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MEDICAL SUPPORT MANUAL FOR UNITED NATIONS PEACEKEEPING OPERATIONS

UNITED NATIONS
DEPARTMENT OF
PEACEKEEPING
OPERATIONS

MEDICAL SUPPORT MANUAL FOR UNITED NATIONS PEACEKEEPING OPERATIONS

2nd Edition

Medical Support Manual for United Nations Peacekeeping Operations (2nd Edition)

The manual is distributed by the Department of Peace-keeping Operations/ Office of Planning & Support/ Medical Support Unit, New York, 1999. The first edition was issued in 1995 and has since been revised.

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General

There has always been a requirement for a standard reference document on the medical support aspects of United Nations peacekeeping operations. To meet this requirement, the Medical Support Manual for United Nations Field Operations was published and distributed in 1995. This aimed to outline operational and procedural guidelines for medical support in the field. With new developments and changes, as well as input from Field Missions and other agencies, this manual has been updated and incorporates lessons learnt from recent peacekeeping operations.

Structure of the manual

This manual comprises a set of chapters, annexes and appendices, with a table of contents and an index providing references to relevant sections of the text. It serves as a comprehensive reference text for the medical officer in the field, as well as a guide for medical planners in the United Nations Headquarters, Field Missions or national militaries from troop-contributing countries. It is also a useful reference source for the training of United Nations peacekeepers and medical personnel.

Relationship to other official documents

The contents of this manual are compatible with the financial rules and regulations of the United Nations, administrative issuance, official UN guidelines and other documents relevant to the administration of United Nations field operations.

Distribution and up-keep

The Chief, Medical Support Unit, Department of Peacekeeping Operations (MSU/ DPKO), controls the distribution of this Manual. In consultation with the Medical Services Division (MSD), he is responsible for the regular review of its contents and for revision of its text where required. The manual will be updated and distributed every 3 years. Any comments by its users is appreciated.

Acknowledgements

The authors would like to thank the Medical Services Division, UN HQ, for its assistance in reviewing the manual, to Field Missions and national agencies for their invaluable input, and to the Training Unit, DPKO, for its assistance in publication matters.

This manual is dedicated to the gratis military medical officers
who have formed the backbone of the Medical Support Unit since its inception
and without whom its publication would not have been possible.

Page

Chapter

1

INTRODUCTION

1.01 United Nations Medical Support Mission for Peacekeeping Operations

The mission statement reads:

> "The United Nations' medical support mission is to secure the health and well-being of members of United Nations peacekeeping operations through planning, co-ordination, execution, monitoring and professional supervision of excellent medical care in the field."

1.02 United Nations Medical Support Precepts

United Nations (UN) medical support will comply with the following precepts:

A. International Convention for the Treatment of the Sick and Wounded. Medical support for UN operations will comply with the Geneva Convention and its Protocols, as well as the Laws of War as they pertain to medical units and their personnel.

B. Entitlement to Medical Care. All persons entitled under the terms of the Geneva Conventions shall, without discrimination, receive medical treatment on the basis of their clinical needs and the availability of medical resources.

C. Standards of Medical Support. Medical support to UN personnel must meet standards that are acceptable to all participating nations. The aim must be to provide a standard of medical care comparable to prevailing peacetime medical care.

D. Timely and Responsive Medical Support. Medical support to a UN peacekeeping force must maintain a high state of readiness and availability, providing timely, responsive and continuous care to any patient or casualty within the medical system.

1.03 UN peacekeeping operations are characterised by unique features that impact fundamentally on the provision of medical support.

These include:

A. Political complexity and dynamic nature of peacekeeping operations.

B. Geographic, demographic, cultural and linguistic variations within Mission areas.

C. Specific prevailing epidemiological and disease patterns.

D. Multi-national participation in peacekeeping operations, with varying national standards of training, operational procedures, equipment and supplies.

1.04 Medical support plans

Medical support plans must therefore be designed for each mission to meet specific operational demands. These must remain flexible to adapt to changing demands and circumstances. These plans must be acceptable to the respective Mission Headquarters and the participating Troop Contributing Countries (TCCs), and is to be approved by the Department of Peacekeeping Operations, United Nations HQ.

1.05 Medical Support Manual for UN Peacekeeping Operations

This manual has been jointly produced by the Medical Support Unit and the Medical Services Division. It incorporates comments from Field Missions, Troop-Contributing Countries and from experiences gleaned from past and ongoing peacekeeping missions. It aims to provide:

A. A basis for UN medical operational doctrine, organisational framework and procedures.

B. A comprehensive reference guide for planning, co-ordinating and executing medical support for UN peacekeeping operations.

C. A tool for training peacekeepers and medical personnel on medical aspects of UN peacekeeping operations.

Chapter

2

THE UN HEADQUARTERS MEDICAL ORGANIZATION

2.01 Introduction

There are two bodies that are directly involved with medial care for UN personnel in peacekeeping operations. These are the Medical Services Division (MSD) which develops and promulgates medical support and health care policies for UN peacekeeping missions, and the Medical Support Unit (MSU), Department of Peacekeeping Operations (DPKO), which is the executive arm of the UN for planning, co-ordinating and monitoring medical support in the field. There is a close and mutual professional working relationship between the two, each with clearly defined terms of reference.

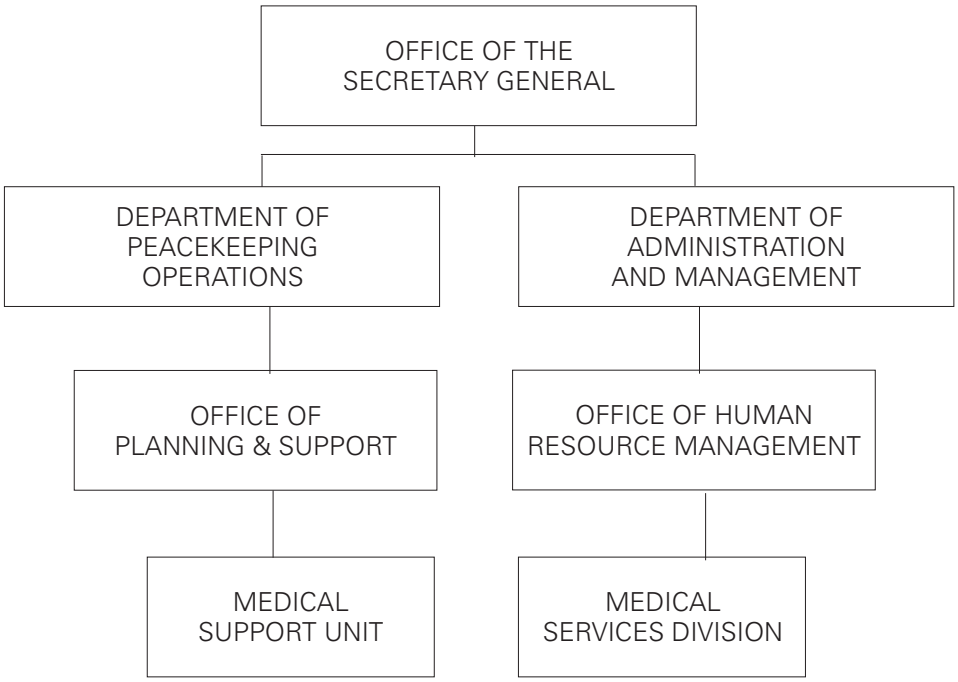


Figure 2-1. Relationship between MSD and MSU

2.02 The Medical Support Unit (MSU)

A. The MSU is a unit within the Field Administration and Logistics Division (FALD) of the Office of Planning and Support (OPS), Department of Peacekeeping Operations. Its terms of reference are:

1. To advise DPKO, the Military Adviser's Office and field missions on all medical operational matters.
2. To develop and document operational medical policies, doctrine and guidelines.

3. To plan and co-ordinate medical support for new, ongoing and liquidating missions between DPKO, the Mission HQ and troop-contributing countries.
4. To oversee maintenance of medical support for field missions, including budgeting, contracts, medical equipment, supplies, services and reimbursement to troop-contributing countries.
5. To ensure compliance of UN medical units, personnel, supplies and equipment to internationally accepted standards.
6. To develop medical training policies, standards and programs for UN peacekeepers and medical personnel, and participate actively in their training.
7. To collect, collate, analyse and disseminate medical data and intelligence on Mission areas.
8. To assess and update military medical units under the UN Standby Arrangements System.

2.03 The Medical Services Division (MSD)

A. The MSD is organized into 3 clusters, which are the UN Cluster, Peacekeeping Cluster and UNDP/ UNFPA/ UNICEF Cluster. Its functions may be grouped into the following areas:
   1. Service to the entire UN system.
   2. Service to New York based UN staff of the Secretariat and its agencies.
   3. Service to the administrative organs of the UN common system (UNDP, UNFPA and UNICEF).
   4. Service vis-à-vis peacekeeping operations.

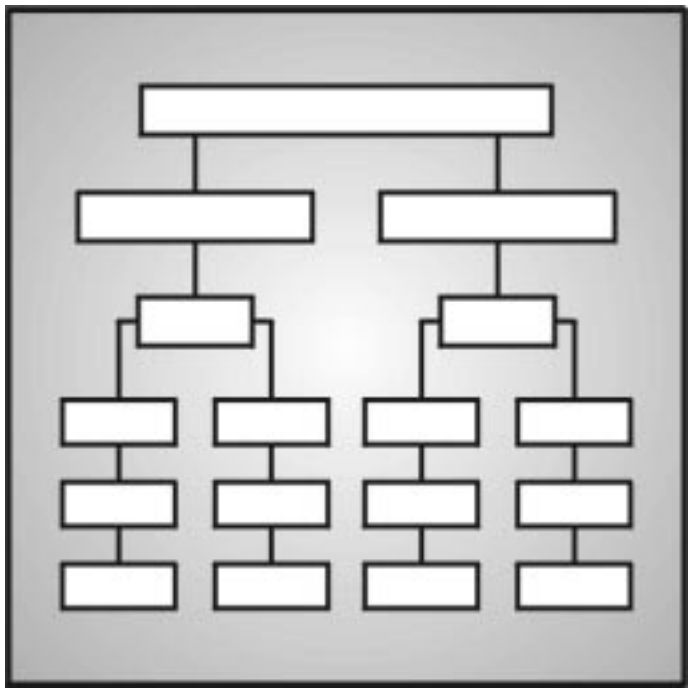
B. Its functions vis-à-vis peacekeeping operations are:
   1. To develop and update UN medical policies for use by DPKO, Chief Administrative Officers (CAO) and medical officers in the Missions.
   2. To establish and continuously review medical standards for personnel being assigned to peacekeeping and other missions.

3. To make on-site assessment of host nation and regional medical facilities.
4. To provide medical briefings at UN HQ to visiting Force Medical Officers (FMedO), Force Commanders (FC) and Contingent Commanders from troop-contributing countries.
5. To advise on immunizations and disease prophylaxis.
6. To determine medical fitness of UN staff members, Military Observers and Civilian Police selected for mission assignment.
7. To advise on and assist with medical evacuation and repatriation of UN staff, Military Observers, Civilian Police, UN troops and local-contracted staff members.
8. To verify medical bills and advise on compensation claims submitted by or on behalf of UN staff members or peacekeepers, whenever the Organization is liable for treatment provided.
9. To certify sick leave for UN staff, Military Observers and Civilian Police.
10. To review and verify the extent of service-incurred disability for UN peacekeepers and advise the UN Joint Staff Pension Fund on queries concerning disability benefit.

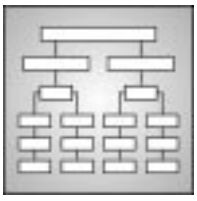
Chapter

3

STRUCTURE OF MEDICAL SUPPORT IN PEACEKEEPING OPERATIONS



3.01 Structure and Organization



There is a clear command structure within a peacekeeping force, with the most senior medical officer in the Mission, the Force Medical Officer (FMedO), subordinated directly to the Force Commander (FC) or the designated Head of Mission. The FMedO acts on behalf of the Force Commander on all medical matters and controls all UN field medical units providing Force-wide coverage. He also exercises professional supervision over organic medical units attached to their national contingents, which remain under the command of their respective Unit Commanders. Similarly, he seeks professional supervision from the MSD and MSU at UN HQ on policy and operational matters respectively. These agencies work closely to ensure effective medical support for the Mission.

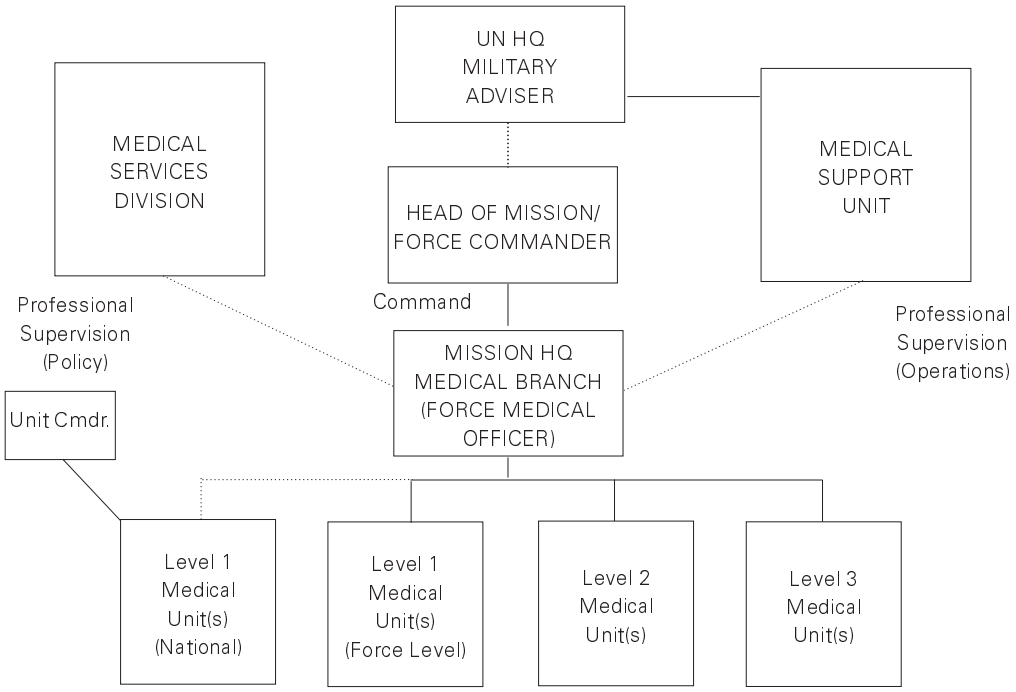
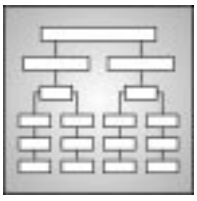


Figure 3-1. UN Medical Support Organization.

3.02 Terms of Reference of Key Medical Personnel

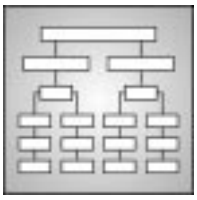


A. Director, Medical Services Division (vis-á-vis peacekeeping operations).

1. Reviews and promulgates medical policies concerning peacekeeping.
2. Establishes UN Medical Technical Standards for mission personnel, including immunisation and disease prophylaxis requirements.
3. Provides medical clearance for mission assignment for UN staff members, Military Observers and Civilian Police Monitors.
4. Provides technical advice on local medical facilities with a mission area.
5. Oversees administration of UN clinics and dispensaries established in mission areas, as well as international and local-contracted UN medical personnel.
6. Provides medical briefings at UN HQ for designated FMedOs, FCs and national Contingent Commanders from troop-contributing countries.
7. Advises on compensation claims in the capacity as Medical Adviser to the Advisory Board on Compensation Claims for service-related injury, illness or death.
8. Reviews and updates guidelines and publications on health-related aspects of UN peacekeeping operations.

B. Chief, Medical Support Unit (DPKO).

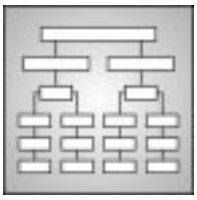
1. Advises on medical operational matters and medical planning for new, ongoing and liquidating UN field missions.
2. Reviews UN Medical Support policies and procedures together with the Medical Services Division.
3. Surveys new mission areas and host country medical facilities; collects epidemiological data from local and other health authorities; and provides medical operational advice for potential peacekeeping missions.
4. Approves the Medical Support Plan for UN peacekeeping missions, and co-ordinates with other organs of DPKO and troop-contributing countries in executing this plan.



5. Monitors and audits medical support provided to peacekeeping missions, through routine returns and reports, as well as the conduct of technical surveys and visits to the Mission areas.
6. Validates all medical operational and administrative issues, including budgets, contracts, requests and medical logistics support for peacekeeping missions.
7. Briefs designated FMedOs, FCs and Contingent Commanders from troop contributing countries on medical operational issues.
8. Ensures standards of contingent-owned medical equipment and supplies from troop-contributing countries, and advises on reimbursement to these countries.
9. Collects and analyses medical data from peacekeeping missions, and oversees their recording and updating in the DPKO Peacekeeping Database.
10. Reviews and updates manuals, guidelines and procedures related to medical support for peacekeeping operations.
11. Oversees the medical aspects of training UN peacekeepers and medical personnel, including setting training standards and requirements, teaching materials and the conduct of courses and conferences.

C. Force Medical Officer (FMedO).

1. Plans, directs, advises and supervises all activities related to the Mission's medical support plan.
2. Senior medical adviser to the Force Commander (FC), and supervises all contingent medical officers in the Mission.
3. Exercises functional control of all medical assets provided for the Mission.
4. Conducts initial and regular medical assessments and surveys.
5. Gathers and distributes information on the general medical situation and health risks within the operational area.
6. Assesses and advises on the suitability of the host country's medical facilities for use by UN personnel, and

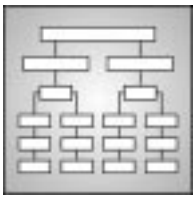


liases on the establishment of contracts with these facilities.

7. Monitors utilization and consumption of medical supplies and consumables, co-ordinates procurement actions with the Mission's logistics staff, and certifies requisition of medical equipment and supplies.
8. Provides guidance and oversees implementation of preventive health measures, disease prophylaxis and field hygiene, including food and water inspections, sanitation and waste disposal.
9. Prepares medical Standard Operational Procedures (SOPs) for the Mission and responsible for briefing and disseminating this to all medical personnel.
10. Sets treatment and evacuation policies within the Mission, and advises on treatment for non-UN Force personnel, civilians and humanitarian actions.
11. Oversees and ensures standards of medical facilities and treatment provided.
12. Co-ordinates medical matters with other UN bodies, Governmental and Non-Governmental-Organisations (NGOs) and local health authorities, within the Mission area.
13. Oversees collection and reporting of epidemiological and casualty data as required by UN HQ.
14. Notifies relevant agencies of incidents involving severely ill or wounded cases and deaths, and follows up on their condition, treatment, evacuation and repatriation.

D. Senior Medical Officer (SMedO).

1. Senior medical officer of his/ her national contingent and the senior medical adviser to the national Contingent Commander, as well as the FMedO's point of contact on medical matters.
2. Implements the Medical Support Plan for the Mission in accordance with UN medical policies and the FMedO=s directions.
3. Oversees health-care, hygiene and implementation of preventive medicine measures in contingent's area of operations.



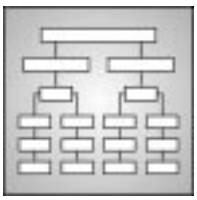
4. Co-ordinates casualty evacuation and mass disaster response within his area of responsibility.
5. Maintains standards of medical treatment provided by medical units under his control.
6. Ensures medical resupply to his national contingent, medical units and team sites within his area of responsibility.
7. Oversees training and education of contingent personnel and medical personnel.
8. Prepares reports required by the UN HQ and the FMedO and ensures their timely submission.

E. Medical Unit Commander.

1. Responsible for his/ her medical unit's efficient and effective operation in accordance to the Mandate given.
2. Implements the Medical Support Plan for the Mission as directed by the FMedO and/ or SMedO.
3. Oversees health-care, hygiene and implementation of preventive medicine measures within the unit's area of responsibility.
4. Co-ordinates casualty evacuation within his area of responsibility.
5. Maintains standards of medical treatment provided by his medical unit.
6. Ensures medical resupply to his medical unit and team sites within his area of responsibility.
7. Oversees training and education of all personnel in his unit.
8. Prepares reports required by the FMedO and SMedO and ensures their timely submission.
9. Oversees welfare and discipline of his staff.

3.03 Briefing and Debriefing of Mission Personnel

A. Briefing and debriefing of FMedOs will be conducted at the outset of new missions and, if possible, after the draw-down or liquidation of existing missions. These will be conducted by the Director of MSD and the Chief of MSU at UN HQ in New York.



B. At the initial briefing, the FMedO will be provided with materials including the Medical Support Manual, epidemiological surveys and reports, instructional materials (e.g. stress management, AIDS prevention), as well as instructed on the requirements for casualty reports and routine returns.

C. At the termination of his tour of duty, a final report will be prepared and submitted to the MSU and MSD by the outgoing FMedO. If this can be arranged, a debriefing session will be held at the MSU. The report will be distributed to all parties concerned, attached with the Unit's comments.

