresh people in but we have some new recruits from the University at Kirkuk and the one at Erbil so it may all balance out perfectly, as usual.

I hope we can cover three nearby camps (or two ends of a large camp and a third camp) for 4 months and make a decision based on the data that we accumulate doing scheduled repeat-outpatient-visit services ranging from obstetrics, to STD treatment, to mental health etc.

International research provides clear evidence of the correlation of reliable access to effective practices with better population health outcomes. While it is not always possible for a patient to see her own nurse or her other medical team members, efforts are made to ensure that continuity of care remain central to access planning and quality which is why I favour a small leave-behind presence (Two-Staff, Land Rover and Tent) when the Mobile RSAC moves onward in rotation.

Establishing wait time targets in basic RSAC care is exceedingly difficult. Therefore, in lieu of setting access targets, we focus on enhancing access, specifically through same-day scheduling for things like pharmacological dispensing, blood tests, inoculations etceteras all done the same day as the face-to-face.



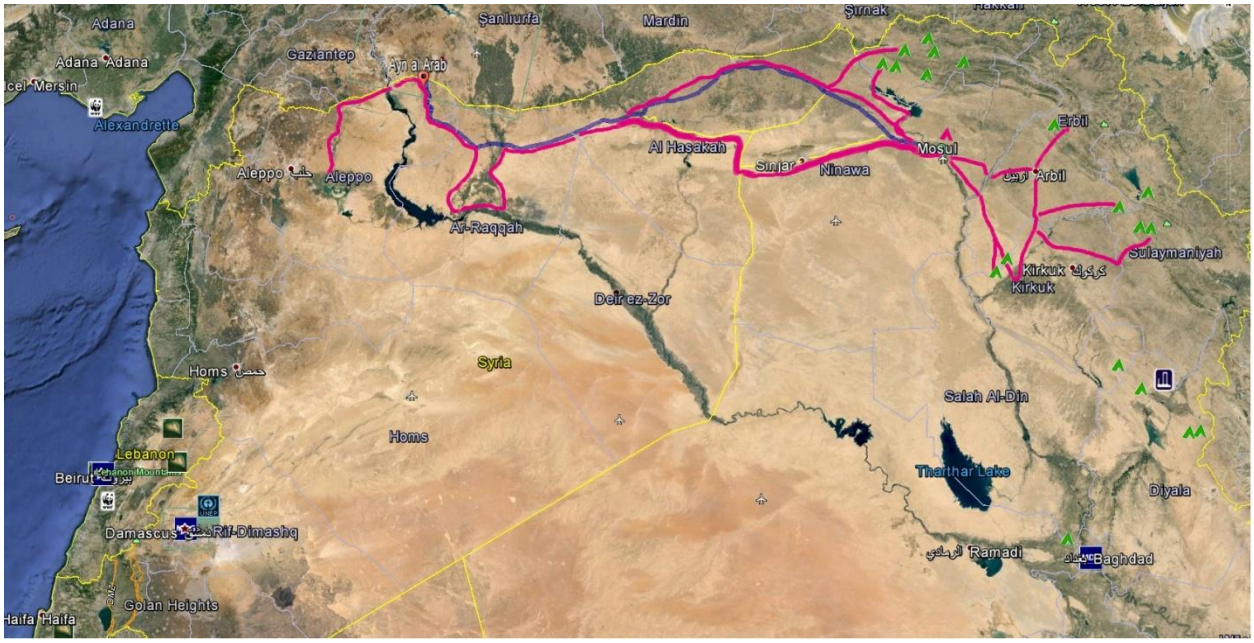
Demographics of the population such as age, gender, language spoken, culture, socioeconomic status, and medical complexity determine the number of patient visits within a time line. We tend to favour the Murray and Tantau model which leaves 65 per cent of the day's bookings open for walk-ins or deferrals and 35 per cent booked. It works like this: The 35 per cent are for patients who 'couldn't make it in on Friday and chose Saturday instead' or 'patients whom the intake deliberately scheduled today for follow-up'. Direct visits, after-hour appointments, and Smartphone communication or other digital follow up can take up shortfalls. The goal is to see all patients scheduled and unscheduled, avoiding as much as possible, long wait times. That's the basic model.

We have a performance model for this work and need to see a certain number of patients per month to justify the location. Most return pt visits are weekly. So you see a 20ft Mobile RSAC unit supported by a two-staff, a land-rover and a tent to do follow ups when the Mobile RSAC unit moves to the next camp could well be the precursor to

dropping a 40ft RSAC unit if the patient load calls for that. (The 40ft units have triple the staff and can handle four times the number of pts as a 20ft RSAC Unit.)

Every five days we make a move--the 20ft Units are good for this. The follow ups are pt progress and treatment monitoring. Procedures are only done in the Mobile Units. We really do want to stick to our mission and don't want to get into a bog where we are locked down doing general practice work only. We in this manner focus on finding and regularly seeing as many sexual violence pts as we can. We prevent suicides, quash the spread of dangerous STDs, and collect sexual-violence testimonial and forensic evidence related to law enforcement; and everyone is better served by that focus.

See our map attached we compiled since 2012. The upside-down-Vs indicate refugee camps. The coloured tracks are old routes, some from back to the end of 2011 before everything moved into Turkey.



You can see where we have been operating from tents and Land Rovers. The objective then was to collect cases and identification of perpetrators as well as caring for patients.

We will always stay quite mobile in Iraq with the small unit and make assessments as we go. Where we have a patient load building past our limits we will drop a 40ft Mobile Clinic and move the 20ft to open up new territory and patients.

We may end up in Turkey which is where the majority of Syrian refugees are headed. We will need to make some adjustments as time passes and we learn more about the movement of displaced persons. We'll try to follow the patients. That will take us to camps and urban ghettos.

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