RINJ RSAC Mobile and Fixed Clinics for Kurdistan (Iraq), Rojava & Various African Nations

https://rinj.org/Volunteer/ Do it.

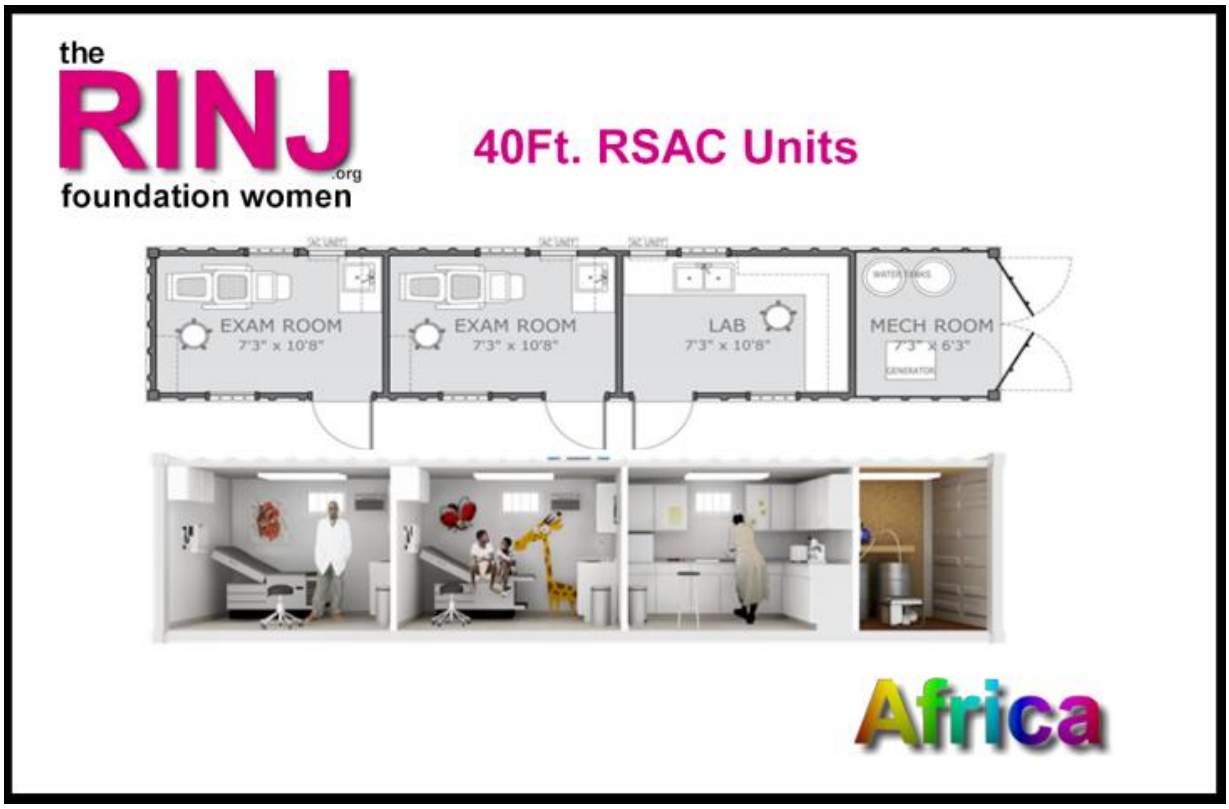
Note: Nurse (RNs, RPNs, NPs, MDs) Volunteer positions are available still in Rojava and some nations in Africa. https://rinj.org/Volunteer/

RINJ RSAC MOBILE CLINICS The 20 foot RSAC units have a 55 gallon water tank and pump system. This allows for one week of water supply at normal usage. The split a/c is D/C inverted and very efficient. All equipment and lighting is universal power with universal outlets. Solar equipment/system can be programmed for 110 volt – 220 volt 50/60 hz.

There are six solar panels that can be permanently mounted on the roof which can produce 1500 watts of electricity. There are eight sealed lead-acid solar batteries which is the primary source of stored power. The whole clinic's average power consumption with all equipment on (including a/c unit) is 500 watts. Even on a rainy/cloudy day our supply verses demand of power is usually 4:1 ratio.