3.04 UN Levels of Medical Support

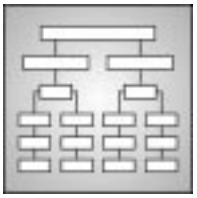
Levels of medical support for UN peacekeeping missions have been standardized. This is necessary to ensure that the highest standards of medical care is provided to peacekeepers, particularly as medical units and personnel can come from different countries with varying standards of medical care. These levels are as follows:

A. Basic Level.

This effectively refers to basic First Aid and preventive medicine practised at the smallest sub-unit level. As there is no doctor present, care is provided by the peacekeeper, or by a trained paramedic or nurse, using basic medical equipment and supplies. A summary of the training and equipping requirements can be found below, with further details regarding equipment provided in *Appendix 2-1.*

TREATMENT CAPABILITY	TREATMENT CAPACITY	EQUIPMENT REQUIREMENT	REMARKS
- First Aid by non-medical personnel or paramedic - Core skills: 1. Cardiopulmonary resuscitation 2. Haemorrhage control 3. Fracture immobilisation 4. Wound dressing (including burns) 5. Casualty transport and evacuation 6. Communications and reporting		- First Aid Kit - Personal field dressing - Pocket mask (optional)	-Troop-contributing country to prepare peacekeeper with the required medical skills. - Peacekeeper to be trained in accordance with standards stipulated by MSU.

Figure 3-2. Basic Level Medical Support.



B. Level One Medical Support.

This is the first level where a doctor is available. It provides first line primary health care, emergency resuscitation, stabilization and evacuation of casualties to the next level of medical care within a peacekeeping mission. A schematic representation of a Level One unit is shown below.

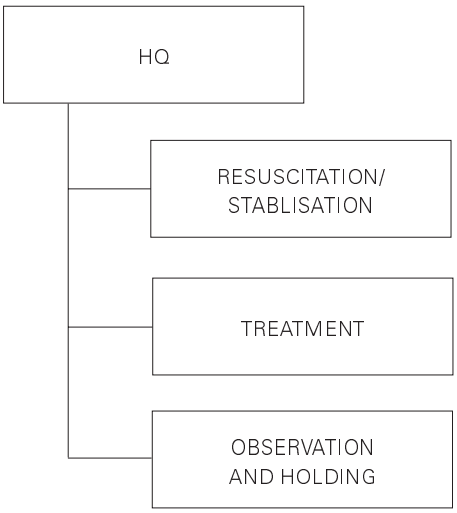


Figure 3-3. Structure of Level One Medical Unit.

Tasks of Level One Medical Unit:

1. Provide primary health care to a peacekeeping force of up to 700 in strength, with at least 20 ambulatory patients per day.
2. Conduct entry medical examination for peacekeepers if this has not already been done, and arrange for any necessary investigations.
3. Perform minor surgical procedures under local anaesthesia, e.g. toilet and suture of wounds, excision of lumps.
4. Perform emergency resuscitation procedures such as maintenance of airway and breathing, control of hemorrhage and treatment of shock.
5. Triage, stabilize and evacuate a casualty to the next level of medical care.
6. Ward up to 5 patients for up to 2 days each, for monitoring and inpatient treatment.

7. Administer vaccinations and other disease prophylaxis measures required in the mission area.
8. Perform basic field diagnostic and laboratory tests.
9. Maintain the capability to split into separate Forward Medical Teams (FMTs) to provide medical support simultaneously in two locations.
10. Oversees implementation of preventive medicine measures for the contingents and personnel under their care.

A Level One medical unit is to have adequate medical supplies and consumables for up to 60 days. Further details on the capabilities, staffing, equipping and infrastructural requirements of a Level One unit can be found below, while the UN standard equipping list of such a unit is provided in *Appendix 2-2.*

TREATMENT CAPABILITY	TREATMENT CAPACITY	MANPOWER REQUIREMENT	EQUIPMENT REQUIREMENT	INFRA-STRUCTURE
1. Treatment of common illnesses 2. Advanced life support - airway maintenance - ventilation - haemorrhage control - treatment of shock and dehydration 3. Trauma management - fracture immobilisation - wound & burns management - infection control- analgesia 4. Minor surgery 5. Casualty evacuation 6. Preventive medicine	- Treatment of 20 ambulatory patients per day - Holding capacity of 5 patients for up to 2 days - Medical supplies & consumables for up to 60 days	2 x Medical Officer 6 x Paramedic/Nurse 3 x Support Staff NB: Capability of splitting into 2 x FMTs, each with 1 doctor and 2-3 paramedics	- Resuscitation and life support equipment, fluids and drugs - Field dispensary - Clinic and ward equipment set - Surgical sets for minor surgical procedures - Splints, bandages and stretchers - Portable doctor and paramedic bags/ kits - Basic field laboratory kit - Sterilization equipment & refrigerator - 1-2 x Ambulance	- Tentages or containers - Building (if available) - Basic general support and office facilities

Figure 3-4. Level One Medical Support.

C. Level Two Medical Support.

This is the next level of medical care and the first level where surgical expertise and facilities are available. The mission of a Level Two medical facility is to provide second line health care, emergency resuscitation and stabilization, limb and life-saving surgical interventions, basic dental care and casualty evacuation to the next echelon. A schematic representation of a Level Two unit is shown in below.

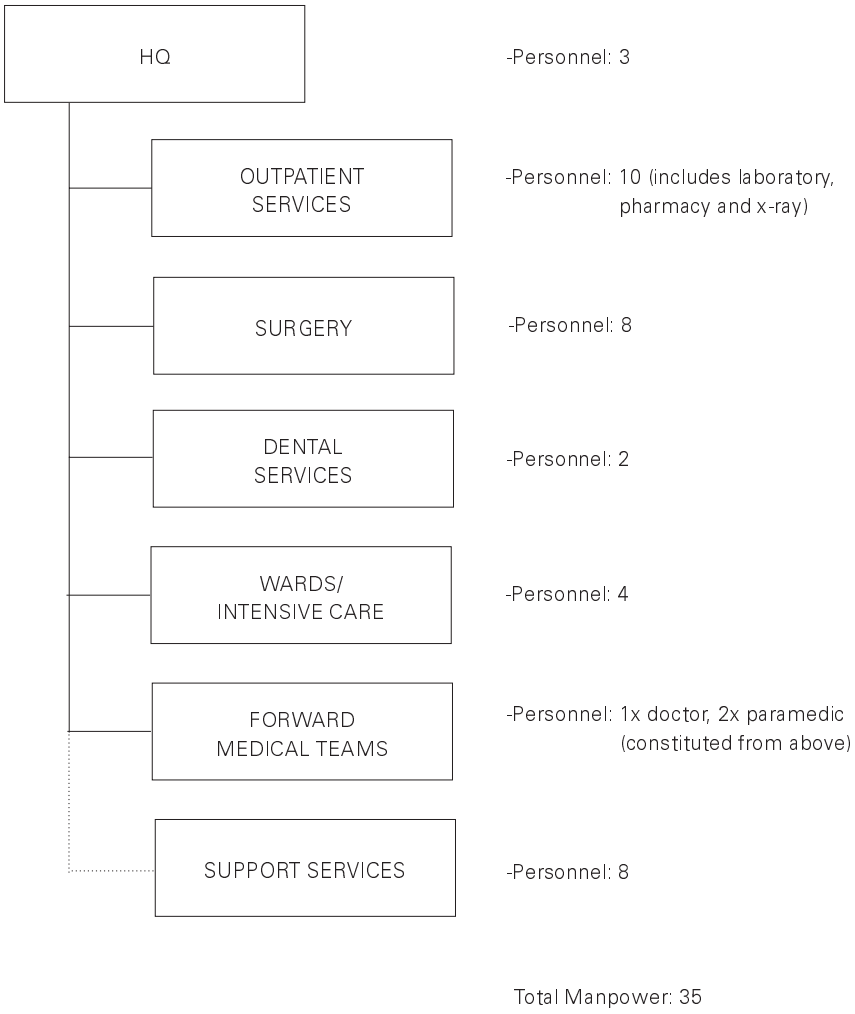
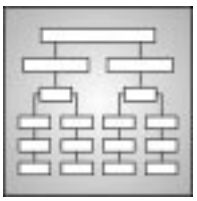


Figure 3-5. Structure of Level Two Medical Unit.

Tasks of Level Two Medical Unit:

1. Provide primary health care to a peacekeeping force of up to 1000 in strength, with the capacity of treating up to 40 ambulatory patients per day.



2. Conduct entry and routine medical examination for peacekeepers if this is required, including any necessary investigations.
3. Perform limb and life saving surgery such as laparotomy, appendectomy, thoracocentesis, wound exploration and debridement, fracture fixation and amputation. This must have the capacity to perform 3-4 major surgical procedures under general anesthesia per day.
4. Perform emergency resuscitation procedures such as maintenance of airway, breathing and circulation and advanced life support, hemorrhage control, and other life and limb saving emergency procedures.
5. Triage, stabilize and evacuate casualties to the next echelon of medical care.
6. Hospitalize up to 20 patients for up to seven days each for in-patient treatment and care, including intensive care monitoring for 1-2 patients.
7. Perform up to 10 basic radiological (x-ray) examinations per day.
8. Treat up to 10 dental cases per day, including pain relief, extractions, fillings and infection control.
9. Administer vaccinations and other disease prophylaxis measures as required in the mission area.
10. Perform up to 20 diagnostic laboratory tests per day, including basic hematology, blood biochemistry and urinalysis.
11. Constitute and deploy at least 2 FMTs (comprising 1 x doctor and 2 x paramedics) to provide medical care at secondary locations or medical support during land and air evacuation.
12. Maintain adequate medical supplies and consumables for up to 60 days, and the capability to resupply Level One units in the Mission area, if required.

Details on the capabilities, capacity, manpower and equipping requirements of a Level Two unit are shown below, while a detailed organisational chart and the UN standard equipping list for this can be found in *Appendix 2-3.*

TREATMENT CAPABILITY	TREATMENT CAPACITY	MANPOWER REQUIREMENT	EQUIPMENT REQUIREMENT	INFRA-STRUCTURE
1. Treatment of common medical conditions 2. Triage 3. Advanced lifesupport and intensive care 4. Life and limb-saving surgery under anaesthesia 5. Pharmacy 6. Basic dental care 7. Basic laboratory facility - Blood group & cross matching - Hemotology - Gram staining - Blood film - Urinanalysis 8. Basic diagnostic radiography 9. Hygiene control and preventive medicine 10. Casualty evacuation to Level 3 or 4	- Up to 40 outpatient visits per day - 3 to 4 major surgeries per day - 10 to 20 in-patients for up to 7 days each - 5 to 10 dental treatments per day - 10 x-rays and 20 laboratory tests per day - Medical supplies and consumables for 60 days	2 x Surgeons (general & orthopedic) 1 x Anaesthetist 1 x Internist 1 x General Physician 1 x Dentist 1 x Hygiene Officer 1 x Pharmacist 1 x Head Nurse 2 x Intensive care nurses 1 x OT Assistant 10 x Nurses/Paramedic 1 x Radiographer 1 x Laboratory technician 1 x Dental Assistant 2 x Drivers 8 x Support staff Total: 35	- Clinic and ward equipment - Resuscitation room equipment - Standard operating room fixtures and equipment - Intensive care equipment - Field laboratory and radiography facility - Dental chair and equipment - Hospital support equipment, e.g. autoclave, fridge - 2 x Ambulance	1. Hospital - Reception / Admin - Resuscitation room - Outpatient consultation rooms - 1-2 wards - 1-2 bed ICU - Operating room - Pharmacy - X-ray section - Laboratory section - Dental section - Sterilization area 2. Support Services - Kitchen - Laundry - Storage facility - Maintenance facility - Communications - Generator - Office - Sanitation & waste disposal - Accommadation & messing

Figure 3-6. Level Two Medical Support.

D. Level Three Medical Support.

This is the highest level of medical care provided by a deployed UN medical unit. It combines the capabilities of Level One and Two units, with the additional capability of providing specialized in-patient treatment and surgery, as well as extensive diagnostic services. It is important to note that a Level Three unit is rarely deployed, and that this level of support is generally obtained from existing civilian or military hospitals within the Mission area or in a neighboring country. A schematic representation of a Level Three unit is shown below.

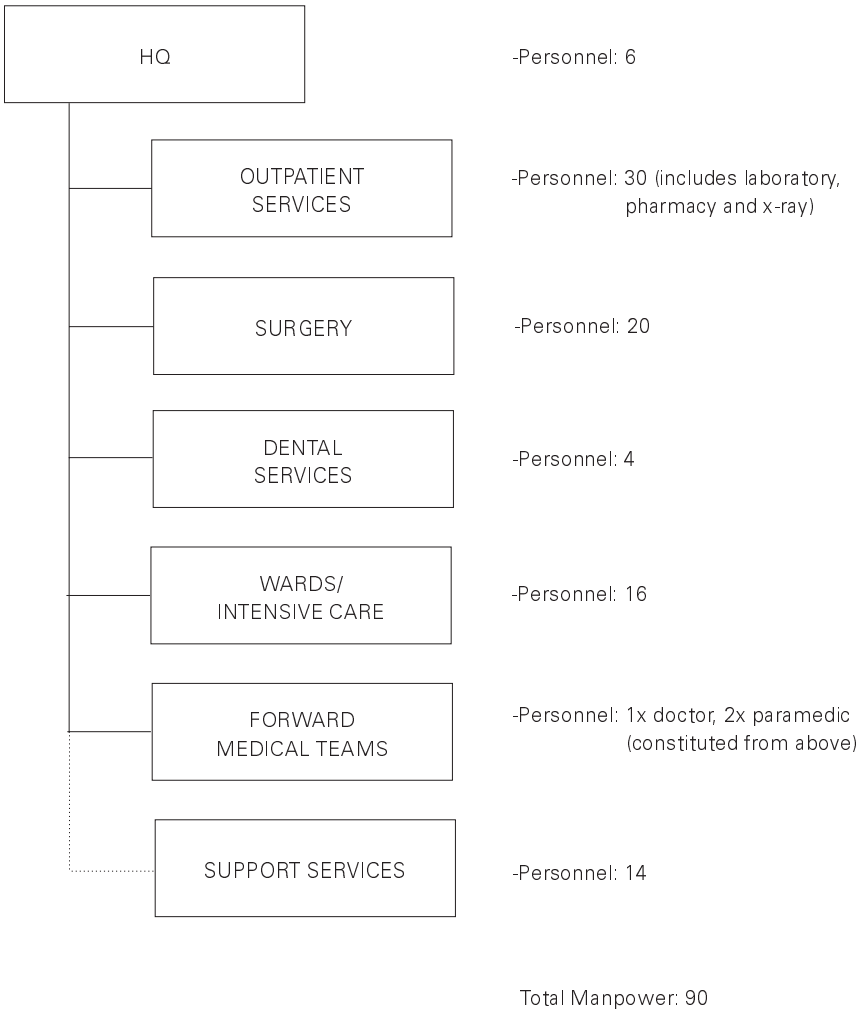
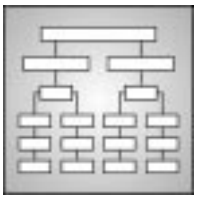


Figure 3-7. Structure of Level Three Medical Unit.



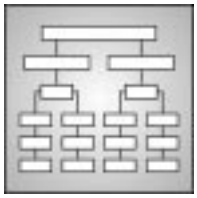
Tasks of Level Three Medical Unit:

1. Provide primary health care to a peacekeeping force of up to 5000 in strength, with the capacity to treat up to 60 ambulatory patients per day.
2. Provide specialist medical consultation services, particularly in areas like Internal Medicine, Infectious Diseases, Tropical Medicine, Dermatology, Psychiatry and Gynaecology.
3. Perform up to 10 major general and orthopedic surgical procedures under general anesthesia per day. Availability of specialist surgical disciplines (e.g. neurosurgery, cardio-thoracic surgery, trauma surgery, urology, burns unit) is an advantage.
4. Perform emergency resuscitation procedures such as maintenance of airway, breathing and circulation and advanced life support.
5. Stabilize casualties for long-haul air evacuation to a Level 4 facility, which may be located in another country.
6. Hospitalize up to 50 patients for up to 30 days each for in-patient treatment and care, and up to 4 patients for intensive care and monitoring.
7. Perform up to 20 basic radiological (x-ray) examinations per day. Availability of ultra-sonography or CT scan capability is an advantage.
8. Treat 10-20 dental cases per day, including pain relief, extractions, fillings and infection control, as well as limited oral surgery.
9. Administer vaccination and other preventive medicine measures, including vector control in the mission area.
10. Perform up to 40 diagnostic laboratory tests per day.
11. Constitute and deploy at least two FMTs (comprising 1 x doctor and 2 x paramedics) to provide medical care at secondary locations or medical support during casualty evacuation by land, rotary and fixed-wing aircraft.
12. Maintain adequate medical supplies and consumables for up to 60 days, and the capability of limited resupply Level One and Level Two medical units, if required.

Details on the capabilities, manpower, equipment and infrastructural requirements for a Level Three facility is shown below, with detailed organizational chart and standard UN equipping list found in *Appendix 2-4.*

TREATMENT CAPABILITY	TREATMENT CAPACITY	MANPOWER REQUIREMENT	EQUIPMENT REQUIREMENT	INFRA-STRUCTURE
All capabilities of Level Two facility. In addition: 1. Specialist consultation services 2. Multi-discipline surgical services 3. Post-operative & intensive care 4. Full laboratory services 5. Diagnostic radiology, ideally with ultrasound & CT-scan 6. Pharmacy 7. Dental surgery and x-ray	- Up to 60 outpatient visits per day - Up to 10 major surgeries per day - Up to 50 inpatients for up to 30 days each - 10-20 dental treatments per day - 20 x-rays and 40 laboratory tests per day - Medical supplies and consumables for 60 days	16 x Doctors - General surgeons - Orthopedic surgeon - Anaesthetists - Internists - General physician - Dermatologist - Psychiatrist - Other specialists 1 x Dental Surgeon 1 x Dentist 2 x Dental Asst 1 x Hygiene Officer 1 x Pharmacist 1 x Pharmacist Assistant 50 x Nursing staff - Head nurses - ICU nurses - OR Assistants - Nurses - Paramedics 2 x Radiographer 2 x Lab technician 14 x Support staff Total: 90	As for Level Two facility. In addition: - OR fixtures and equipment for general surgery & orthopedics - Intensive and high-dependency care equipment - Laboratory and radiography equipment - Dental chairs and x-ray - Ambulances - General transport	1. Hospital - Reception/ Admin - Resuscitation room - 4 x Outpatient consultation room - 2-4 x Ward - 4-bed ICU - 2 x Operating room - Pharmacy - X-ray unit - Laboratory unit - Dental surgery (2 chair) - Dental x-ray room - Sterilization room 2. Support Services - Kitchen - Laundry - Storage facility - Maintenance facility - Communications - Generators - Fuel store - Water purification - Sanitation and waste disposal - Accommodation & messing

Figure 3-8. Level Three Medical Support.

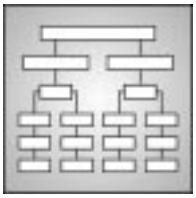


E. Level Four Medical Support.

A Level Four medical facility provides definitive medical care and specialist medical treatment unavailable or impractical to provide for within a Mission area. This includes specialist surgical and medical procedures, reconstruction, rehabilitation and convalescence. Such treatment is highly specialized and costly, and may be required for a long duration. It is neither practical nor cost-effective for the UN to deploy such a unit within the Mission area. Such services are generally sought in the host country, a neighboring country, or in the troop-contributing country itself. The UN can arrange transfer of a patient or casualty to such a facility, and for reasons of cost, compensation and pension, continues to monitor the patient's progress.

Indications for UN medical staff to utilize Level 4 facilities include:

1. When the distance from Mission area to the country of origin is too far, and the patient or casualty is in urgent need of specialist medical treatment.
2. When the patient requires only short-term specialist treatment and is expected to return to duty within 30 days.
3. When the troop-contributing country is unable to provide appropriate definitive treatment (this excludes chronic medical conditions diagnosed prior to the peacekeeper's deployment into the Mission area, or for which he is already receiving treatment).
4. When the UN receives an offer from a specific nation to provide definitive care, an arrangement requiring a contract or Letter of Assist (LOA) with the respective country and allocation of the appropriate funds.



F. Forward Medical Team.

A Forward Medical Team (FMT) is a small, highly mobile medical unit of about 3 men that is configured and equipped to provide short-term medical support in the field. This is generally constituted as and when required from existing medical units within the Mission area (including personnel, equipment and supplies), but may be a separate entity requested from troop-contributing countries and deployed with an independent mission. FMTs depend on the units they support for all service support requirements. Standard medical equipping requirements are listed under *Appendix 2-5*.

Tasks of Forward Medical Team:

1. To provide primary healthcare and emergency medical services at a medical post supporting an isolated military contingent of about 100-150 personnel.
2. To provide first line medical support for short-term field operations in areas without immediate access to UN medical facilities.
3. To provide continuous medical care during land and/or air evacuation of casualties particularly for seriously ill or unstable casualties, and where evacuation distances are long or where delays are anticipated. This includes medical evacuation out of the Mission area into a nearby country or medical repatriation, if indicated.
4. To provide a medical team for Search and Rescue missions.

To function effectively in the above operations, it is important for FMTs to be well equipped despite their size, including the requirement for life-support medical equipment. All equipment and supplies need to be portable and configured for use in confined spaces like ambulances and helicopters. There may be a requirement for electrical equipment to be aviation-certified for use within aircraft.

Chapter

4

MEDICAL SUPPORT PLANNING

4.01 Principles of Medical Support

It is the aim of UN medical support to provide a standard of medical care in peacekeeping operations that approaches that prevailing in times of peace. This is guided by the following principles:

A. Provision of a high standard of health care that is acceptable to all participating troop-contributing countries in the Mission and that meets internationally recognised standards.

B. Accessibility of medical facilities and services to all members of the peacekeeping force, and its availability in a timely and responsive manner.

C. Continuity of medical care between different levels of medical support, linked by effective land and air evacuation services.

D. Integration and preservation of local, national and UN medical infrastructure and systems, to maximize utilization of medical resources in a cost-effective manner.

4.02 Planning Considerations

The medical requirement for every peacekeeping mission differs and is influenced by a number of considerations. Developing the Medical Support Plan requires understanding of the Mandate for the Mission, its operating concept and an assessment of the existing medical infrastructure and prevailing health threats in the Mission area. Factors that influence planning of medical support include:

A. **Troop Strength and Deployment.**
Although not absolute, the extent of medical support is largely determined by the strength of a peacekeeping force, with a higher level of support for larger missions. The number and location of medical units also depends on the overall deployment plan for the force, in terms of both time and space.

B. **Type of Peacekeeping Operation.**
Medical support is determined by the Mandate of the Mission, the nature of peacekeeping activity and security risks within the Mission area. It is anticipated that "Observer Missions" require relatively less support than higher risk operations like "Peace enforcement" or demining.

C. **Standard of Local Medical Infrastructure.**
Should local hospitals and clinics within the Mission area fail to meet UN accepted standards, or where these are not readily accessible, there is a requirement to deploy a higher level of medical support within the Mission, regardless of its troop strength or deployment.

D. **Geographical Factors.**
Terrain, accessibility by land and air, physical distance, climate and other geographical factors have a major influence on the medical assets required and their deployment within the Mission area. Where there is good land communications and/ or adequate air evacuation assets, local medical facilities and those in a nearby country may be utilized, instead of deploying UN medical units. Where access is poor, medical units of varying sizes and capabilities may be deployed throughout the Mission area.

E. **Medical Threat Assessment.**
This would have to take into account common illnesses and endemic diseases (particularly tropical infectious diseases), accidents, hostile action and other potential hazards like land-mines, chemical and biological agents. An assessment of available medical intelligence on the Mission area should be made, complemented by a medical survey of the area. Emphasis has to be placed on preventive medicine and disease prophylaxis.

1. Disease and Non-Combat Injury (DNCI) Rate.
This is expressed as a daily percentage rate, and is an indicator of the daily workload for a deployed medical unit. It is Mission dependent and is affected by the area of operation, level and type of activity, weather conditions and the fitness level of the contingent. An average rate of 1.34% of all deployed personnel per day is expected, with 10% requiring hospitalization.

2. Combat Casualty Rate. Although not directly applicable in the context of peacekeeping operations, this is an estimate of the casualty rate in the event of a military encounter. It is expressed as a daily percentage rate of the combat troops and includes Wounded in Action (WIA), Killed in Action (KIA), Taken hostage or Missing in Action (MIA) and Combat Stress casualties.

4.03 The Medical Support Plan.

Planning medical support for UN peacekeeping operations generally follows similar processes as that for other military operations and exercises. The concerns and considerations have been discussed earlier, with the key requirement being the integration of independent multi-national medical units into a cohesive medical support system, often within a hostile mission area with limited medical infrastructure. This requires systematic examination of the Mission factors, as well as understanding of the UN medical support system and policies. Developing the plan requires close interaction and co-ordination with other departments, section and units within the UN organization and external agencies. An outline illustrating the medical planning process is shown below, highlighting key components of the plan. The Medical Facility checklist used by the UN during technical surveys is attached as *Annex 4-1*.

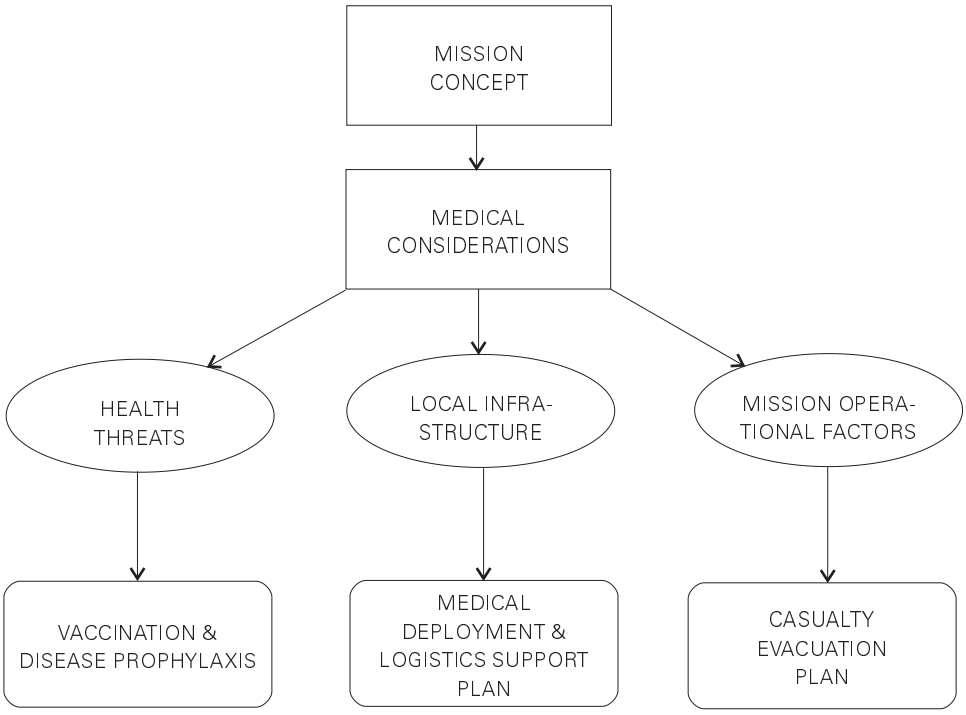


Figure 4-1. Medical Support Planning Process.

4.04. The medical support plan

This encompasses identifying the principal medical considerations and recommending steps to ensure maintenance of health and providing an integrated health-care system from Basic to Level 4 medical support, including the resources, logistics support and co-ordination measures required for its full implementation. Each aspect is important to ensure provision of comprehensive medical support to the peacekeeping force.

A. **Preventive Medicine.**

1. Identifying and highlighting major health threats to UN personnel, including endemic diseases, occupational hazards, environmental factors and psycho-social stress factors within the Mission area.
2. Outlining disease and accident prevention and control measures, and advising commanders on their implementation. This includes immunization and disease prophylaxis requirements for the Mission and related training requirements for Mission personnel.
3. Auditing process to assess the effectiveness of these measures, including collection and reporting of health statistics and epidemiology.

B. **Medical Facilities.**

It is important to outline the concept of deployment of medical units and the casualty evacuation chain by both land and air. It has to be ensured that every member of a peacekeeping force has ready access to a medical facility, which will manage his or her daily health-care requirements. Should it become necessary, this facility will further provide emergency medical treatment and evacuation services to the next level of medical care. There is a need to balance between the treatment capability at each level and its ability to evacuate casualties to the next level. The integrated plan should clearly define the facility providing each level of medical support, and may include national and UN medical units, as well as local hospitals within the Mission area. If required, Letters of Assist or contracts may have to be issued for use of national or local facilities.

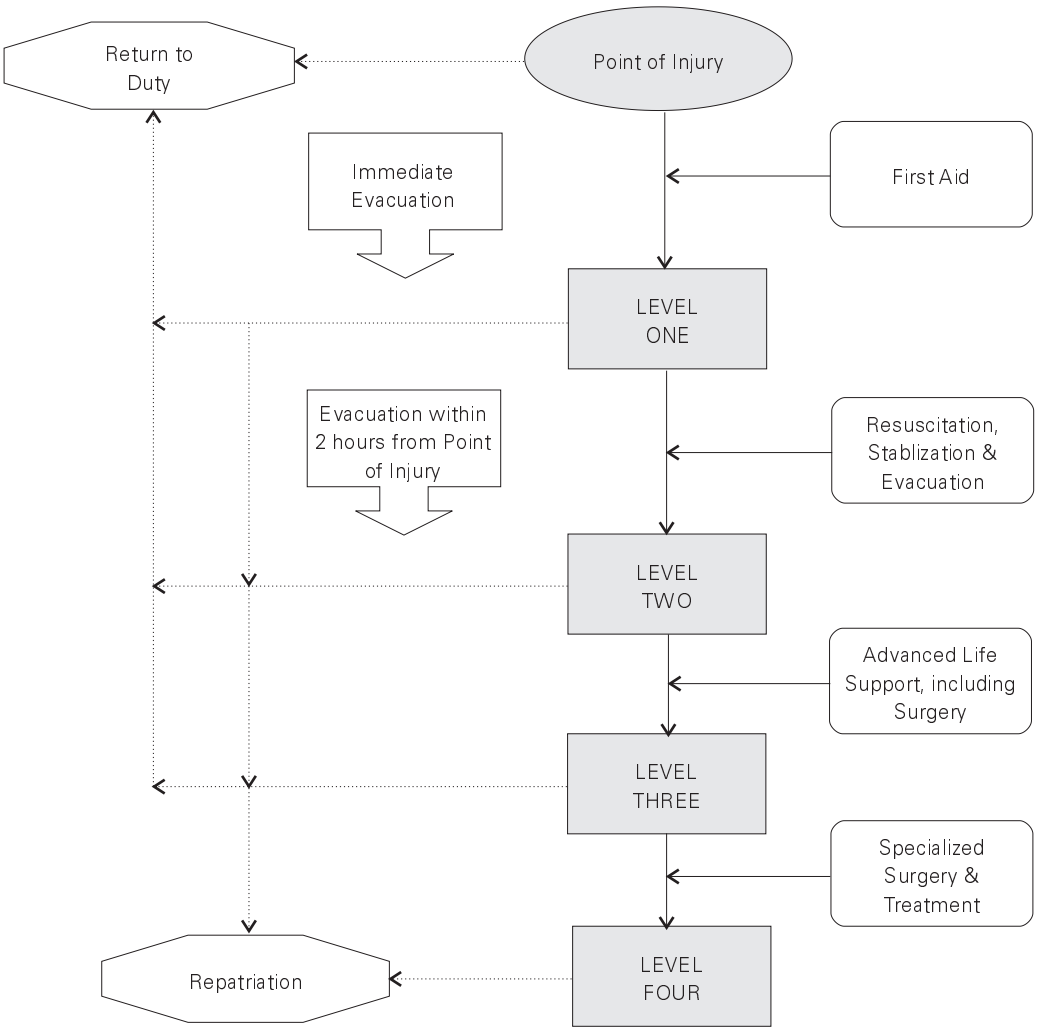


Figure 4-2. Medical Support Structure for Field Missions

C. **Medical Resources.**

1. Medical Manpower.
   Defining the size, structure and capability of medical units at each level, including their ability to split or detach Forward Medical Teams to support secondary positions or evacuation missions.

2. Evacuation Assets.
   The numbers and types of ambulances available at each medical facility, as well as the availability of rotary and fixed-wing evacuation platforms supporting each level. It is important to note details like the distance from medical units to airfield, activation time for Casevac and night flying capability.

3. Medical Logistics.
   This encompasses medical equipment, supplies and

consumables, including their storage and maintenance requirements. It is important to establish a resupply system for both UN-owned and national materials, a process requiring central control and co-ordination through the Mission administration. In larger missions, tight control and specialized management may be required and a trained pharmacist could be assigned. A Medical Warehouse may also be set up to centralize storage and distribution of supplies.

D. **Command, Control, Communications and Information.** For any plan to work, it has to be clearly communicated to each medical unit or person executing it. This process commences with the efficient management and distribution of medical information collected through medical reconnaissance, available medical intelligence or from the analysis of data collected from the field. There has to be clear instructions on lines of accountability and control, as well as comprehensive instructions on UN medical policies. Co-ordinating instructions concerning the transfer of patients and casualties between different medical facilities will have to be clearly laid out.

E. **Training of Medical and Non-medical Personnel.** Medical skills and experiences tend to vary significantly amongst medical personnel in peacekeeping missions. This is more so when there is a multi-national force, with medical units and personnel from different countries. Even amongst those who are highly skilled and experienced, professional skills may deteriorate with time if not used. There is a need, therefore, to have a regular training program, with the training plan targeted at the maintenance and standardization of core skills and procedures.

UNITED NATIONS NATIONS UNIES

MEDICAL SURVEY AND RECONNAISANCE CHECKLIST

MISSION AREA: _____
DATE OF SURVEY: _____
EVALUATED BY: _____

	MEDICAL FACILITY (Name, Address, Telephone)	TYPE	LEVEL	USE BY UN
FACILITY 1				
FACILITY 2				

TYPE: *G – Government P – Private M – Military O – Others/ NGO*
LEVEL: *UN Level of Medical Support 1 to 4*
USE BY UN: Y – Yes/ meets UN standards N – No/ does not meet UN standards E – Emergencies only

MEDICAL FACILITY CHECKLIST

		FACILITY 1	FACILITY 2
NUMBER OF BEDS			
1	PRIVATE ROOM (1 PER ROOM)		
2	SEMI-PRIVATE (2 PER ROOM)		
3	OTHERS		
4	TOTAL BED CAPACITY		
STAFFING			
1	DOCTOR (FULLTIME)		
2	DOCTOR (PART TIME)		
3	NURSE / PARAMEDIC		
4	OTHERS		
5	TOTAL STAFF LEVEL		
SPECIALIST MEDICAL DISCIPLINES			
1	ACCIDENT / EMERGENCY		
2	INTERNAL MEDICINE		
3	ENDOSCOPY		
4	SURGERY – GENERAL		
5	SURGERY – ORTHOPEDIC		
6	SURGERY – NEUROSURGERY		
7	SURGERY – OPHTHALMOLOGY		
8	SURGERY – ENT		
9	BURNS UNIT		
10	OTHERS:		

		FACILITY 1	FACILITY 2
INTENSIVE CARE			
1	INTENSIVE CARE BEDS		
2	LIFE SUPPORT EQUIPMENT *		
RADIOLOGY SERVICES '			
1	BASIC X-RAYS		
2	X-RAYS WITH CONTRASTS		
3	ULTRASOUND		
4	2-D ECHOCARDIOGRAM		
5	CORONARY ANGIOGRAM		
6	CT SCAN / MRI		
LABORATORY SERVICES ''			
1	BASIC HEMATOLOGY		
2	BLOOD BIOCHEMISTRY		
3	LIVER FUNCTION TEST		
4	RENAL FUNCTION TEST		
5	THYROID FUNCTION TEST		
6	BLOOD GLUCOSE		
7	SERUM LIPIDS		
8	URINE MICROSCOPY		
9	CULTURE & SENSITIVITY		
BLOOD BANK			
1	SCREEN FOR HIV '		
	HIV SCREENING METHOD		
2	SCREEN FOR HEPATITIS '		
3	SCREEN FOR MALARIA '		
4	BLOOD AVAILABILITY(PACKETS)		
5	SOURCE OF BLOOD		
6	RARE BLOOD GROUPS		
PHARMACY			
1	RANGE OF DRUGS *		
2	AVAILABILITY OF DRUGS * (STOCK-HOLDING)		

		FACILITY 1	FACILITY 2
DENTAL SERVICES			
1	NO. OF DENTAL CHAIRS		
2	DENTAL X-RAY #		
3	DENTAL SURGERY #		
EVACUATION SERVICES			
1	AMBULANCES		
2	HELICOPTER PAD #		
3	DISTANCE TO AIRFIELD		
HYGIENE AND SANITATION #			
1	GENERAL HYGIENE *		
2	WARDS *		
3	VENTILATION *		
4	AIR-CONDITIONING		
5	TOILETS *		
6	WATER SUPPLY *		
7	KITCHEN *		
8	OTHER COMMENTS		

 # To indicate availability of specialist medical service with a ✓

** Subjective assessment using following scale:*
VG – Very good, G – Good, A – Average, P – Poor, VP – Very poor

MISSION AREA INFORMATION

The following additional information is useful in the assessment of medical and civil infrastructure of a potential Mission area for peacekeeping operations. This data is to be submitted in the form of a report, using the following points as guidelines.

General Information

Location
Topography
Road conditions
Climate
Temperature range: summer & winter
Rainy season
Natural disasters

Political & military factors of medical importance
Refugees & Internally displaced personnel
Religions
Languages
Cultural factors of medical importance

Communications support
Lighting and power supply
Currency and exchange rate
Availability of local supplies

Medical Infrastructure

Government health organization
Private hospitals and clinics
Military medical facilities
NGOs / WHO / UN agencies
Other medical facilities

Ambulance services
Air ambulance service
Airfield / airport

Anti-venom center (if available)

Ongoing health projects
Public health education

Epidemiology & Hygiene

General hygiene in public places & streets
Hygiene of city & country
Garbage, flies/insects, stray animals
Waste disposal
Pollution (land, water & air)

Public health status
Endemic diseases: occurrence, drug-resistance
Vector-borne diseases
Sexually transmitted diseases
Insects, plants, animals of medical importance
Nutrition & deficiency diseases
Quarantine requirements

Water: source, quality, quantity, contaminants
Food: source, quality, quantity, contaminants
Hygiene in restaurants/
Illicit drugs
Prostitution

Medical Supplies

Availability of medical supplies & equipment
Suppliers: name, addresses, telephone, fax
Country of origin of pharmaceuticals
Availability of blood & blood products
Language of packaging and labels

Availability of medical warehouse (civ./mil.)
Name, address, telephone, fax
Suitability for UN use
Availability of blood storage

Local transport services (civ./ mil.)
Name, address, telephone, fax
Means, capability, capacity
Cold chain for blood & vaccines

Customs requirements

Chapter

5

HEALTH CARE POLICIES AND PROCEDURES

5.01 Medical Examination and Clearance

All personnel deployed in UN missions must be physically, mentally and emotionally fit. The examining physician must determine fitness of an individual by a thorough medical examination, and take into consideration that he or she would be deployed in a potentially hostile environment. The standard of living may be poor, with frequently changing work environment, scanty recreational facilities and unstable security situation, producing a very stressful living condition. In addition, the individual is exposed to occupational risks, as well as prevalent endemic diseases to which he may have decreased resistance. Fitness, therefore, must not simply imply the absence of disease, but also the ability to work effectively under such circumstances.

A. **Military Contingents of Peacekeeping Force.**
Medical examination and clearance of personnel from national contingents of a peacekeeping force remain the responsibility of the troop contributing country. The respective national medical standards are employed to determine fitness of an individual for deployment. As a rule, UN medical standards (discussed below) should be taken as the minimum acceptable for deployment in any peacekeeeping operation.

B. **Military Observers, Civilian Police and UN Civilian Staff.**
UN Military Observers, Civilian Police monitors and civilian staff, including those recruited locally, will be examined in accordance to UN medical standards to determine fitness for duty. The UN document, MS-2 (*Annex 5-1.* Entry Medical Examination) is to be used and the following information required:

1. Medical history and a complete physical examination, findings which are to be recorded within the MS-2.
2. Results of laboratory investigations, including hematology, blood chemistry, urinalysis and Venereal Disease Research Laboratory (VDRL) test.
3. An electrocardiogram (ECG/ EKG), to be done for all candidates above 40 years of age. However, the examining physician may request for this if there is a clinical indication.
4. Chest x-ray, the findings which must be recorded in the form.

The completed original MS-2 form is to be forwarded to the UN Medical Services Division, New York. It is the responsibility of UN HQ to ensure that medical clearance is obtained prior to deployment in the field of such personnel, and forms that are incompletely filled may result in undue delays in processing deployment. It is important to note that only medical examinations and investigations conducted within 3 months of the proposed deployment date are considered valid.

C. **Medical Examination During Tour of Duty and Upon Departure.**

UN Military Observers and Civilian Police are required to undergo a full medical examination while in the Mission area, under the following circumstances:

1. Following service-related accident or serious injury.
2. When his or her tour of duty is extended for 3 months or more.
3. Upon completion of tour of duty in a Mission, unless a medical examination had been conducted within 3 months of this date. This is no longer a requirement for international and local recruited civilian staff.

It is the responsibility of the Chief Administration Officer (CAO) to make the necessary arrangements for medical examination and to forward the reports to the UN Medical Director. The document, MS-6 (Periodic Medical Examination) is to be used for repeat examinations. The FMedO and respective SMedO are responsible to ensure that medical examination of military personnel comply with UN requirements.

5.02. UN Medical Standards and Policies

A. **Conditions that Preclude Peacekeeping Service.**

The following medical conditions generally preclude service in a peacekeeping mission and must be assessed on an individual basis, considering the severity of the condition and the particular assignment for which he or she is being selected

1. Ischemic heart disease
2. Hypertension requiring medication
3. Diabetes mellitus
4. Malignancy

5. History of gastro-duodenal ulcers – past history of a single instance of duodenal ulcer should not preclude service
6. Ulcerative colitis
7. Asthma, chronic bronchitis and emphysema
8. Chronic nephritis and urolithiasis
9. Chronic low back condition
10. Skin diseases like extensive eczema, cystic recurrent acne and skin cancer
11. Allergies requiring sustained supportive treatment
12. Conditions requiring special continuing medication such as steroids, anti-tuberculous drugs, chemotherapy, anti-depressant and anti-psychotic drugs
13. Endocrine disturbance, e.g. hyperthyroidism
14. Known allergies to anti-malarial medication
15. Immune compromise, including AIDS

B. **Psychiatric Conditions.**

Candidates, who have a history of situational maladjustment, anxiety neurosis or neurosis with somatization, should be carefully evaluated. Those who are on treatment, or who have previously required minor tranquilizers for relatively long periods should not be selected.

C. **Alcohol.**

The stress of deployment in peacekeeping missions and the environment of such areas create conditions favouring excessive alcohol consumption. Candidates who have a history of problems related to the use of alcohol or are known to be heavy drinkers should be screened carefully.