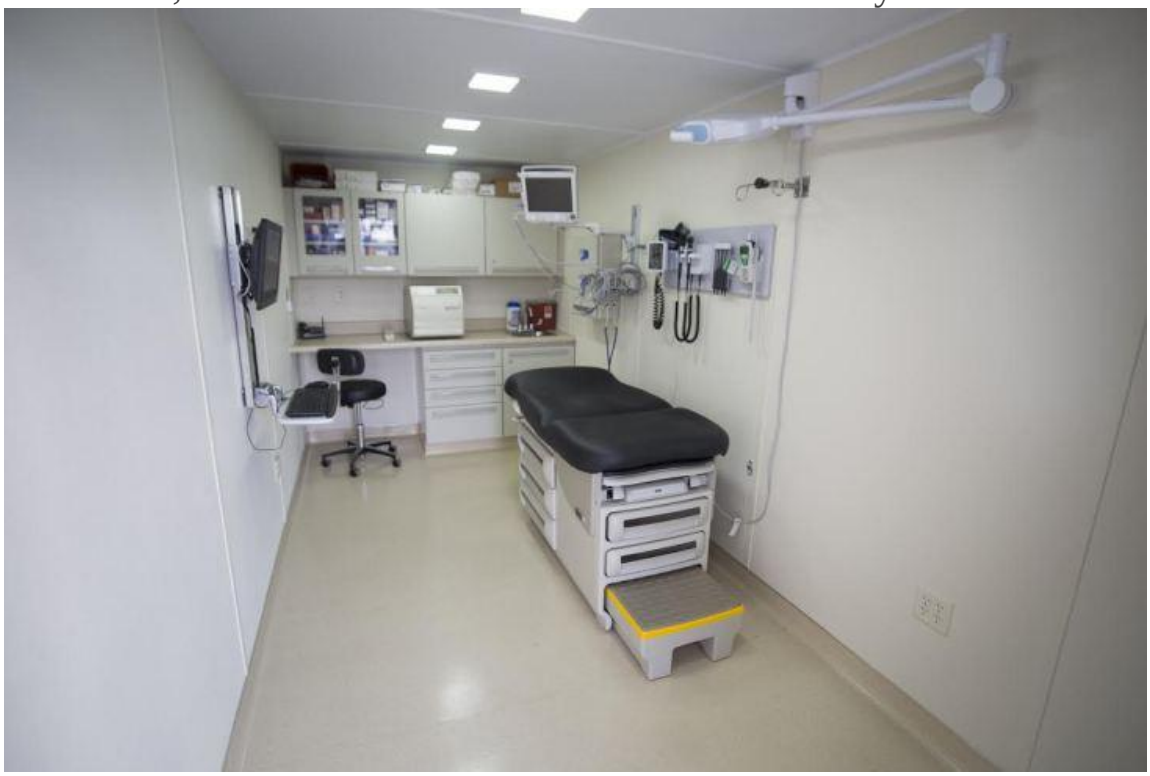
Every surface can be disinfected. We use Parkland Plastic Non-frp on the ceilings and the walls. The flooring is Armstrong seamless vinyl and is coved

up the walls 3 inches. There is four inches of 1/2 lb icynene expandable foam insulation in the walls and ceilings which in effect gives you a R16 value. Electrical is to international code. Walls are steel studded and Everything is level 1 commercial product. Meaning we have designed our units to be very durable to withstand the most austere environments.



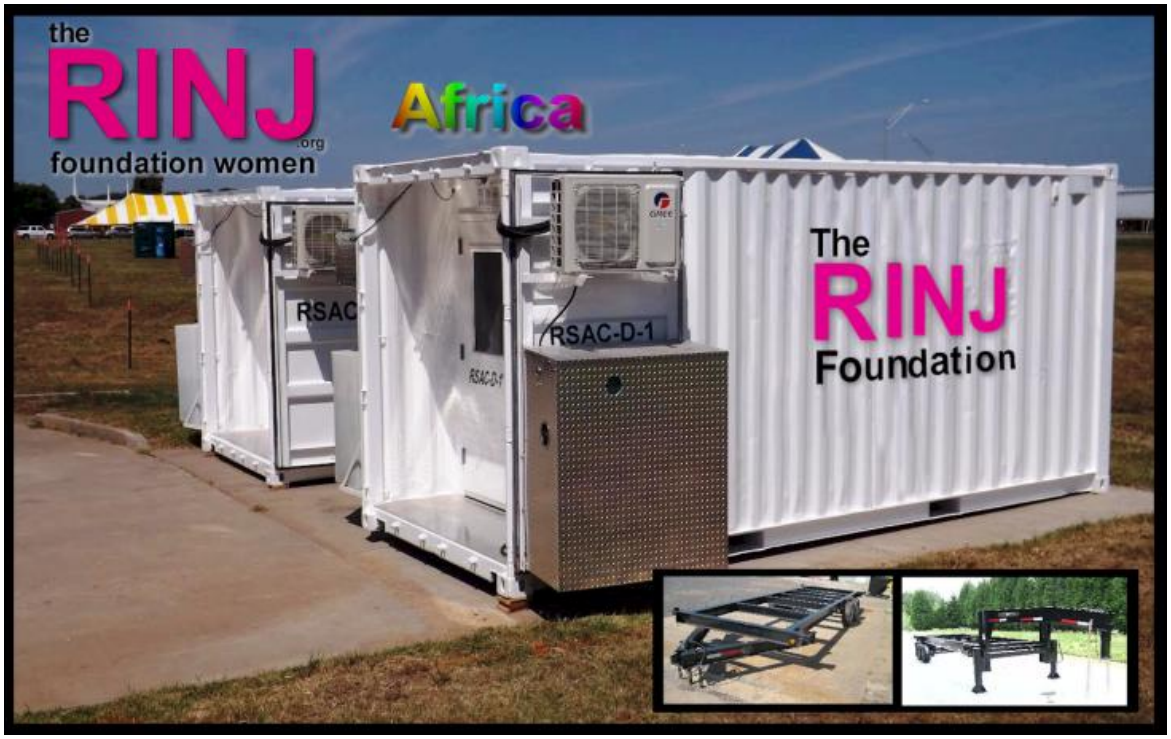
International research provides clear evidence of the correlation of reliable access to effective practices with better population health outcomes. While it is not always possible for a patient to see her own nurse or her other medical team members, efforts are made to ensure continuity of care remains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

Establishing wait time targets in basic RSAC care is 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 but they can't move.)

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, not in tents.