D. **HIV/ AIDS.**

1. Many troop-contributing countries screen their military personnel for HIV infection prior to sending them on overseas assignments. The national policies regarding enlisting and employing HIV-positive individuals in the military vary.
2. In UN peacekeeping operations, HIV-positive individuals who do not show clinical manifestations of AIDS are not precluded from peacekeeping service. It is however recommended that such individuals should not be

selected, as treatment available within the Mission area may not be adequate to meet their special requirements. Exposure to endemic infections and exhaustive immunization requirements may also be detrimental to their health. In addition to the individual's health concerns, there is also the risk of his or her transmitting HIV to medical personnel, fellow peacekeepers and sex workers in the Mission area.

3. Should a known HIV-positive individual be deployed in a UN mission, his/ her status should be made known to the FMedO and attending doctor, to ensure that proper medical precautions are taken and adequate medical care provided. This information should be kept strictly "Medical-in-Confidence".

4. Any individual who develops clinical AIDS or its complications, should be repatriated to his home country for further treatment once the diagnosis has been made. The UN medical support system is not obliged and does not have the resources to manage this condition.

5.03 Entitlement To and Provision of Medical Services

The entitlement of UN personnel to medical services is determined by his or her deployment status in the Mission. These services are generally provided by UN deployed medical units, but may also be sought at UN clinics or dispensaries run by contracted personnel or UN volunteers (UNVs) if these are present, or at local medical facilities.

A. **Members of Military Contingents.**
All contingent members of a peacekeeping force are required to seek medical treatment at the medical unit supporting their respective sector or locality. The FMedO is responsible to ensure that such support is available to every contingent serving in the Mission. Should treatment be sought at local clinics or hospitals at the individual's personal choice, reimbursement of medical expenses will be an individual or national responsibility, with the exception of serious illness or injury, where treatment should be sought at the nearest medical facility.

B. **Military Observers and Civilian Police.**
Arrangements are made by the UN to provide Military

Observers and Civilian Police Monitors with medical coverage during their assignment in the Mission area. This covers any illness or injury that occurs while performing official duties or taking authorized time off, and which is attributable to conditions and hazards within the area of assignment. As such peacekeepers may not have direct access to UN medical facilities, they may seek treatment at clinics or hospitals of their choice, with the exception of mandatory UN medical examinations which must be carried out by a UN designated physician. Medical claims, including hospitalization, are to be settled directly by the CAO, or reimbursed to the individual upon presentation of bills and supporting documentation.

C. **UN International Staff Member.**
Field Service category personnel and internationally recruited staff members assigned to a Mission have similar medical entitlements as Military Observers. However, as they also subscribe to health insurance schemes provided by the UN, this should not be interpreted as a provision for payment of medical expenses irrespective of other medical coverage, but as a supplement to such cover in order to obviate heavy medical costs should these arise. Reimbursement is only authorized for expenses unrecoverable under the respective insurance scheme. The CAO is responsible to ensure that all staff are covered by one of the UN insurance schemes.

D. **UN Locally Contracted Staff Member.**
Locally contracted General Service and National Officer staff members are automatically subscribed to a contributory Medical Insurance Plan (MIP), if they hold a contract of 3 months or longer. This insurance is extended to their direct family members based on a voluntary contribution. This entitles them to reimbursement of hospital and medical services, including laboratory investigations, x-rays, immunization and medicine. The administering office has the authority to settle medical claims under MIP, with any doubtful cases referred to the relevant headquarters for advice. Should they have no immediate access to medical care or where medical infrastructure within the Mission Area is inadequate, health-care may be sought at UN medical facilities.

E. **Local Population (under UN Humanitarian Mandate).**
If medical support to the local population has been specifically addressed in the UN Mandate for the Mission, this has to be

carefully planned and co-ordinated between the Mission HQ, host country's health services, other UN agencies and Non-Governmental Organizations (NGOs) in the Mission area. The primary responsibility of UN medical units, however, remains the provision of medical support to the peacekeeping force.

F. **Local Population (in absence of UN Humanitarian Mandate).**

The provision of medical care to the local population is a sensitive matter, and must be weighed against humanitarian principles and the ethical code of medical practice. The official UN policy is that there is no obligation to provide or to take responsibility for medical services to the local population, unless the Mission=s Mandate states otherwise. However, emergency medical care must always be provided regardless of person or party, but the case must be transferred to a local or NGO medical facility as soon as possible. Such obligations, in accordance with international law, also extend to prisoners of war, refugees, internally displaced persons (IDPs), detainees and non-UN combatants. Medical plans must detail the degree of care to be offered to these groups (generally limited to urgent medical care) and how continuity of care is to be provided. Should evacuation by air be required, each case has to be considered individually by the Mission HQ.

5.04 Compensation for Injury, Illness or Death Attributable to Service

Provisions are made by the UN to cover costs incurred for treatment and hospitalization, as well as to make financial awards for disability or death to members of a peacekeeping mission. Such claims are reviewed by an Advisory Board on Compensation Claims (ABCC) appointed by the Secretary General to validate these claims, determine the degree of incapacity and the relevant award. The regulations governing award of such compensation are as follows:

A. **Criteria to Qualify for Compensation.**

1. Injury, illness, disability or death must have occurred in the Mission area.
2. It must have occurred while performing duty on behalf of the UN, or at the time of officially designated rest time.

3. It must have occurred while travelling on behalf of the UN by means of transportation provided by or paid for by the same.

Where illness, injury or death occurs after completion of the assignment, or where this arises as a result of wilful misconduct or intent of the individual, the above provisions will not apply. Where the individual is entitled to similar provisions through other arrangements, reimbursement is only authorized for expenses unrecoverable under the respective scheme. All doubtful cases will be given sympathetic consideration.

B. **Submission Procedure for Compensation Claims.**

Each case of service-related injury or death is to be reported immediately to the Field Administration and Logistics Division (FALD), with copies forwarded to the Secretary of the ABCC and to the Director, Medical Services Division. This information shall serve as the basis for consideration of any subsequent claims. (Details of the reporting procedure and forms are discussed in Chapter VII). Any such claim has to be submitted within 4 months of injury, onset of illness or death.

The following documentation is required for each claim for compensation:

1. Claim submission by the claimant, or on his/ her behalf by the respective Government.
2. Medical report by the attending UN doctor, at the time of the incident as well as after complete convalescence. This is provided to the UN Medical Director, who is the Medical Adviser to the ABCC.
3. Board of Inquiry report, and if this is not available, an Administrative Report from the claimant's immediate supervisor, as well as any statements by witnesses.
4. Medical bills and expenses.
5. Death certificate and marriage and birth certificates of the claimant's dependants, if applicable. A "Designation of Beneficiary Form" (UN P-2) should be made available if this had been filled by the deceased.

C. **Award and Method of Payment.**

1. Should the Board of Inquiry determine that injury was service-incurred, the FMedO, in consultation with the SMedO of the respective contingent and a senior doctor

managing the patient, will assess the degree of disability according to UN guidelines. This assessment will be reviewed by the Medical Director, Medical Services Division, prior to submission to FALD for processing of the claim. In the event of differences in the medical determination of the UN and the respective Government, a qualified third party opinion will be sought.

2. If a contingent member has been medically repatriated or evacuated out of the Mission area following injury, assessment of disability will be made by the appropriate medical authority of the troop-contributing country according to the above guidelines.

3. For military contingent personnel, maximum compensation comprising a lump sum payment of US$ 50,000, is awarded for service-incurred death. For permanent disability, a specified percentage of this amount will be made, based on the schedule of awards outlined by the American Medical Association (AMA) Guide to Evaluation of Permanent Impairment (4th edition). Payments will be made in accordance to the respective Government's instructions regarding this, and the amount payable to beneficiaries shall not be less than the amounts reimbursed to member states.

D. **Incidents not Attributable to Service.**
In the case of illness, injury, disability or death not attributable to service, the UN does not take responsibility and does not pay compensation to the individual or his dependants, except for payment of reasonable medical expenses in the field, and transportation or burial of remains in the case of death.

5.05 Medical Confidentiality

A. Medical information is to be treated as confidential and privileged information, and this confidentiality must be maintained at all times. Any medical records or information must not be released without proper authorization, and under no circumstances, should be provided to anyone not directly involved in the patient's care. An exception would be in the event of a formal investigation or Board of Inquiry, where there

is direction from a relevant authority to release such information.

B. Care has to be taken also, to ensure confidentiality in the transfer of patient medical records, in submission of reports and in routine administrative processes (e.g. compiling and submitting disbursement vouchers for medical expenses). Where a patient's identity and medical status may be revealed in such documents, these should not be transmitted via unsecured means like e-mail or facsimile, but should be properly sealed and marked with instructions "To be opened by addressee only".

ANNEX 5-1. GUIDELINES FOR THE USE OF MEDICAL EXAMINATION FORM MS-2 FOR MILITARY AND CIVILIAN POLICE OBSERVERS

1. A pre-deployment medical examination is required for all military and civilian police observers being considered for a mission assignment with the United Nations. This examination must have taken place within the preceding three months and shall be completed and recorded on form MS–2.
2. Before conducting this examination, the examining physician must review pages 1 and 2 of the form to make sure that the candidate has answered all questions and has filled out all spaces allocated for him/her. If there are any unanswered questions, the candidate must be asked to complete them before the medical examination is conducted.
3. The examining physician shall fill all spaces allocated for him/her, on pages 3 and 4 of that form. In doing so, he/she must remember that:

   *His/her writing as well as that of the candidate is legible;

   *Questions requiring numerical values are not answered with common terms like "normal", "OK", etc.; (For example, measurements of blood pressure and pulse must be given in numbers and units: 120/80 mm Hg and 75 beats / minute, etc.)

   *All laboratory results, in accordance with page 4 of MS-2, are provided in numerical values including their units; (if such results are submitted in a separate laboratory form, the results must be legible and securely attached to the MS-2 form).

*Chest x-ray film and EKG tracing are not longer required to be enclosed; (however, report of an x-ray chest taken within the last year, and that of a recent EKG are requested).

*All positive answers given by the candidate have been pursued thoroughly; (for example, if the candidate has indicated that he/she had suffered from ulcer of the duodenum in 1990, it is relevant to inquire as to how the diagnosis was established, the treatment prescribed and the outcome of the treatment. The finding of this inquiry must be briefly stated by the physician in the space allocated for comment on page 4 of the MS-2 form); and

*Conclusion about the health status of the candidate and suitability or unsuitability for the task are clearly stated and relate to the comments.

4. The completed examination form with all its attachments must be received at the UN Medical Service, New York, at least one month prior to deployment.
5. The name of the examining physician, address, date and signature must be filled out at the end of page 4 of MS-2.
6. Strict adherence to the above-mentioned guidelines is essential since the medical examination is the basis for providing medical clearance, which is a requirement for UN mission deployment. Incomplete medical examination forms will be returned to the place of origin, thus denying medical clearance for the proposed mission.

FAO	GATT	IAEA	ILO	ITC	ITU	UN	UNDP	UNESCO	UNICEF	UNIDO	WHO	WIPO	WMO

CONFIDENTIAL

ENTRY MEDICAL EXAMINATION

UNITED NATIONS AND SPECIALIZED AGENCIES

I hereby authorize any of the doctors, hospitals or clinics mentioned in this form to provide the United Nations Medical Service with copies of all my medical records so that the Organization can take action upon my application for employment.

I certify that the statements made by me in answer to the questions below are, to the best of my knowledge, true, complete and correct. I realize that any incorrect statement or material omission in the medical information form or in any other document required by the Organization renders a staff member liable to termination or dismissal.

Date: . . . . . Signature: . . . . . .

Pages 1 and 2 are to be completed by the candidate

FAMILY NAME (IN BLOCK CAPITALS)	GIVEN NAMES	MAIDEN NAME (FOR WOMEN ONLY)	SEX ☐ M ☐ F

ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)

. . . . . .

. . . . . .

. . . . . .

DATE OF BIRTH

NATIONALITY

POSITION APPLIED FOR (DESCRIBE NATURE OF WORK)

. . . . . .

. . . . . .

. . . . . .

DUTY STATION

TELEPHONE

BIRTHPLACE

PRESENT MARITAL STATUS

Single ☐

Married ☐ DATE: . . . . . Divorced ☐ DATE: . . . . . .

Separated ☐ DATE: . . . . . Widowed ☐ DATE: . . . . . .

Have you ever undergone a medical examination for the United Nations or one of its agencies? . . . . . .

Have you ever been employed by the United Nations or one of its agencies? . . . . . .

If so, please state when, where and for which Organization: . . . . . .

FAMILY HISTORY

Relative	Age (if still alive)	State of Health (If still alive, present state; if deceased, cause of death)	Age at death	Have members of your family had the following illnesses or disorders?	Yes	No	Who?
Father				High Blood Pressure			
Mother				Heart Disease			
Brothers				Diabetes			
Sisters				Tuberculosis			
Spouse				Asthma			
Children				Cancer			
				Epilepsy			
				Mental Disorders			
				Paralysis			

TO BE COMPLETED BY THE OFFICIAL REQUESTING THE MEDICAL EXAMINATION	TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE
Name of Official:	Medical Classification: 1a 1b 2a 2b
Department or Unit:	Comments: . . . . .
Date:	Date: Signature:

VERY IMPORTANT: Please indicate the recruiting Agency or Organization:

– 2 –

Each question requires a specific answer (yes, no, date, etc.); to leave a blank or draw a line is not sufficient. If the questionnaire is not fully completed and enquiries are therefore needed, time may be lost.

1. Have you suffered from any of the following diseases or disorders? Check yes or no. If yes, state the year.

	YES Date	NO		YES Date	NO		YES Date	NO		YES Date	NO
Frequent sore throats			Heart and blood vessel disease			Urinary disorder			Fainting spells		
Hay fever			Pains in the heart region			Kidney trouble			Epilepsy		
Asthma			Varicose veins			Kidney stones			Diabetes		
Tuberculosis			Frequent indigestion			Back pain			Gonorrhoea		
Pneumonia			Ulcer of stomach or duodenum			Joint problems			Any other sexually transmitted disease		
Pleurisy			Jaundice			Skin disease			Tropical disease		
Repeated bronchitis			Gall stones			Sleeplessness			Amoebic dysentery		
Rheumatic fever			Hernia			Any nervous or mental disorder			Malaria		
High blood pressure			Haemorrhoids			Frequent headache					

2. Are you being treated for any condition now?_____ Describe: _____
3. Have you ever coughed up blood? _____
4. Have you ever noticed blood in your stools?_____ In your urine?_____ Give details: _____
5. Have you ever been hospitalized (hospital, clinic, etc.)? _____
   Why, where and when? _____
6. Have you ever been absent from work for longer than one month through illness?_____ If so, when?_____
   And for what illness? _____
7. Have you had any accidents as a result of which you are partially disabled?_____ If so, what and when?_____
   Do you have any other disability?_____
8. Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst? _____
   If so, please give his/her name and address: _____
   For what reason? _____ Date of the consultation:_____
9. Are you taking any medicine regularly?_____ If so, which?_____
10. Have you gained or lost weight during the last three years?_____ If so, how much? _____
11. Have you ever been refused life insurance?_____If so, state reason: _____
12. Have you ever been refused employment on health grounds?_____If so, state reason:_____
13. Have you ever received or applied for a pension or compensation for any permanent disability?_____ Degree? _____
    Please give details: _____
14. Have you ever stayed in a tropical country?_____ If so, for how long?_____
15. Have you in the past suffered from any condition which prevented travel by air? _____
16. Do you consider yourself to be in good health?_____ Do you have full work capacity?_____
17. Do you smoke regularly? ☐ Yes ☐ No If so, what do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars
    For how many years have you smoked? _____ How much per day? _____
18. Daily consumption of alcoholic beverages: _____
19. Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future? _____
    Give details: _____
20. Give any other significant information concerning your health: _____
    _____
    _____
21. What is your occupation? _____ Indicate the last three posts you have occupied: _____
    _____
22. List any occupational or other hazards to which you have been exposed: _____
    _____
23. Have you been rejected for military service for medical reasons? _____
24. **FOR WOMEN** Are your periods regular? ☐ Yes ☐ No
    Are they painful? ☐ Yes ☐ No
    Do you have to stay in bed when they come? ☐ Yes ☐ No
    If so, for how long?_____ Date of your last period: _____
    Do you take contraceptive pills? ☐ Yes ☐ No If so, for how many years have you been doing so?_____ Have you ever been treated for a gynaecological complaint? ☐ Yes ☐ No
    If so, which?_____

– 3 –

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

GENERAL APPEARANCE Height: cm. _____ Weight: kg. _____

Skin: _____ Scalp : _____

SIGHT, MEASURED VISUAL ACUITY

Gross vision	: Right _____	Left _____	Pupils: Equal? _____ Regular? _____
Vision with spectacles	: Right _____	Left _____	Fundi (if necessary): _____
Near vision	: Right _____	Left _____	Colour vision: _____
With correction	: Right _____	Left _____	

HEARING (test by whispering)

Right : Normal: _____ Sufficient: _____ Insufficient: _____

Left : Normal: _____ Sufficient: _____ Insufficient: _____

Ear drum : Right: _____ Left: _____

NOSE - MOUTH - NECK

Nose : _____ Pharynx: _____ Teeth : _____

Tongue: _____ Tonsils: _____ Thyroid: _____

CARDIOVASCULAR SYSTEM

Pulse rate : _____ Auscultation : _____ Peripheral arteries

Rhythm : _____ Blood pressure : _____ – carotid : _____

Apex beat : _____ Varicose veins : _____ – posterior tibial: _____

– dorsalis pedes: _____

Electrocardiogram (if indicated or after age of 45) – Please attach tracing

RESPIRATORY SYSTEM

Thorax:

Breasts

DIGESTIVE SYSTEM

Abdomen: _____ Spleen: _____

Liver : _____ Hernia: _____

Rectal examination: _____

NERVOUS SYSTEM

Pupillary reflexes: – To light: _____ – On accommodation: _____

Patellar reflexes : _____

Achilles reflexes : _____

Plantar reflexes : _____

Motor functions : _____

Sensory functions : _____

Muscular tonus : _____

Romberg's sign : _____

MENTAL STATE

Appearance: Behaviour:

GENITO–URINARY SYSTEM

Kidneys: Genitals:

SKELETAL SYSTEM

Skull : _____ Upper extremities: _____

Spine: _____ Lower extremities: _____

LYMPHATIC SYSTEM

CHEST X-RAY (Full size film – Please send film itself, the radiologist's report is not sufficient. Lateral film not necessary unless indicated medically.)

– 4 –

LABORATORY

The results of all the following investigations must be included except where marked "if indicated".
Except by prior agreement, only the investigations mentioned are done at the Organization's expense.

Urine : Albumin _____ Sugar _____ Microscopic _____

Blood : Haemoglobin : _____ % _____ grams/l Leucocytes: _____
Haematocrit : _____ % _____ Differential count (if indicated): _____
Erythrocytes : _____ Blood sedimentation rate: _____

Blood chemistry (if these tests can be carried out on the spot):

Sugar : _____ Urea or creatinine: _____
Cholesterol : _____ Uric acid : _____

Serological test for syphilis: Please attach laboratory report

Stool examination (if indicated):

COMMENTS (Please comment on all the positive answers given by the candidate and summarize the abnormal findings)

CONCLUSIONS (Please state your opinion on the physical and mental health of the candidate and fitness for the proposed post)

The examining doctor is requested before sending this report to verify that the questionnaire, pages 1 and 2 of this form, has been fully completed by the candidate and that all the results of the investigations required are given on the report. Incomplete reports are a major source of delay in recruitment.

Name of the examining physician (in block capitals):

_____

Address: _____

_____

_____

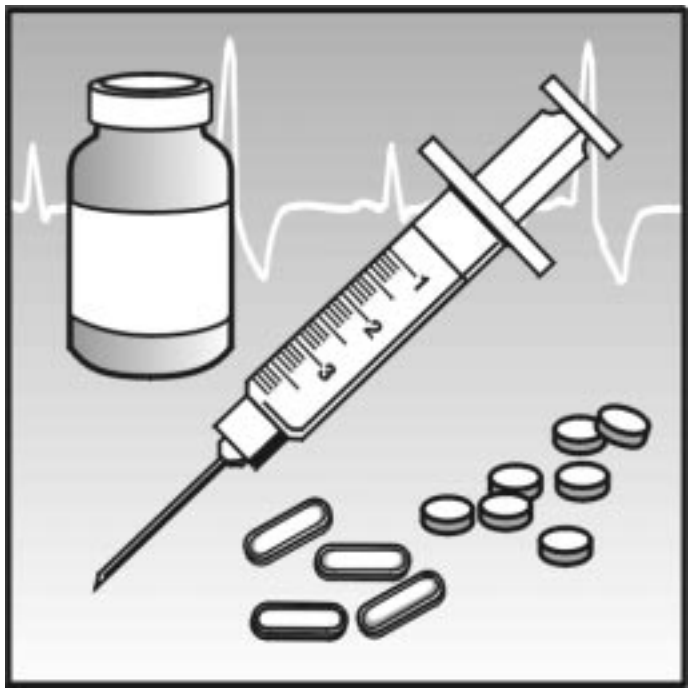
Signature: _____

Date: _____

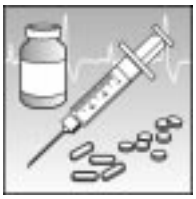
Chapter

6

PREVENTIVE MEDICINE



6.01 Introduction



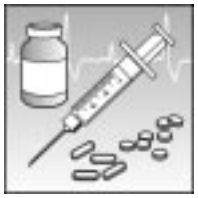
Preventive medicine is one of the most important aspects of medical support in the field. Through effective measures, significant results can be achieved in terms of reduced man-days lost, lower morbidity rates and lower treatment costs. Preventive medicine incorporates immunization, disease prophylaxis, vector control, hygiene and sanitation. Health hazards and occupational threats must be fully evaluated prior to and as a continuous process during deployment. It has to be stressed that preventive health measures involve every individual in the Mission area, and that proper health education and training is the key to successful implementation of these measures.

A. The FMedO is responsible to oversee preventive medicine practice within the Mission area and is guided by directives issued by the Medical Services Division and Medical Support Unit. He is also expected to constantly update himself with epidemiological and health data, through contact with local health authorities and international agencies (e.g. WHO, ICRC) within the Mission area. It is also his task to collect, collate and analyse medical statistics submitted monthly to him by the medical units.

B. The SMedO and contingent doctors are responsible for implementing preventive medicine practices for the military contingents and personnel under their charge. It is their task to monitor immunization status of troops under their care, as well as to directly manage any required vaccination or disease prevention program. This includes the distribution of anti-malarial tablets and condoms, as well as the conduct of health inspections of food, water and sanitation. In addition, they are responsible for health education and medical training, which is generally conducted by medical personnel under their charge.

6.02 Immunization Policy

A. The Medical Services Division recommends the vaccination and chemoprophylaxis requirements within a Mission area, which should be the minimum requirement observed by all troop contributing countries here. These requirements are divided into those that are *mandatory* (e.g. Diphtheria, Pertussis, Tetanus, Poliomyelitis, Typhoid, Yellow fever if indicated, Hepatitis B for medical staff) and those that are *recommended*



(Meningococcus, Rabies, Hepatitis A, Hepatitis B, MMR). The exact immunization regimen will vary with the Mission area.

B. It is a national responsibility (and at national expense) to ensure that all personnel have received at least the initial dose of mandatory vaccinations before deployment into the Mission area. The immunization status of each individual is to be properly documented for monitoring by the respective contingent doctor. It would be ideal if each member of the contingent is provided with the WHO International Certificate of Vaccination, or its national equivalent.

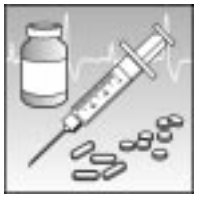
C. Should a multiple dose immunization regimen not be completed prior to deployment, the UN has the responsibility for subsequent vaccinations, including administration of booster doses, if required. The Mission HQ will procure the required vaccines in this instance, with the assistance of the Medical Support Unit.

D. Should troops deploy into a Mission area without the required vaccinations, this will be provided by the supporting medical unit, but all costs incurred will be deducted from the reimbursement to the troop contributing country. The FMedO is required to submit a record of all vaccinations administered in the field, indicating the names, UN ID numbers and nationalities, as well as the types and doses of vaccinations given.

E. Failure to follow UN-recommended immunization and chemoprophylaxis policies may result in the denial of entry into the host country, as well as rejection of any resulting medical claims and compensation.

6.03 Malaria Prophylaxis and Vector Control

Malaria is endemic in most tropical countries, particularly in Africa, South America and South Asia, with 400 million individuals infected and 1.5 million dying from the disease each year. It is one of the major diseases affecting peacekeepers and an important cause of morbidity and mortality. In 1995, health statistics from UNAVEM (Angola) showed that 970 out of 7,005 UN peacekeepers had malaria. This indicates a general lack of awareness of the disease among peacekeepers, as well as inadequate or incorrect use of environmental and personal protection. Prevention of malaria is further hampered by delays in diagnosis by doctors unfamiliar with



the disease, development of Anopheles mosquitoes resistant to standard insecticides and resistant-strains of *Plasmodia*. To date, there is also no effective vaccine against the organism. Steps that should be taken to control the disease include:

A. Avoid setting up camp locations near stagnant water bodies (e.g. marshes, ponds).

B. Routine inspection and destruction of mosquito breeding sites in the camp vicinity. The use of oiling is recommended, while organophosphate insecticides should be considered for water bodies rich in vegetation.

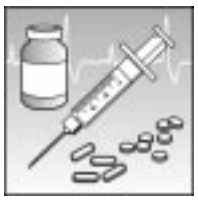
C. Residual spraying of insecticides on both internal and external walls and window- sills to destroy resting adult mosquitoes. This is more effective than space spraying, and should be conducted at least once in 3 months. Hand-operated compression sprayers are generally adequate, and organophosphate, carbamate or synthetic pyrethroids can be used.

D. Proper use of mosquito bed nets and appropriate dressing after dusk. Impregnation of bed nets and even clothing with Permethrin or similar compound has been shown to increase protection against mosquitoes. This should be repeated every 6 months.

E. The obligatory use of insect repellents after dusk, with repeat applications at night if the soldier is on duty. DEET-based repellents (N,N-diethyl-m-toluamide) are recommended, particularly sustained released formulations and ointments.

F. Supervision and even enforcement of malaria prophylaxis. Mefloquine (Lariam) 250mg per week is generally recommended for most mission areas, while Doxycycline 100mg daily is advised for individuals with G6PD deficiency or allergy to quinine based drugs. It is a national responsibility to ensure that the recommended prophylaxis is commenced prior to deployment in the Mission area. Following deployment, continuation of prophylaxis will be provided by the medical unit supporting the contingent.

G. Where diagnosis of malaria is suspected or confirmed, it is recommended that the patient be treated at a Level 2 or 3 medical facility, where adequate monitoring and investigations are available.



H. Health education is the key to raising awareness about malaria and to debunk misconceptions about the disease (e.g. the harmful effects of prophylaxis), as well as to reinforce the need for adequate preventive measures.

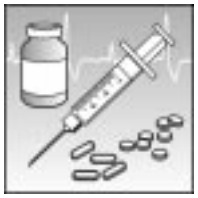
6.04 HIV/ AIDS and Sexually Transmitted Diseases

Sexually transmitted diseases (STD) and AIDS are occupational diseases affecting the military, including UN peacekeeping troops and observers. Prevalence rates of as high as 10-30% have been found among military personnel, including certain troop contributing countries to peacekeeping missions. This rate is estimated to be 2 to 5 times higher than the respective general population, and has been known to be as high as 50 times during deployment in a conflict area.

A. **Risk Factors.**
The following factors contribute to the particular vulnerability of deployed peacekeepers to STD and AIDS, which arise largely from contact with infected sex workers.

1. Lengthy periods away from home and separation from regular sex partners.
2. Influence of alcohol and peers.
3. Less inhibitions and restrictions in new country.
4. Money in the pockets, with less opportunity to spend this during operational deployment.
5. Risk-taking ethos and behavior in the military, which is part of the make-up of any soldier.
6. Ready access to sex workers near campsites and frequented off-duty areas.
7. In some situations, higher tendency for drug abuse and the lack of access to sterile hypodermic needles.
8. Higher chance of exposure to infected blood in the operational environment, either from fellow peacekeepers or the local population, particularly for medical personnel.

B. STD, HIV infection and AIDS are largely preventable through proper health education and training, as well as through the issue of personal protection (condoms) to individual peacekeepers. An effective AIDS prevention program will limit



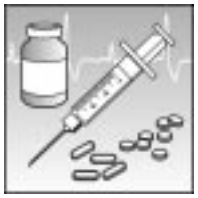
further spread of the disease among peacekeepers and to the local population. Elements of such a program include:

1. Health education on the risks of HIV / AIDS and to debunk myths and misconceptions regarding the disease. This is to be reinforced by publications, posters and other means of communications.
2. AIDS prevention training for peacekeepers prior to and during their deployment in UN peacekeeping operations, with emphasis on proper use of prophylaxis and moderation of behavior in "risky" situations.
3. Supervised regular distribution of condoms to all peacekeepers, both male and female, particularly before time-off or leave. It is a national responsibility to ensure that troops deploy with an adequate supply of condoms. Additional condoms may be obtained from the medical unit supporting the contingent or through a UN channel.
4. Making HIV testing available and accessible to all UN peacekeepers and staff members deployed in the field. Counselling services by medical staff should be made available for infected individuals if this is so requested.
5. Promoting greater awareness among medical personnel and adopting "Universal precautions" in handling patients, particularly during resuscitation and intravenous procedures. Ensuring the proper disposal and decontamination of medical wastes and consumables.

C. Further information regarding AIDS can be obtained from the booklet, "Protect Yourself, and Those You Care About, Against HIV/AIDS", published jointly by DPKO and the Joint UN Program on HIV/AIDS (UNAIDS). This is distributed to all military observers, civilian police monitors and military contingents serving in peacekeeping missions.

6.05 Hygiene and Sanitation

It is a combined UN and national responsibility to ensure quality control for procurement, storage and preparation of food, as well as for the supply of potable water. Adequate provisions must also be made to ensure high standards of sanitation and proper disposal of wastes. Although not directly responsible, the FMedO and contingent medical personnel are to assist logistics, engineering and



hygiene inspection personnel in maintaining these standards. Specific tasks include:

A. Assisting inspection of food preparation and storage areas, and ensuring their proper transportation.

B. Routine examination and certification of kitchen personnel, including bacteriological examination of stools for pathogens, if this can be conducted.

C. Investigation of any suspected outbreak of food poisoning or gastroenteritis.

D. Formulating Mission area policies concerning consumption of local food and water.

E. Ensuring that regular checks on the quality of potable water are conducted by logistics personnel.

F. Medical advice on the proper disposal of wastes, including human and medical wastes.

G. Identifying and implementing prophylactic measures to reduce environmental and occupational related illness.

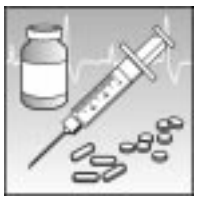
6.06 Road Traffic Accidents

It is important to note that road traffic accidents are the main cause of serious injury and fatalities in peacekeeping missions. In a study conducted in 1997, it was shown that out of a total of 876 accidents reviewed, 64% comprised road traffic accidents. Most resulted from human error on the part of the peacekeeper, or of another party. Although not directly responsible for accident prevention, the medical doctor in the field has a duty to advice the contingent commander if road safety measures are not being adopted. Strict enforcement of such measures will lead to reduction in loss of human life and limb. Basic components of a road safety program include:

A. Commander's emphasis on road and vehicular safety.

B. Clearly documented safety regulations and Standard Operating Procedures (SOPs) which are understood by all drivers and vehicle occupants. These measures have to be strictly enforced (e.g. speed limits, use of seat-belts, alcohol control, vehicle breakdown drill).

C. Certified driving standards for military and heavy vehicles, and orientation drives for new drivers.



D. Regular maintenance schedules, with system of close supervision and accountability.

6.07 Stress Management

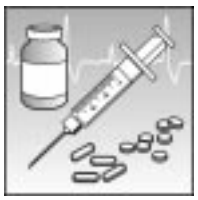
Stress is the physical and psychological process of reacting to and coping with events or situations that place extraordinary pressure upon a human being. It is a normal reaction to an abnormal situation, but can lead to breakdown of coping mechanisms if allowed to build-up after prolonged or repeated exposure. Many peacekeepers are confronted with intense, traumatic and even life-threatening situations, which place serious and often prolonged levels of stress on them. It is important for the medical doctor in the field to be able to recognize different types of stress reactions, the factors that contribute towards them and to be familiar with measures that can be taken to deal with them.

A. **Types of Stress Reactions.**

1. Basic Stress.
   Minor stress encountered in daily situations that produce tension, frustration, anger and irritation. This is largely determined by an individual's physical and psychological attributes, and can generally be overcome. However, if allowed to accumulate, it can escalate beyond the point where it can be controlled, affecting the individual's disposition and work.

2. Cumulative Stress.
   This results from accumulation of stress that occurs too often, lasts too long or becomes too severe, with the end result that the individual is no longer able to cope with it. This leads to depression, work-related problems and relationship problems with his colleagues.

3. Traumatic Stress.
   This is a traumatic experience in which an individual is exposed to a single, sudden and violent physical or psychological assault, in which there is threat or harm to himself/ herself or to another individual.



4. Post-Traumatic Stress Disorder (PTSD).

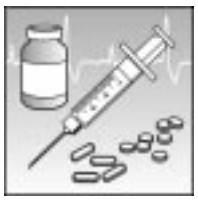
   This refers to the persistence of symptoms arising from an episode of traumatic stress (analogy of a wound that does not heal), which continues to disturb the individual and prevents him from returning to a "normal" lifestyle.

B. **Factors Contributing to Stress among Peacekeepers.**

1. Difficult or unclear mission, giving rise to frustration and/or feeling of helplessness in carrying it out, as well as loss of confidence in leadership.
2. Not professionally trained for the task at hand (e.g. Military Observer or Civilian Police, who can only monitor and report, and cannot directly intervene in the situations they are observing).
3. Need to show impartiality to different parties in a conflict, despite personal beliefs and convictions.
4. Lack of appreciation by the victims and occasionally, hostility and lack of co-operation from the local authorities.
5. Lack of security and concern about personal safety.
6. Stress related to use of weapons.
7. Need to suppress emotions.
8. Uncomfortable living conditions.
9. Separation from home, family and friends.
10. Cultural differences, language difficulties and dietary changes.
11. Lack of recreation.
12. Traumatic stress (e.g. witnessing violence or death, experiencing intimidation or threat, serious accident or life-threatening illness).

C. **Managing Stress.**

It is important to recognize the emotional, functional and physical changes accompanying stress-related reactions. While these cannot be totally prevented, awareness of such problems by an individual or his colleagues, openness in discussing such problems, and the availability of professional help should this be required, are key factors to successfully managing stress. Components of a stress prevention program include:



1. Pre-deployment screening of psychological and physical profile of key appointment holders, Military Observers and Civilian Police monitors.
2. Pre-deployment training on what to expect and how to cope with stress.
3. Ongoing health education on work-related stress, particularly how to identify sources of stress, recognize stress and take basic steps to relieve it.
4. Planned program for social activities, sports and recreation at the HQ or Unit level.
5. Group sessions for feedback and peer-sharing.
6. Debriefing of personnel following exposure to traumatic events, to be conducted in group sessions, and preferably with participation of trained counsellors.
7. Training of medical personnel to recognize signs and symptoms of stress and to manage such conditions.
8. Access to professional counselling should this be required. This is generally available at Level 2 or Level 3 medical support.

Further details on how to manage stress can be found in the "United Nations Stress Management Booklet" printed by DPKO, which is distributed to peacekeepers prior to depolyment.

Chapter

7

CASUALTY TREATMENT AND EVACUATION

7.01 Triage

Medical triage is the categorization of a patient or casualty based on clinical evaluation, for the purpose of establishing priorities for treatment and evacuation. This facilitates the effective use of limited medical resources and ensures the survival of the greatest possible number in a multiple casualty scenario. Triage is generally conducted by the most experienced doctor or paramedic. This is a continuous process as the casualty's condition may deteriorate, particularly during evacuation. It should be performed upon arrival at a medical facility and again, prior to evacuation for further treatment.

A. Classification. Different triage classifications have been adopted by international and national health care organizations. These categorize a patient or casualty according to the urgency for evacuation or treatment, taking into consideration his/ her likely prognosis. Some systems are based on trauma scoring, while others depend primarily on clinical judgement. It is important for medical units to be familiar with the triage classification and tags of other units within a Mission area.

B. Triage Categories. The UN recommends adopting a 4-category triage nomenclature based on the severity of the medical condition and urgency for treatment.

1. Priority 1 (RED: Immediate). This category has the highest priority for treatment or evacuation, as urgent resuscitative interventions are required to ensure survival of the casualty or patient. Examples include airway obstruction, respiratory emergencies, shock and severe trauma. It is likely that such cases will die within 2 hours or earlier, in the absence of appropriate medical treatment.

2. Priority 2 (YELLOW: Urgent). This comprises cases that require early treatment, particularly surgery, and it is recommended that evacuation to a surgical facility take place within 6 hours of injury. Examples include visceral injury, closed thoracic injury without threatening asphyxia, major limb injuries and fractures, closed head injury, open eye injury and moderate burns.

3. Priority 3 (GREEN: Delayed or Hold). Treatment is less urgent in this category and can be deferred if there are other casualties requiring limited treatment or evacuation assets. Examples include simple closed fractures, soft tissue injury, closed chest injury and maxillary-facial injury.

4. Priority 4 (BLACK: Expectant or Deceased). This category refers to casualties whose injuries or illness are so serious that they have minimal chances of survival or who are dead on arrival. Should there be competition for limited medical resources, such cases will have lower priority for evacuation or treatment, despite the severity of their condition. Examples include brain-stem death and terminal illness.

7.02 Treatment and Holding Policy

A. Treatment available at a medical facility is determined by the level of medical support it provides (see chapter 3). At the lower levels, the emphasis is on resuscitating a casualty and stabilizing him for evacuation to the next level. In serious injuries, definitive treatment is rarely available here and efforts should be made to minimize delaying subsequent evacuation.

B. The organization of medical resources within a Mission area is determined by the treatment and evacuation capability at each level. If difficulties or delays in evacuation are anticipated, these levels must correspondingly have greater treatment capability. The holding policy (also known as evacuation policy) within a Mission balances the treatment capability of each level against the availability of evacuation assets. This is achieved by stating the maximum period a patient may be treated at each level, following which he will be transferred if he cannot return to duty. This policy is determined by:

   1. Limitations on evacuation caused by unavailability of evacuation assets, operational constraints, weather or topography.
   2. Demand on medical resources, e.g. when large numbers of patients are anticipated, the holding duration may shorten.
   3. Availability of medical assets, e.g. at the start or draw-down of a Mission, there are relatively little facilities and holding period is relatively short.

7.03 Medical Evacuation and Repatriation

A. The responsibility for planning and establishing an effective medical evacuation system lies with the planning staff in DPKO and the administration and medical staff in the Mission area. The FMedO co-ordinates all in-theatre evacuation activities, with the support of the Mission administration and the guidance of the Medical Services Division. Details of the evacuation plan are to be included within every Mission's Standard Operating Procedures (SOP). There are three categories of patient or casualty transfer, these being:

1. Casualty Evacuation (Casevac). Evacuation of a casualty from the site of injury to the closest medical facility, which should ideally be conducted within 1 hour of injury.
2. Medical Evacuation (Medevac). Evacuation of a casualty between two medical facilities, either within the Mission area (in-theatre) or out of it (out-of-theatre). The casualty may either return to duty (RTD) within the time-frame stipulated in the holding policy, or be repatriated.
3. Medical Repatriation. Return of a patient or casualty to his home-country because of medical reasons, following which he would be unlikely to return to duty.

B. **Planning Determinants.**

1. Mission Holding Policy. As discussed above, a Mission holding policy has to be set from the onset of an operation, which dictates the maximum period (in days) a patient may be held at each level of medical care. This in turn determines the treatment capability and capacity required at each level and the supporting evacuation requirements.
2. Fitness for Evacuation. The clinical condition of a patient is the key criterion in determining timing and means of evacuation between levels of care.
3. Evacuation Time to Medical Facility. Evacuation must be conducted in a timely manner, allowing a patient requiring life or limb-saving intervention to receive this as early as possible. It is recommended that casualty evacuation to a Level 2 or 3 facility should take no more than 4 hours from the time of injury.
4. Air Evacuation. While not always possible, it is ideal to have dedicated helicopters for medical evacuation,

manned by Forward Medical Teams equipped with essential life-support equipment and supplies. Should Level 2 and/or 3 support not be available within the Mission area, rotary or fixed-wing aircraft must be made available at short notice for Medevac to such facilities.

C. **Medical Evacuation (Medevac).**

Medevac will be considered when available local medical facilities are not adequate to provide the necessary treatment. Policies and procedures concerning Medevac are as follows:

1. Internationally recruited staff members, Military and Civilian personnel may be evacuated at United Nations' expense for the purpose of securing essential medical care or treatment not available within the Mission area. Locally recruited staff, their spouses and dependant children may be evacuated in emergency situations when the medical risk is very high or when a life-threatening condition is present
2. In emergency situations, the Chief of the Mission or Force Commander may directly authorise medical evacuations, after consultation with the FMedO and the Chief Administration Officer (CAO). Prior approval by UN HQ is not required within the Mission area.
3. Evacuation may be by land or air transportation and should be to the closest appropriate medical facility to the duty station. The nature of illness or injury, the type of treatment required and the language spoken must also be taken into consideration. The use of dedicated means of transport clearly marked with the Red Cross/ Red Crescent insignia is preferred.
4. It is essential that the patient's pre-evacuation and in-flight treatment is adequately documented and accompanies the patient to the next medical facility. If indicated, travel of an accompanying doctor or nurse may be authorized.
5. For childbirth, psychiatric conditions and illnesses requiring prolonged recuperation, medical evacuation to the place of home leave or repatriation to the home country should be encouraged.
6. Should a staff member prefer medical evacuation to his/ her place of home leave, as opposed to the recommended

place of evacuation, such travel may be authorized as advanced home leave.

7. Should a nation prefer to evacuate its own personnel contrary to the opinion of the medical officer in charge or the FMedO, it becomes a national responsibility and at the nation's expense.

8. In non-emergency cases, UN HQ approval is to be sought prior to Medevac. In emergencies, this is not required, although UN HQ is to be informed immediately after Medevac has taken place. These are to be submitted to the Field Administration and Logistics Division (FALD) and the UN Medical Director, according to the format outlined in *Annex 7-1.*

9. After having been certified fit by the attending doctor, a copy of the certificate should be forwarded to the Director, MSD, who will either approve or deny return to the duty station. In cases of serious illness or injury, the patient may not return to duty at UN cost prior to approval by the Medical Director. This does not apply for non-emergency cases.

10. Procedures for Medevac of Military personnel must be detailed in the Standing Operations Procedure (SOP) for the Mission. Guidelines for Medevac of UN staff are outlined in the UN Field Administration Manual (Manual 4), while further details can be found in the Revised ST/AI on Medical Evacuation.

D. **Medical Repatriation.**

Medical repatriation is evacuation of a patient or casualty back to his/ her country or parent duty station. Policies and procedures concerning repatriation are as follows:

1. Repatriation on medical grounds apply to all personnel who are unlikely to be fit to return to duty based on the holding policy (evacuation policy) established, or who require treatment not available within the Mission area. In general, 30 days is the accepted guideline for holding policy.

2. Medical repatriation is the responsibility of the FMedO, in co-ordination with the respective national contingent commander and the Chief Administration Officer (CAO).

Once an individual is repatriated, further medical care is a national responsibility.

3. Military personnel arriving in the Mission area who are unfit for duty will be repatriated immediately at the nation's expense. If repatriation is required for a chronic medical condition diagnosed or under treatment at the time of Mission assignment, expenses may have to be borne by the Troop Contributing Country.
4. Pregnant women should be repatriated by the end of the fifth month of gestation.
5. All personnel with clinical symptoms or signs of AIDS must be repatriated.
6. Authorization for repatriation must be obtained in advance from the Director, Medical Services Division. A written recommendation must be submitted by the FMedO or doctor in charge, regardless of whether costs are to be borne by the UN, a national government or the individual concerned. Requests for medical repatriation must be made using the format outlined in *Annex 7-1*. Once authorized, the CAO proceeds to arrange repatriation by the Mission or contingent via the most economical means.
7. If possible, regular rotation or scheduled service flights should be utilized for repatriation. Payment of travel subsistence allowance and terminal expenses may be authorized in cases undertaken at UN expense, and baggage allowance is identical to that of personnel rotated on an individual basis. Should an escort be required, this is limited to the free allowance granted by the airline and in accordance to existing rules and regulations.
8. For cases requiring urgent medical repatriation, military or civilian aircraft may be contracted. The UN has since 1989, maintained a standing arrangement with the Government of Switzerland regarding air ambulance services for peacekeeping operations. These services are provided by *La Garde Aerienne Suisse de Sauvetage* (REGA). It has to be noted that REGA provides medical staff and equipment during the evacuation.

7.04 Arrangements Concerning the Deceased

In the event of death of military or civilian personnel, it is imperative that all arrangements for preparation and transport of remains of the deceased are made in conformity with the practices of the government concerned. In the event of death of a UN staff member, the CAO will notify the Medical Services Division, the Medical Support Unit and FALD.

A. Ad hoc Committee.

Upon the death of a member of a Mission, a committee is convened comprising the CAO, Chief Finance Officer, Legal Adviser, FMedO and a representative of the respective national contingent. This committee will review the incident leading to the death, determine management of remains, decide on ceremonies (if any) to take place and appoint an escort.

B. Documentation. The CAO will prepare all necessary documentation, including the travel authorization and documents required by the host government and airline used. In the case of UN staff, 6 copies of the Death Certificate are required, which are to be forwarded to different offices listed under paragraph 13 of the Personnel Directive. All pertinent information is to be relayed to UN HQ in New York and to the country concerned.

C. Autopsy. An autopsy will be performed only if considered necessary from a medical or legal view-point. In view of possible religious or other implications, prior approval by the Contingent Commander and the host government is required.

D. Travel Arrangements. The CAO is responsible for arranging transport of remains to the home country. All arrangements shall be covered by form PT8 in accordance to existing rules and regulations. An escort from the same contingent shall be appointed to accompany the remains and to attend funeral rites and ceremonies in the home country on behalf of the Force Commander.

E. Use of UN Flag. A UN flag will be issued to the escort, to be used for draping the casket during ceremonies in the Mission area and in the home country. The flag shall not be disposed along with the remains of the deceased, but may be given to the next-of-kin of the deceased, if such a wish is expressed.

7.05 Notification of Casualty (NOTICAS)

A. In the event of serious injury, permanent disability or death of a Military member of a Mission, the Unit Commander is to immediately notify the Mission HQ, which will inform UN HQ of the incident through a *preliminary cable*. In the event of death, the unit concerned will advise its national headquarters to inform the next of kin and to notify the Mission HQ when this has been done. No mention of the deceased's name will be made in any public statement before such notifications have been completed. If internationally or locally recruited civilian staff members are involved, the responsibility lies with the CAO.

B. A *Notification of Casualty (NOTICAS)* is subsequently prepared by the Chief Military Personnel Officer of the Mission, containing the casualty's personal data and a brief description of the incident and circumstances under which it occurred. This is to be authorized by the CAO prior to submission to UN HQ. Should there be any change in status of the patient, UN HQ is also to be informed, citing the initial NOTICAS as a reference. Copies are to be submitted to the following agencies at UN HQ:

   (1) Situation Center, DPKO

   (2) Personnel Management and Support Service (PMSS/ FALD/ DPKO)

   (3) Medical Support Unit (MSU/ FALD/ DPKO)

   (4) Military Adviser's Office or Civilian Police Unit (for military and civilian police personnel respectively)

   A sample format of the NOTICAS, including information required is shown in *Annex 7-2*.

C. In the case of UN staff members, a *Medical Statement* by the attending physician will have to be completed in duplicate and forwarded to the Medical Director, Medical Services Division. A copy of this form is attached as *Annex 7-3*.

D. For purposes of official documentation for compensation and claims, a "*Report of Accident or Illness*" is subsequently prepared by the Medical Director, Medical Services Division. Copies of this are distributed to the Advisory Board on Compensation Claims (ABCC) and the Security and Safety Section. A copy of this form is attached as *Annex 7-4*.

7.06 Mass Casualty and Disaster Management

This section refers specifically to situations involving UN personnel, while the provision of humanitarian assistance to the local population will be considered separately. All medical units have to prepare for mass casualty situations and disasters within the Mission area. Contingencies must be planned and resources allocated at the beginning of a new mission, and co-ordinated in line with the Mission's operational and security plans. Plans should be prepared at each level, from the Team Site through the Contingent HQ, Sector HQs and up to Mission HQ level.

A. **Definition.**

A mass casualty situation or disaster is a temporary situation, during which insufficient resources are available to manage the multiple casualties, thereby increasing the likelihood of morbidity and death. This can be the result of a natural or man-made catastrophe, and may be accompanied by substantial material damage to infrastructure and environment.

B. **Medical Support.**

1. In the acute phase, medical units will mobilize all their available resources to provide immediate support. This includes establishing First Aid posts and Medical Regulation Centers at the incident site, as well as to support search and rescue activities.
2. Triage is important here to establish priority for treatment, and for evacuation by land and air to UN, local and NGO medical facilities. It is essential that evacuation of casualties to these facilities is centrally co-ordinated and managed.
3. Treatment provided at the site should be limited to Basic Life Support and casualty resuscitation. The primary objective is stabilization of the injured and their evacuation to adequately staffed and equipped medical facilities.
4. Brief documentation of casualty data, injuries and treatment provided should accompany all casualties. If available, triage tags should be attached.
5. Managing the dead should be planned, including on-site identification (if possible). Close co-operation with the local administration is required to ensure smooth handling

and transfer of remains for definitive identification and burial.

C. **Planning Guidelines.**

1. Identifying risk factors and potential threats, including hostile acts by local parties.
2. Preparing inventory of available medical resources within the Mission area, including evacuation assets and local infrastructure.
3. Contingency planning to include grouping of medical units, defining areas of responsibility and individual tasks, identifying potential casualty holding areas and evacuation routes.
4. Forming Ops Center to centralize medical resource allocation and co-ordination of evacuation.
5. Communications plan including allocation of radio resources and co-ordination with other UN agencies, national authorities and NGOs.
6. Logistics support, including medical supplies.
7. Special medical requirements, including medical debriefing and stress management of victims, rescue and medical personnel.

APPROVAL FORM FOR MEDEVAC / REPATRIATION				
The following information should be submitted to PMSS/DPKO, MSU/DPKO and MSD/DAM for requesting approval of a planned MEDEVAC/ REPATRIATION (Please tick where applicable):				
Personal Information				
International UN Staff:	Locally recruited staff:	MilObs:	CivPol:	Military:
Name (last, first, middle):				
Date of birth:			Passport/VISA No:	
Rank/ Title:			SVC/ Index Number:	
Duty Station:			Nationality:	
Home Address:				
Home Telephone Number:				
MEDEVAC:			**REPATRIATION:**	
Due to:	Illness:	Accident:	Injury:	Death:
	Others:	Specify		
Medevac/ Repatriation requested from:				
Name of Location/Hospital:				
Address of Location/Hospital:				
Telephone and Fax Number:				
Name of Contact Person:				
Port/ Railway Station/ Airport:				
Medevac/ Repatriation Requested to (destination):				
Name of the Hospital:				
Address of the Hospital:				
Telephone and Fax Number:				
Name of Contact Person:				
Airport				
Medevac/ Repatriation means:				
Date of Requested Medevac/ Repatriation:				
Accompanying REGA Personnel Necessary:			Yes:	No:
Accompanying Personnel/ Profession Requested:				
Expected Date of Return to Duty:				

The following additional information is to be submitted to MSD/ DAM and MSU/ DPKO only. Medical information is confidential and should be treated as such, whether within offices or during transmission to UN HQ.	
How, where and when did the accident, injury or illness occur:	
First hospitalization:	
From:	Until:
Hospital:	
Diagnosis:	
Treatment:	
Present hospitalization:	
From:	Until:
Hospital:	
Current Diagnosis:	
Treatment:	
Present Health-Status:	
Special Treatment and Equipment Required During Transport:	
Other Comments:	

The Director, Medical Services Division, UN HQ, can be reached at:

Telephone:	USA-212-963-7082 (during office hours) USA-212-963-6666 (after office hours – through DPKO Situation Centre)
Fax:	USA-212-963-4925

Swiss Air Ambulance (REGA) - can be reached as follows:

Telephone:	* 41-1-385-8585
Emergency:	* 41-1-383-1111
Fax:	* 41-1-385- 8315

NOTICAS							
MISSION:							
NOTICAS NO:				**DATE:**			
1	**Service No.**						
2	**UN ID No.**						
3	**Rank / Civilian equivalent**						
4	**Name** Last First Middle						
5	**Date of Birth**						
6	**Sex**	Male □			Female □		
7	**Nationality**						
8	**Next of kin** Name Address Tel. Relation						
9	**Service category***	MILOB □	CIVPOL □	Troop □	STAFF-I □	STAFF-L □	Others □
10	**Status at time of incident**	On Duty □			Off Duty □		
11	**Casualty type**	Injury □	Illness □	Death □	Missing □		
12	**Incident category**	Accident □	Disease □	Hostile Action □	Others □ Specify:		
13	**Incident** Date Time Location						
14	**Circumstances**						
15	**Remarks**						

** MILOB – Military Observer, CIVPOL – Civilian Police Monitor, Troop – Military contingent member STAFF(I) – UN international staff and UN Volunteer, STAFF(L) – UN Local contracted staff*

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MEDICAL STATEMENT TO BE ANSWERED BY THE STAFF MEMBER'S PHYSICIAN To be forwarded in DUPLICATE to the Medical Director, United Nations, New York, N.Y. 10017		
1	Name of Patient: Home Address:	
2	Place of accident or onset of illness:	
	Date:	Time:
3	Date of first treatment:	
4	Describe in patient's own words how accident or illness occurred:	
5	Describe the nature and extent of injury or illness, and specify all parts of the body involved:	
6	Treatment given:	
7	Probable duration of treatment:	
	Is patient working? Yes: □ No: □	If not, is the patient able to work? Yes: □ No: □
8	If patient is not working and is unable to work, state probable duration of disability:	
9	Was patient unconscious? Yes: □ No: □ If so, for how long?	
10	Were X-rays taken? Yes: □ No: □	
11	Is patient in hospital?Yes: □ No: □ If so, name of hospital:	
12	In your opinion, was the accident, as above described, the cause of injury sustained?	
13	Is the injury or illness likely to result in permanent impairment? Yes: □ No: □ If so, what?	
14	Is patient still under your care? Yes: □ No: □ If not, name and address of attending physician:	
Date:	Signature: (Attending Physician)	

UNITED NATIONS NATIONS UNIES

REPORT OF ACCIDENT OR ILLNESS			
Form to be completed in TRIPLICATE by the Medical Director and distributed as follows: (a) Secretary, Advisory Board on Compensation Claims (b) Security and Safety Section - (Accident Cases) (c) File copy for the Medical Director of the United Nations			
1	Name: (Mr., Mrs., Miss)		Date of Birth:
2	Home Address:		Home Tel. No.:
3	Department, Division, Section:	Tel. Ext.:	Name of Supervisor:
4	Occupation		
5	Place of accident, or onset of illness:	Date: Time (a.m./p.m.):	Date disability began:
6	Details of how accident or illness occurred (as related by staff member):		
7	Name of witness(es):		
8	State nature of injury or illness:		
9	Did you provide medical care?		If so, when?
10	Did you refer staff member to a physician?	□ Yes □ No	If yes, when?
11	Probable length of absence from work:		
12	In case of illness, is the disease endemic in, and peculiar to, the area where onset is stated to have occurred:		
13	In your opinion, was the accident, as described under Item 7, the cause of the injury sustained?		
14	Will the injury or illness result in permanent impairment?		If so, what?
15	Does the Medical Service record disclose any other facts pertinent to the formulation of a conclusion in this case?		
Date:		Signature: (Medical Director)	

Chapter

8

MEDICAL LOGISTICS

8.01 Introduction

Medical logistics has a number of unique characteristics that require specialist technical knowledge and management, and which is essential to ensure continuity of treatment in the field. In UN peacekeeping missions, the following considerations are important in planning medical logistics support:

A. The lack of standardization in formulating, packaging and labeling medical supplies and drugs, which are generally produced for national markets. The use of trade names in place of generic names, and labeling in foreign languages present particular problems to medical personnel in the field.

B. Differences in clinical regimes and protocols adopted by doctors from different countries and backgrounds. Doctors from developing nations may be unfamiliar with expensive, third generation pharmaceutical products and new medical equipment widely in use in more developed countries.

C. The need to maintain high quality control of medical supplies and equipment, ensuring that these meet accepted international standards.

D. The generally limited shelf-life of medical products, which requires tight control of inventory to ensure constant availability of supplies and to minimize wastage.

E. Special transport and storage requirements for certain medical products, including the need to maintain the cold-chain during transport (e.g. vaccines, blood products) and for refrigeration.

8.02 Categories of Medical Logistics Support

Medical logistics support can be broadly categorized into the following:

A. **Medical services.**
This encompasses the provision of primary healthcare, preventive medicine, emergency medical treatment and casualty evacuation services to the peacekeeping force. In addition, treatment capabilities required may include dental care, specialist medical treatment including surgery, laboratory and radiological investigations.

B. **Medical supplies.**
This encompasses the procurement, transportation, distribution, storage and accounting of medical supplies, pharmaceuticals, consumables, blood products and medical stationery, to ensure the continuous running of medical facilities deployed in the field.

C. **Medical equipment.**
This refers to Minor equipment required for the routine operation of medical facilities, as well as Major and Special Case equipment and instruments, including mobile medical containers and their auxiliary units.

D. **Maintenance of equipment.**
This covers periodic preventive maintenance of medical equipment, as well as all repairs, including labour costs, spare parts and transportation (if required). Maintenance services may be provided by the UN, troop-contributing country, international contractor or local contractor, depending on the type of lease established.

8.03 Medical Standards and Quality Control

In UN peacekeeping missions, there is a requirement for standard categorization and nomenclature of medical products, in view of the need to cater for multi-national medical units and personnel. This enables users of different national backgrounds to identify the product and ensures greater safety in prescribing, dispensing and administering drugs. This also facilitates requisition, the international bidding process adopted by the UN, and regulates medical supply through national channels. There is also a need to maintain high standards of quality control of products, to ensure that these can be confidently used in the field.

A. **UN Catalog of Medical Items for Peacekeeping Operations.**
It is recommended that the generic names of medical products and pharmaceuticals are used instead of trade names. In 1996, UN HQ introduced a Medical Catalog listing the generic names in English (INN) of more than 1000 essential drugs and consumables commonly used in field missions. This includes detailed specifications of formulation, strength, packaging, shelf-life and storage conditions for these products. This serves

as a reference guide for medical requisitions for UN field missions, and its use is recommended to avoid incorrect or incomplete requisitions. A copy of the catalog can be obtained from the MSU/DPKO upon request.

B. **Quality Control and Assurance.**
Steps have to be taken to ensure that drugs supplied are of acceptable quality and have a reasonable period of remaining shelf-life. These must be properly stored, packaged and transported, meeting any special conditions stipulated. Recommendations on the procurement of drugs and medical supplies, as well as packaging and labelling requirements are included in *Appendix 3*.

8.04 Responsibility for Medical Logistics Management

A. The overall planning and budgeting for medical logistics for UN missions is the responsibility of the **Medical Support Unit (MSU)** which is part of the Field Administration and Logistics (FALD). A technical survey is first conducted in the potential Mission area, following which a concept of operations is developed and the specific medical requirements determined. Negotiations then take place with potential troop-contributing countries for the deployment and sustenance of medical units in accordance to standards stipulated by the UN (UN Levels of Medical Support). A contract is finally established between the UN and the respective country regarding the provision of these services.

B. Medical resupply and maintenance of medical equipment are generally the responsibility of the **troop-contributing country (TCC)** under the new system of Contribution Agreement. This, as well as the old system still in place in earlier missions, will be described subsequently.

C. The **FMedO** is responsible for planning and managing medical supplies and equipment within the Mission area. In larger Missions, he may be assisted by a Medical Supply Officer or pharmacist. He is required to work closely with the Chief Logistics Officer or Chief Admin Officer (CAO) to establish an effective medical logistics system.

D. As it often takes time to establish a functioning medical supply chain for new missions, a medical unit should remain self-

sufficient without resupply for an initial period of 60 days, including all pharmaceuticals and consumables. The **Medical Unit Commander** is responsible for accounting for medical supplies and to initiate the request for additional supplies should these be required.

8.05 Reimbursement of Troop Contributing Countries

There are currently 2 systems for reimbursing Troop Contributing Countries (TCCs) for services and supplies provided for a UN Mission. The new **Contribution Agreement** system reimburses TCCs based on a fixed monthly rate on a per capita basis according to UN standard requirements. The old system still in place in some of the older missions, entails a **Letter of Assist (LOA)** Arrangement, in which the UN reimburses the TCC for the cost of goods and services, as well as the depreciation value of equipment, in accordance to agreed guidelines. Alternatively, the UN may take responsibility for provision of equipment and supplies. Advantages of the new system are as follows:

A. This simplifies accounting and logistics management, reducing the administrative workload for the peacekeeping Mission, UN HQ Secretariat and TCC.

B. It standardizes reimbursement rates on an equitable basis, and allows for more precise budgeting for Missions by both the UN and the TCC. There is also less delay in reimbursement of the TCC, as this is no longer worked out "post facto" after deployment.

C. It allows standards to be applied to services, supplies and equipment provided by TCCs, providing for transparency of deployment, accountability, as well as a degree of quality assurance.

D. Resupply through a national channel is likely to be more responsive than the UN procurement system, which often requires a tender and evaluation process for the required equipment or supplies.

8.06 Contribution Agreement based on Standard Reimbursement Rates

This new system, which has been adopted for peacekeeping missions after 1 July 1996, requires the UN HQ and TCC to sign a Contribution Agreement (or Memorandum of Understanding, MOU) prior to deploying in the peacekeeping mission. This stipulates the level of medical support and types of services to be provided by the TCC, as well as any financial obligations on the part of the UN.

A. This system caters for 2 main categories of reimbursement:

1. Reimbursement (contract) for medical services, supplies, consumables and medical equipment under a self-sustainment arrangement.
2. Reimbursement (contract) for Major equipment and Special Case equipment under a wet or dry lease contract.

B. **Self-sustainment Arrangement for Medical Services and Supplies.**

All medical services, supplies, consumables and minor medical equipment will be reimbursed based on a standard self-sustainment rate according to the supported strength within the Mission area.

1. Self-sustainment covers all necessary medical treatment, equipment, instruments and supplies required for the day-to-day running of the medical facility. Medical resupply, related transportation costs and maintenance of Contingent Owned Equipment (COE) remain the responsibility of the TCC.
2. Standard elements of this system, including current rates of reimbursement (calculated in USD per capita per month) are as follows:

Medical – Basic	2.00
Medical – Level 1	16.25
Medical – Level 2	37.50
Blood & Blood Products	13.00
Dental	10.00

3. Medical items are not subject to accountability upon entry into and departure from the Mission area, but should be subjected to inspection and verification to ensure that they meet agreed standards. Should a contingent provide less

equipment or supplies than that stipulated in the agreement, the TCC will only be reimbursed for the actual numbers. On the other hand, any personnel, equipment or supplies over and above the agreed numbers remain the sole responsibility of the TCC and are not subject to reimbursement by the UN.

4. Should a TCC under a Contribution Agreement receive medical supplies through the UN or another country, any costs incurred will be deducted from the reimbursement amount.

5. In exceptional cases, the UN may request a specific service from the TCC under a Letter of Assist (LOA) agreement. This will be discussed subsequently.

6. Details concerning the above can be found in the "Manual on Policies and Procedures Concerning Reimbursement and Control of Contingent Owned Equipment of Troop Contributing Countries Participating in Peacekeeping Missions" published by DPKO in 1996.

C. **Reimbursement for Contingent-Owned Equipment (COE).**

In addition to self-sustainment rates, TCCs are also reimbursed for use of and depreciation in value of contingent-owned equipment (COE).

1. In the case of medical equipment, this is applicable only for Level 2 and above medical support. Such equipment provide force-level medical support and have to be specified within the Contribution Agreement.

2. Reimbursement of standard **Major Equipment** is based on generic fair market value rates. However, most medical equipment fall under a **Special Case** category, where standard rates of reimbursement have not been defined, but are determined based on the original cost, age of the equipment and specific mission factors. The Medical Support Unit will be required to review the TCC's equipment costing submission to advise on an acceptable rate of reimbursement.

3. **Wet Lease Rate**: Equipment must be provided and maintained in fully operational condition. Reimbursement based on a Wet Lease rate requires the TCC to provide the

major equipment, accessories, spare parts and any necessary maintenance and repairs.

4. **Dry Lease Rate**: Reimbursement based on a Dry Lease rate requires the TCC to provide only the major equipment and accessories, while the UN takes responsibility for maintenance and spare parts.
5. Recommended lists of standard medical equipment and supplies required for each level have been established by the Medical Support Unit (see *Appendix 2*). These provide a guide to TCCs for configuring medical units for peacekeeping operations and ensure that these are able to meet operational requirements and expected treatment capabilities.

8.07 Letter of Assist Arrangement

A Letter of Assist (LOA) is a document issued by the UN to a government or agency, authorizing the provision of goods or services to a UN peacekeeping mission. Reimbursement will be made for the cost of the goods or services, as well as for depreciation value of equipment in accordance to agreed guidelines.

A. In the case of medical support, LOAs may be raised for the following:
    1. Medical services
    2. Medical supplies and consumables
    3. Maintenance and depreciation of COE
    4. Spare parts
    5. Transport of equipment and personnel
B. According to financial rules and regulations of the UN, LOAs may be issued only for goods and services that are:
    1. Of a strictly military pattern or nature;
    2. Not of a strictly military pattern or nature but:
        (a) Of a volume available only through a government or where the exigencies of the mission render piecemeal procurement impractical;

(b) Require transportation services for the movement of UN military personnel or goods to or from a Mission area, which are not readily available commercially; or

(c) Where specific requirements peculiar to a contingent are obtainable only from their own country and if these expenses are not higher than those incurred by commercial procurement.

C. With the newly established Contribution Agreement system, it is DPKO's policy to establish contracts based on LOAs only in exceptional cases, except in some of the older missions which have not adopted this system.

8.08 Other Arrangements

A. **In and Out Survey Arrangement.**
Another method of reimbursement for the provision of COE is to establish a contract under an In and Out Survey arrangement. This survey provides the basis for reimbursement and depreciation claims. Reimbursement is based on a flat rate and calculated as a percentage (generally 6-10%) of the actual value of the COE per year.

B. **Resupply by UN.**
Under special circumstances, medical equipment and supplies may be provided by the UN. This includes procurement by UN HQ or local procurement by the Mission, resupply through UN medical depots and warehouses, as well as donation of supplies and equipment through other UN agencies. If a TCC receives medical supplies through the UN in spite of a Contribution Agreement, any costs incurred will be deducted from the reimbursement amount.

8.09 Raising a Requisition

With the new Contribution Agreement system, medical equipment and supplies are provided by the TCC and arranged through national logistics channels. On occasion, there may be a requirement for a medical unit to raise requisitions for medical items through the UN procurement channel. In the case where there is a designated lead nation taking overall responsibility for medical support, a collective requisition may be raised by the respective medical unit on behalf of

other units in the Mission area. The following are to be noted with respect to medical requisition by the Mission:

A. All requests must be validated and approved by the FMedO, who is responsible for supervising the procurement, distribution and utilization of medical supplies in a cost-effective manner. In certain missions, he has the assistance of a Medical Supply Officer or pharmacist.

B. In Missions with a medical store or warehouse, the FMedO may direct the use of items here if these are in stock, or propose appropriate alternative if these are available.

C. Approved requisition requests are passed to the Chief Administration Officer (CAO), who will initiate procurement action which is determined by the availability of the item in the region and whether the estimated value falls within his financial limits. This could be based on direct quotations, but may require competitive bidding and involvement of the Local Committee of Contracts (LCC). If the item cost is beyond the CAO's and LCC's financial authority for regional procurement, this will be referred to UN HQ.

D. At UN HQ, the request is validated by the Medical Support Unit before being sent to the Field Administration and Logistics Division (FALD) and/or the Procurement and Transport Division (PTD). This may require the raising of an LOA and/or referral of the case to the HQ Committee on Contracts (HCC). A flow chart illustrating the procurement process is shown in *Annex 8-1*.

E. To avoid problems concerning reimbursement, it is important that a TCC or medical unit seeks approval from DPKO for the provision of medical supplies and equipment prior to shipment into the Mission area. This is with the exception of national resupply for items reimbursed under self-sustainment rates.

F. It is important that medical requisitions observe the following guidelines:

    1. Generic names of pharmaceutical products are to be used instead of trade names, and the serial number of the item according to the UN Catalog of Medical Items for Peacekeeping Operations is to be quoted (see *Appendix 3*). Proprietary products will only be accepted when a generic equivalent is unavailable.

    2. Requisition requests must include all relevant specifications, including type of formulation, strength and

quantity required. A copy of the standard procurement form is attached as *Annex 8-2*.

3. To facilitate management of medical procurement, it is recommended that a separate requisition form is raised for each of the following categories of medical items:
   (a) Drugs
   (b) Medical consumables
   (c) Dental medicines and consumables
   (d) Laboratory items and consumables
   (e) Hygiene items and consumables
   (f) X-ray items and consumables
   (g) Medical equipment, instruments and accessories
4. Where possible, disposable medical supplies and equipment are to be requested. If reused, medical products must be sterilized in accordance with internationally accepted standards. Level 1 medical units are to have at least basic facilities for chemical sterilization, while Level 2 and 3 units should have proper facilities for both chemical sterilization and autoclaving.

8.10 Receiving & Inspection Reports

The Procurement Section in a field mission is responsible for receiving, inspecting and certifying acceptance or rejection of all items purchased and/or received. These supplies and equipment are then certified using the Receiving and Inspection Report (R&I Report).

A. Should a delivery of supplies and/or equipment be rejected, the reasons for rejection will be noted within the R&I Report.

B. It should be noted that the R&I Report is required for any claims of reimbursement, including for LOA agreements. It is therefore important that these reports are promptly issued and completed documents forwarded by the Mission administration to FALD.

8.11 Disposal of Medical Waste

The FMedO is required to advise the CAO and/or Chief Logistics Officer on the proper disposal and destruction of medical wastes and expired medical products (drugs and consumables). This involves accounting for and writing-off expired items and supervising their disposal by burial or incineration according to internationally accepted procedures. Particular attention must be paid to the disposal of biohazard materials. The FMedO is responsible to ensure that all medical units within the Mission area comply with these standards.

8.12 Blood and Blood Products

The provision of blood and blood products is one of the critical concerns of medical support in the field. This has to meet exacting standards of quality assurance, which begins with collection, processing and testing, and continues with proper transport and storage.

A. Blood and blood products should be available in Level 2 medical facilities, particularly if evacuation time to the next level of medical support is anticipated to exceed 3 hours. This must be available in Level 3 and 4 hospitals.

B. All blood products (blood, blood components and plasma derivatives, including some vaccines) must meet the latest WHO requirements for the collection, processing and quality control of such products. Testing for the following are required:

   1. Erythrocyte antibodies
   2. Treponema agglutination test
   3. HIV 1 and 2
   4. Hepatitis C virus
   5. Hepatitis B surface antigen
   6. ALT (alanine aminotransferase) / GPT (glutamic pyruvic transaminase)

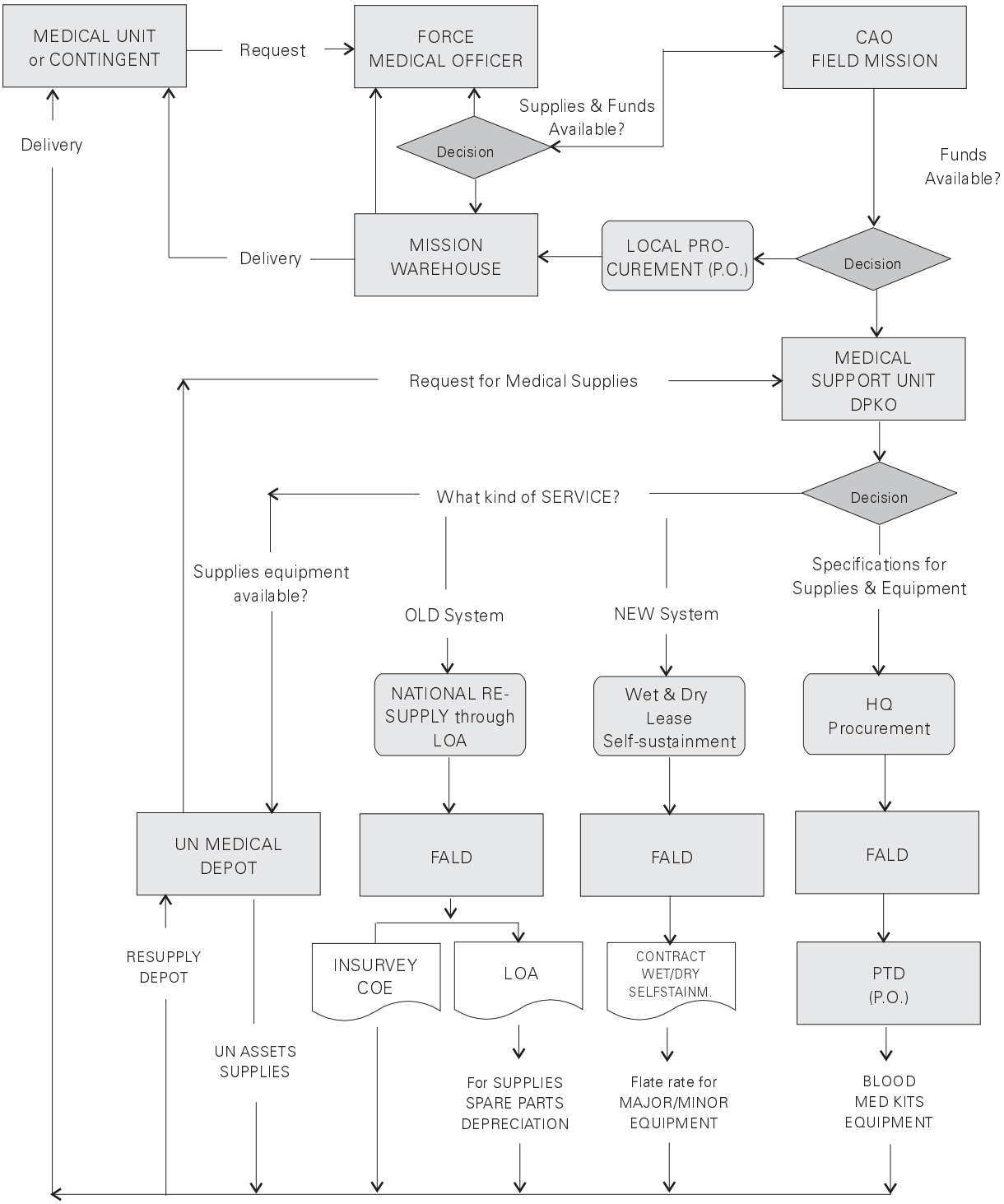
C. To maintain the highest standards for blood and blood products, UN HQ generally co-ordinates their central procurement and transport into the Mission area. Where national blood supply standards meet those stipulated by the UN, the TCC may be requested to supply this under a self-sustainment agreement.

D. Should a contingent request a national supply of blood products without UN authorization, its use is limited only to their nationals and will be provided at their own risk and at no additional expense to the UN.

E. In large-scale emergencies where it is imperative to obtain blood from the field, great care must be taken to ensure quality control. The donor's personal and medical history must be documented, including history of recent illness and unprotected sex with sex workers. Emergency blood is to be used only based on the clinical decision that it is mandatory to save a life. The FMedO is required to establish a blood support plan for such contingencies.

F. Blood or packed red cells must be maintained at a temperature of between +5°C to +8°C or 41°F to 46°F during transport and storage (the cold chain must be maintained at all times). A special blood refrigerator or blood box must be available at Level 2 and above medical units for this purpose, ideally with temperature control and alarm, as well as back-up power supply.

G. All transfusions will only be performed after full compatibility cross-matching in accordance with international standards. This will not be carried out based exclusively on records, labelling or verbal information on blood types.


MEDICAL UNIT or CONTINGENT
Request
FORCE MEDICAL OFFICER
CAO FIELD MISSION
Supplies & Funds Available?
Decision
Delivery
Funds Available?
Delivery
MISSION WAREHOUSE
LOCAL PRO-CUREMENT (P.O.)
Decision
MEDICAL SUPPORT UNIT DPKO
Request for Medical Supplies
What kind of SERVICE?
Decision
Supplies equipment available?
OLD System
NEW System
Specifications for Supplies & Equipment
NATIONAL RE-SUPPLY through LOA
Wet & Dry Lease Self-sustainment
HQ Procurement
UN MEDICAL DEPOT
FALD
FALD
FALD
RESUPPLY DEPOT
INSURVEY COE
LOA
CONTRACT WET/DRY SELFSTAINM.
PTD (P.O.)
UN ASSETS SUPPLIES
For SUPPLIES SPARE PARTS DEPRECIATION
Flate rate for MAJOR/MINOR EQUIPMENT
BLOOD MED KITS EQUIPMENT

REQUISITION FORM FOR MEDICAL SUPPLIES AND EQUIPMENT

Originator: ..... Date of request:.....

Requesting unit:.....

Suggested Vendor:.....

Shipment by: Air □ Sea □ Road □ Suggested date of arrival:.....

Shipping address: .....

Field Requisition No:..... Account code:.....

CATEGORY OF MEDICAL ITEM*: .....

ID NO.	GENERIC DESCRIPTION	TYPE	STR.	ADDITIONAL INFORMATION	QTY	UNIT PRICE	TOTAL COST(US$)
TOTAL AMOUNT (US$)							

All requests should be made according to the "Catalogue of Medical Items for Peacekeeping Operations" and the ID Numbers according to this are to be quoted in the first column. Generic names of all products are to be used. Trade names shall only be added when this is the specific proprietary product requested. In this case, the country of manufacture and if possible, the manufacturer, should be identified in the "Additional Information" column, along with other information that may assist in identification of the product.
All requests are to be printed clearly in the English language.
All cells must be filled, except the "Unit Price" column (shaded grey).
** Please note that requisitions for each of the following 7 categories are to be raised separately:*
Drugs, Medical consumables, Dental medicines & consumables, Laboratory items & consumables, Hygiene items & consumables, X-ray items & consumables, Medical equipment, instruments & accessories.

Chapter

9

MEDICAL RECORDS AND REPORTS

9.01 Medical Records and Documentation

Accurate documentation is an integral part of medical care and enables the provision of optimal treatment through the various levels of medical support. This includes recording of significant medical findings, the treatment plan, as well as any treatment provided. This has to be recorded at every level and should accompany the patient or casualty to the next medical facility. Good medical records further facilitate easy processing of administrative matters like medical claims, compensation and determining the degree of disability.

A. Medical documentation commences prior to deployment of military or civilian personnel into a Mission area. All personnel participating in a UN operation are required to submit their health records to the medical authorities within the Mission area. This information should include a summary of significant medical history, current medical treatment (if any), known drug allergies, blood grouping and an updated international certificate of vaccination.

B. These records are to be securely filed by the respective medical unit or authority responsible for the daily health-care of the individual. Personal medical records are to be treated as "Medical-in-Confidence" and should not be provided to anyone not directly involved in patient care (see *Chapter 5.05*).

C. If illness or injury occurs, the diagnosis and treatment provided must be accurately documented in these records, including any medical leave issued. As patient or casualty care may be disrupted by his receiving treatment by different doctors at different levels of medical support, there is a need to outline a clear treatment plan at each medical facility. Patient progress must also be periodically recorded under the "Progress Notes".

D. The medical records are to accompany the patient or casualty during evacuation to the next level of medical support, including repatriation to his home country. These must be properly sealed and marked with the instructions "Medical-in-Confidence - To be Opened by Addressee Only."

E. Upon ending his tour of duty or completion of a Mission, the health records are to be issued to the respective individual or unit in a sealed envelope, to be handed over to the respective national health authority or to his regular physician.

F. Should a medical unit be repatriated, all medical records are to be handed over to the unit replacing it, or in the absence of the latter, to the Mission HQ. No medical or treatment records should be left unattended within the Mission area, and if these are no longer required, should be destroyed or repatriated with the respective unit.

9.02 Medical Reports

Routine medical reports are important in medical support operations to constantly inform and update senior Mission personnel and UN HQ on the medical status of the Mission. These provide indicators of the capabilities of medical units and their daily utilization, as well as reflect the overall health status of Mission personnel. The information is maintained in the medical component of the DPKO Peacekeeping Database, and is useful to monitor trends and to analyze data, with the view of implementing timely corrective measures and improving medical support.

A. The FMedO is responsible to ensure that all information pertaining to the medical care of military and non-military personnel in a UN operation are reported accurately and in a timely manner. He oversees the collection and compilation of data from medical units within the Mission, and submits this to the Medical Support Unit (MSU/ DPKO). All medical units, including those in national contingents, must comply with the FMedO's instructions on reporting procedures.

B. Information on serious injuries and diseases requiring Medevac or hospitalization must be submitted as soon as possible to UN HQ. This is required for entry into the Peacekeeping Database.

C. There are basically three types of reports that the FMedO is required to submit to the MSU. These are outlined as follows:

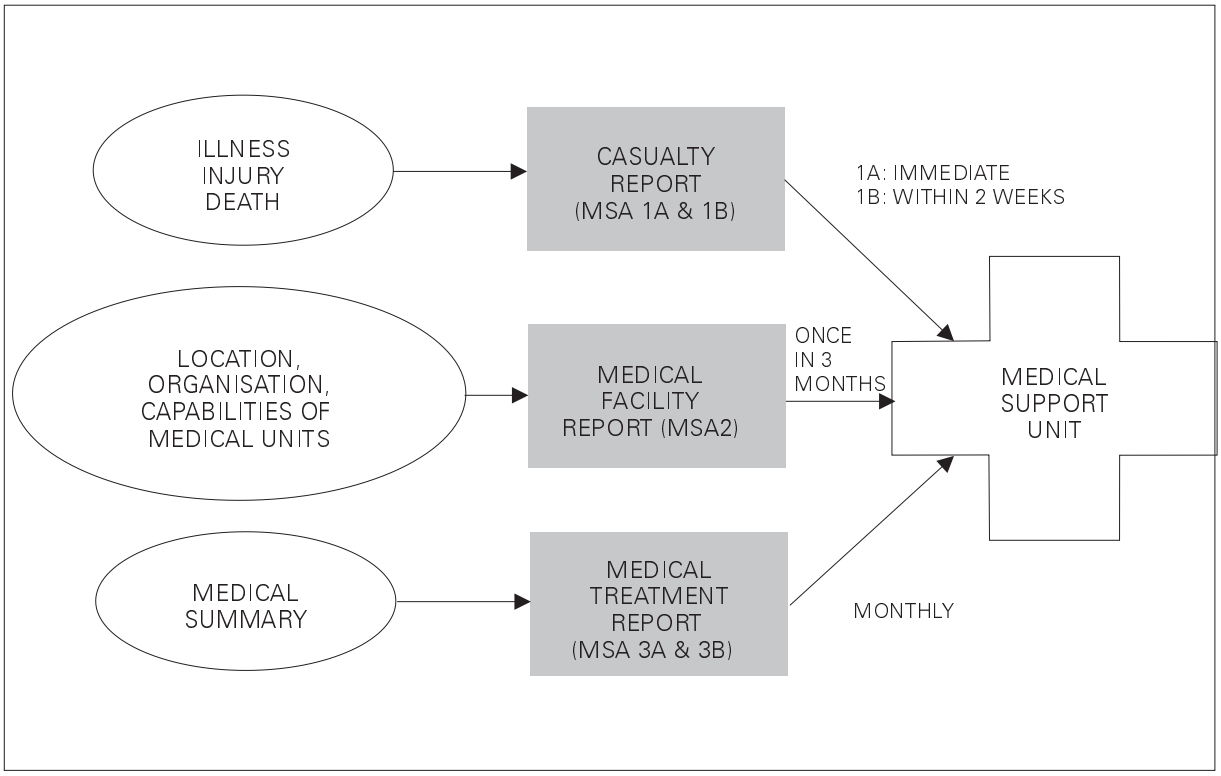


Figure 9-1. Regular Reports to Medical Support Unit, DPKO.

D. **Medical Staff Aid 1A (Casualty Incident Report).** Medical Staff Aid 1A (MSA-1A) is to be used for reporting serious accidents or diseases that require Medevac or hospitalization. This is a summary that lists all casualties involved in a particular incident, including pertinent medical information and an assessment of the severity of each casualty. The FMedO is required to send this to the MSU/ DPKO within 24 hours of the incident occurring. A copy of MSA-1A is attached as *Annex 9-1*.

E. **Medical Staff Aid 1B (Casualty Individual Report).** Medical Staff Aid 1B (MSA-1B) contains detailed information regarding the condition of each individual casualty, including a record of evacuation and treatment. This should be reported once information regarding the casualty's outcome is available, and should be sent within 2 weeks of the incident occurring. Subsequent information could be forwarded when this becomes available, in which case the original report number is to be cited. A copy of MSA-1B is attached as *Annex 9-2*.

F. **Medical Staff Aid 2 (Medical Facility Report).** Medical Staff Aid 2 (MSA-2) is a detailed record of the composition and capability of a medical unit, and is to be submitted by every UN and contingent medical unit deployed within the Mission. MSA-2 is to be submitted every 3 months, or

following any rotation or change in composition of medical units. This information provides the MSU/ DPKO an overview of the medical support readiness within the Mission area, as well as facilitates administrative procedures like reimbursement of respective troop-contributing countries. A copy of MSA-2 is attached as *Annex 9-3*.

G. **Medical Staff Aid 3A (Medical Treatment Report per Capita).**

Medical Staff Aid 3A (MSA-3A) is a summary of medical outpatient and inpatient attendances at UN medical facilities within a Mission area. This is to be compiled by the FMedO for all units within the Mission, and is to be submitted monthly (prior to the 5th day of the preceding month). It is an indicator of the workload at each medical facility by personnel type, and reflects the adequacy of medical resources within the Mission area, particularly if medical services are provided for local civilians and displaced personnel. The following points are to be noted in compiling MSA-3A (see *Annex 9-4*):

1. As this report is an indicator of total workload, all daily outpatient attendances are to be recorded, including repeat visits for the same medical condition. In the event where an individual is treated at different levels for the same condition, each attendance will be reflected as part of the data at each of these levels.
2. Medical outpatient treatment includes all medical consultations, routine medical examinations, follow-up treatment and dental care. This does not include visits primarily for vaccinations or routine investigations (e.g. chest x-ray), where consultation with a doctor is not required.
3. Should UN personnel be referred to local hospitals (Level 2 and above) supporting the Mission, this should be reflected under the respective level, indicating the name of each hospital as a separate entry.

H. **Medical Staff Aid 3B (Medical Treatment Report by Diagnosis).**

Medical Staff Aid 3B (MSA-3B) summarizes the medical health of UN personnel within the Mission area and provides important epidemiological information for monitoring and planning purposes. It identifies common medical conditions and injuries, allowing preventive measures to be taken and provides a guide

as to the effectiveness of such measures. It is also useful for determining medical logistics requirements for different missions. The following points are to be noted in compiling MSA-3B (see *Annex 9-5*):

1. MSA-3B is to be completed by every UN and contingent medical unit and submitted to the respective FMedO monthly. The FMedO is required to compile this information, showing the total number of cases treated in each disease category within the Mission area as a whole. As this report is for epidemiological purposes, it is important to avoid "double-counting".
2. Unlike MSA-3A, only the initial diagnosis for a medical condition is to be reported here, unless this is a relapse or recurrence of a previously treated condition. Repeat and follow-up visits for the same condition or chronic illness at the same medical facility will not be reflected. Similarly, a patient treated both as an outpatient and inpatient for the same condition will only be reflected under the "Inpatient" column.
3. Should a patient or casualty be evacuated or referred to a higher level UN medical unit, this should be indicated only under the "Medical Evacuation to UN Facility" column by the referring unit, and will not be computed within the overall data for the Mission by the FMedO. This case will instead, be reflected in the data of the receiving Level 2 or Level 3 unit.
4. Should evacuation take place to a non-UN medical facility, this has to be indicated as such in the "Medical Evacuation to Others" column by the referring unit. This data will be included in the FMedO's compilation.
5. MSA-3B has been designed to reflect the health status of UN personnel in a Mission area. As such, statistics of the "local population" treated (including family members of local staff, non-UN international staff, refugees and internally displaced persons) will not be included. Where the mandate for the Mission specifically includes humanitarian aid to the local population, such aid provided is to be recorded using a separate copy of MSA-3B.

I. All medical reports should be transmitted to the MSU/ DPKO electronically, using the appropriate form-template. If electronic

mail is not available, reports may be transmitted by facsimile or mail.

J. The monthly medical data is to be accompanied by a brief Medical Report by the FMedO, incorporating his comments on any health trends or problems encountered by medical units.

K. At the end of his tour of duty, the FMedO is further required to submit a Final Report to MSU/ DPKO and the Medical Services Division. This should highlight his observations, assessments and recommendations on medical administrative and operational matters. This should highlight medical issues faced in the Mission area, including epidemics, potential health threats, problems encountered by medical units and his assessment of local hospitals. A copy of this report should also be made available to the new FMedO taking over his duties.

L. Any queries regarding the above Medical Staff Aids can be referred directly to the MSU/ DPKO.

MEDICAL STAFF AID 1A CASUALTY INCIDENT REPORT			Date of Incident :			TYPE OF INCIDENT: Weapon ☐		Mines ☐	
Mission :			Time of Incident :			Accident ☐		Disease ☐	
Report No :			NOTICAS NO :			Others ☐		Specify :	
Reporting Date :			NOTICAS Date:			No of Casualties :			
S/N	Name	Rank	Gender (M/F)	UN ID No.*	Duty Station	Service Status#	Birthdate (ddmmyy)	Nationality	Medical Condition@

** UN ID No.: UN Identification Number*

 # Service Status: MILOB - Military Observer, CIVPOL - Civilian Police Monitor, TROOP – Military Contingent Member, STAFF(I) - UN International Staff, STAFF(L) – UN Local Contracted Staff, UNV – UN Volunteer, OTHERS

@ Medical Condition: P1 - Priority 1 (Severe), P2 - Priority 2 (Intermediate), P3 - Priority 3 (Light), P4 - Priority 4 (Expectant), Dead

MEDICAL STAFF AID 1B CASUALTY INDIVIDUAL REPORT						
MISSION:		Report No:		Date of Report:		
NAME:				UN ID No:		
DISEASE / INJURY		Weapon incident ☐ Mine incident ☐ Vehicle incident ☐		Disease ☐ Others: ☐	Remarks:	
AREA OF INJURY May have more than one area affected		Head & Neck ☐ Thorax ☐ Abdomen & Pelvis ☐		Extremities ☐ Superficial ☐ Others: ☐	Remarks:	
MEDICAL CONDITION		P1 [ ] P2 [ ] P3 [ ] P4 [ ] Dead [ ]			Remarks:	
EVACUATION INFORMATION						
S/N	Evacuated From*:	Evacuated To*:	Time taken (hours):	Evacuation Means		
				UN ambulance ☐ UN other vehicle ☐ Civilian vehicle ☐ Other land means ☐	Helicopter ☐ Fixed-wing aircraft ☐ Water-craft ☐ Others: ☐	
				UN ambulance ☐ UN other vehicle ☐ Civilian vehicle ☐ Other land means ☐	Helicopter ☐ Fixed-wing aircraft ☐ Water-craft ☐ Others: ☐	
				UN ambulance ☐ UN other vehicle ☐ Civilian vehicle ☐ Other land means ☐	Helicopter ☐ Fixed-wing aircraft ☐ Water-craft ☐ Others: ☐	
				UN ambulance ☐ UN other vehicle ☐ Civilian vehicle ☐ Other land means ☐	Helicopter ☐ Fixed-wing aircraft ☐ Water-craft ☐ Others: ☐	
Other Comments:						

** Identify medical unit and indicate Level of medical support. Designate site of injury or incident as Level 0.*

Medical Facility	Treatment Summary e.g. First aid, CPR, Antibiotics, Wound dressing, Surgery or No treatment		Blood Transfusion If Yes, indicate blood group and number of units	Duration of stay	Remarks
INCIDENT SITE					
LEVEL 1					
LEVEL 2					
LEVEL 3					
LEVEL 4					
CASUALTY OUTCOME					
Diagnosis					
Secondary Diagnosis					
Trauma Score (If available)					
Outcome	Return to duty (RTD) ☐ Discharge with permanent disability* ☐ Medevac to Level 4 facility ☐ Medical repatriation ☐ Death ☐				
Cause of Death	Primary cause of death				
	Secondary cause (if any):				
	Post-mortem done : Yes / No (Attach Post-mortem report)				

** For permanent disability, give detailed description (use separate sheet if space provided is insufficient).*

MEDICAL STAFF AID 2 UN MEDICAL FACILITY REPORT					
UN MISSION :			Date of report (ddmmyy) :		
MEDICAL FACILITY :			Deployment date From:		To:
1	**LEVEL**	FMT □ Level 1 □ Level 2 □ Level 3 □ Level 4 □			
2	**COMMANDER**	Rank:		Name:	
3	**CONTACT NUMBER**	Phone:	Facsimile:	E-mail address:	
4	**LOCATION** (Nearest town)				
5	**NEAREST AIRFIELD**	Name:	Type: Military / Civilian		Distance (km):
6	**NEAREST HELI-PAD** (LZ)	Name:	Type: Military / Civilian		Distance (km):
7	**PERSONNEL**	**SPECIALITY**	**No.**	**SPECIALITY**	**No.**
		General Practice		Public health	
		Internal Medicine		Psychiatry	
		Emergency / Critical care		Dentist	
		Anesthesia		Dental Assistant	
		General surgery		Pharmacist	
		Orthopedics		Nurse	
		Neurosurgery		Paramedic	
		Cardio-thoracic surgery		Medical / Lab / X-ray technician	
		Surgery, others:		Hygiene /Public health technician	
		Obstetrics / Gynecology		Support personnel	
		Pediatrics		Others:	
		TOTAL PERSONNEL			
8	**INPATIENT BEDS**	General ward		Surgery ward	
		Intensive / Critical Care		Isolation beds	
		TOTAL BED CAPACITY			
		MASS CASUALTY CAPACITY			
9	**INTENSIVE CARE UNIT**	**APPARATUS**	**No.**	**APPARATUS**	**No.**
		Respirator / Ventilator		Defibrillator	
		EKG / Patient Monitor		Others:	

10	**SURGICAL CAPACITY**	No. of surgical tables:			
		No. of surgical teams:			
11	**LABORATORY**	Basic hematology	☐	Microscopy	☐
		Basic biochemistry	☐	Culture and Sensitivity	☐
		Glucometer	☐	Others:	☐
		Urinalysis (dipstick)	☐	Others:	☐
12	**BLOOD BANK**	Blood stock (units):	☐	HIV-screening	☐
		Blood refrigerator / box	☐	VDRL screening	☐
		Blood group & Cross-match	☐	Other screening:	☐
13	**RADIOLOGY**	Basic x-ray	☐	CT Scan	☐
		X-ray with contrast	☐	MRI	☐
		Ultrasound	☐	Others:	☐
14	**DENTAL**	No. of dental chairs:		Dental x-ray	☐
15	**PREVENTIVE MEDICINE**	Hygiene inspection	☐	Vector control	☐
		Water quality control	☐	Veterinary service	☐
16	**PHARMACY**	Dispensary	☐	Medical store	☐
17	**VEHICLE ASSETS**	**TYPE**	**No.**	**TYPE**	**No.**
		Ambulance, 4x4		Helicopter	
		Ambulance, track		Other vehicles	
18	**VALUE OF CONTINGENT-OWNED EQUIPMENT** (assessed during in survey)		US $		
19	**VALUE OF UN-OWNED EQUIPMENT** (assessed during in survey)		US $		

MEDICAL STAFF AID 3A MEDICAL TREATMENT REPORT - PER CAPITA													
MISSION:					Report for month of:				Date:				
	OUTPATIENT						INPATIENT						
	Milob	CivPol	Troop	Staff (I)	Staff (L)	Others	Milob	CivPol	Troop	Staff (I)	Staff (L)	Others
LEVEL ONE													
LEVEL TWO													
LEVEL THREE													

To be submitted monthly to the Medical Support Unit, DPKO, not later than the 5th of the preceding month.

Note: All outpatient attendances including repeat visits for same condition or treatment of individual at different levels for same condition are to be included. Outpatient treatment includes all consultations, routine medical examination, follow-up treatment and dental care. Vaccinations and routine investigations not requiring consultation with a doctor are not inclusive.

Legend: Milob - Military Observer, CivPol - Civilian Police Monitor, TROOP – Military Contingent Member, STAFF(I) - UN International Staff and UN Volunteer, STAFF(L) - UN Local Contracted Staff, OTHERS – Non-UN staff, family members, local population, refugees, internally displaced persons.

MEDICAL STAFF AID 3B **MEDICAL TREATMENT REPORT – BY DIAGNOSIS**					
MISSION:			REPORT FOR MONTH OF:		
MEDICAL UNIT			DATE:		
	OUTPATIENT	INPATIENT	MEDICAL EVACUATION TO:		DEATH
			UN FACILITY	OTHERS	
INJURY					
Weapons & Mines					
Vehicular					
Sports					
Others, specify:					
NON-INFECTIOUS DISEASES					
Cardiovascular					
Pulmonary					
Gastrointestinal					
Urogenital					
Musculo-skeletal					
Neurological					
Eye					
ENT					
Skin					
Tumor / Neoplasm					
Others, specify:					
INFECTIOUS DISEASES					
Upper Respiratory Tract / Influenza					
Pulmonary Tuberculosis (PTB)					
Gastro-enteritis / Dysentery					
Cholera					
Hepatitis A, B, C					
Dengue Fever					
Meningitis					
Malaria					
Amoebiasis					
Giardiasis					

	OUTPATIENT	INPATIENT	MEDICAL EVACUATION TO:		DEATH
			UN FACILITY	OTHERS	
INFECTIOUS DISEASES (Continued...)					
Ascariasis / Filariasis / Other helminths					
Scabies					
Others, specify:					
SEXUALLY TRANSMITTED DISEASES					
Gonorrhea					
Syphilis					
HIV / AIDS					
Others, specify:					
OBSTETRICS / GYNECOLOGY					
Vaginitis					
Pelvic Inflammatory Disease					
Pregnancy					
Others, specify:					
POISONING					
Accidental Poisoning					
Substance Abuse					
Chemical / Biological Agent					
ANIMAL BITES					
Dog					
Snake					
Others, specify:					
DENTAL					
Fillings					
Extractions					
Others, specify:					
MISCELLANEOUS					
Routine medical examination					
Vaccination					

Chapter

10

MEDICAL STANDARD OPERATING PROCEDURES

10.01 Development of Medical SOP

Every UN Mission has its set of Standard Operating Procedures (SOP) which outline all aspects of routine operations and administration. While some of these procedures are common to all peacekeeping operations, others may have to be tailored to meet specific requirements of a particular mandate, operation or function. It is important for the SOP of any mission to be well documented to ensure that it is effectively managed, especially when there is turnover of staff.

A. This chapter provides general guidelines for developing a Medical SOP for a UN peacekeeping mission. It covers important aspects of medical support for a mission, and it is recommended that this format be maintained to ensure that all relevant points are covered. Whilst an attempt has been made to ensure that this is comprehensive, certain sections relevant to specific missions may have been omitted, and these may be included where necessary.

B. The FMedO is responsible for developing, reviewing and updating the Medical SOP of a Mission. This has to be based on policies and procedures set out in the "Medical Support Manual for UN Peacekeeping Operations", directions from the Medical Support Unit (MSU/ DPKO) and in accordance with the rest of the Mission SOP. The SOP has to be established at the onset of a mission, and has to be approved by the MSU, prior to its endorsement by the respective Force Commander. A copy of the final Mission Medical SOP is to be sent to the MSU.

C. For an SOP to be effective, it has to be readily accessible to all personnel dealing with medical administration of a mission, and promulgated to all sub-units which will in turn, develop their individual SOPs based on that of the higher HQ.

D. SOPs are to be reviewed regularly, particularly with a change in the operating circumstances or with a change of deployment. The MSU is to be informed of any amendments or updates to the SOP.

10.02 Format of Medical SOP

It is recommended that the main text of the SOP be kept concise, with detailed procedures attached in the annexes. All standard forms

and formats, including examples, should be attached to ensure consistency and to serve as a reference source for new staff members. The recommended format for the Medical SOP is as follows:

MEDICAL SOP FOR PEACEKEEPING MISSION

A. **Introduction.**

1. Medical mission statement for the peacekeeping operation
2. Objectives of medical support, including key tasks of sub-units
3. Scope of the SOP (contents)

B. **Structure and Organization of Mission.**

1. Structure and organization of Mission and Mission HQ
2. Organizational chart (annex)

C. **Structure and Organization of Medical Support.**

1. Structure and organization of medical support (HQ Medical Branch and medical units)
2. Organizational chart (annex)
3. Functions of medical units
4. Roles and responsibilities of key medical personnel
   a. Force Medical Officer (FMedO) / Dy FMedO
   b. Medical Logistics Officer / Hygiene Officer
   d. Senior Medical Officer (SMedO)
   d. Medical Unit Commander
   e. Contingent Medical Officer
   f. Duty personnel

D. **Work Procedures.**

1. Work routine (daily/ weekly/ monthly)
2. Regular meetings and engagements
3. Relation with higher Medical HQ
4. Relation with medical units in the Mission
5. Relation with other departments and non-medical units in the Mission
6. Relation and dealing with local authorities and hospitals

7. Relation and dealing with NGOs and voluntary organisations

E. **Medical Support Concept.**

1. General concept
2. Level 1 medical support
3. Level 2 medical support
4. Level 3 medical support
5. Level 4 medical support
6. Location and contact numbers of medical units (annex)
7. Composition and capabilities of medical units (annex)

F. **Medical Support Policies and Procedures.**

1. Medical threat assessment of Mission area.
2. Preventive Medicine policy, including:
   - aA. Immunization requirements
   - b. Disease prophylaxis
   - c. Environmental health
   - d. Food and water hygiene
3. Regulations and guidelines concerning entitlement to medical care
   - a. Military Observers, Civilian Police Monitors and Military contingent members
   - b. UN International staff and UN volunteers
   - c. UN locally contracted staff and their family members
   - d. Non-UN personnel, Local population, Internally displaced persons, Refugees
4. Certification of medical leave
5. Reimbursement policy for medical expenses and compensation for disability
6. Dental treatment policy.

G. **Casualty Treatment and Evacuation.**

1. Triage classification
2. Guidelines on emergency medical care

3. Medical holding policy within Mission area
4. Evacuation Policy
   a. Land evacuation within Mission area
   b. Air evacuation within Mission area
   c. Medevac to another country
   d. Medical repatriation
   e. Activation and approval procedure
   f. Airfield information, including important contact numbers (annex)
5. Mass casualty and emergency response
6. Management of dead and remains
7. Notification and reporting procedure

H. **Medical Logistics.**

1. Medical resupply by UN or troop contributing country
2. Distribution of supplies to medical units
3. Requisition of medical items
4. Accounting procedures for equipment, supplies and consumables
5. Stock checks, quality control and inspection of medical items
6. Preventive maintenance and repair of equipment, including reimbursement policy
7. Blood supply, vaccines, anti-venom and other special requirements
8. Disposal of medical wastes
9. Logistics claims procedures

I. **Medical Records and Reporting.**

1. Medical documentation
2. Reporting procedures and Medical Staff Aids
3. Financial records for medical treatment
4. Receiving and Inspection Reports
5. Special reports

6. Board of Inquiry

J. **Communications.**

1. Communications instructions
2. Important contact numbers

K. **Medical Training.**

1. Training of medical personnel (medical and non-medical skills)
2. First-aid training for non-medical personnel
3. Health education for military contingents

Chapter

11

MEDICAL TRAINING

11.01 Background

Whilst there is no lack of medical technical and professional expertise in most peacekeeping operations, difficulties and deficiencies are often encountered which arise from the lack of appreciation of specific problems pertinent to such operations. Several areas of weakness have been identified which contribute to this.

A. Medical support for peacekeeping operations differs from peacetime healthcare, and to some extent, from medical support for conventional military operations. There is a need to work under new operational settings, with new policies, regulations and procedures. There is a need to manage unfamiliar diseases and problems, often with a general lack of medical infrastructure within the Mission area.

B. There is a greater need to operate independently. This applies to non-medical personnel like Military Observers and Civilian Police Monitors, who need a firm grasp of First Aid as they do not always have ready access to medical care. Level 1 and Level 2 medical units also need to function with greater autonomy, as they are required to manage a wide range of medical conditions with relatively limited resources.

C. Peacekeeping operations involve multi-national participation with medical units and personnel from different countries, having different backgrounds, equipment, supplies and varying standards of medical training. There is a need for training to ensure a common understanding of the UN medical support system and to facilitate integration and interoperability of medical units.

D. Medical personnel from some TCCs may have little or no experience with peacekeeping operations. There is a general lack of knowledge of the UN organization and *modus operandi*, of individual roles and responsibilities, of operational requirements and administrative procedures and in dealing with other agencies within the Mission area.

11.02 Types of Medical Training

Professional and technical training of medical personnel remains the responsibility of the troop-contributing country. Such training will take place in accordance to national requirements for registration or

certification of such personnel. There are, in addition, several aspects of medical training specific to UN peacekeeping operations, as well as others required by the Medical Support Unit (MSU/ DPKO) for maintaining the operational readiness and medical proficiency of peacekeepers. These include:

A. **Pre-deployment Training for Peacekeeping Operations.** It is important to train all medical personnel, particularly senior medical appointment holders, on the different aspects of peacekeeping operations and on specific medical problems encountered. This commences with the training of national trainers from troop-contributing countries by DPKO or other agencies providing peacekeeping training. Such trainers will be equipped with knowledge and materials to conduct further training for medical personnel in their home country. The purpose of such training is to provide greater understanding of UN peacekeeping missions, planning and operational parameters, medical support organization, medical policies and administrative and logistics procedures. In addition, it should cover treatment and prevention of common health threats encountered in peacekeeping operations, particularly tropical diseases, HIV/AIDS and stress-related disorders, as well as other aspects of environmental and occupational health. Specific training objectives of such a program are listed in *Annex 11-1*.

B. **Mission-Specific Training.**
Mission-specific training commences prior to deployment within a Mission area, and is largely dependent on the time available for preparing a medical unit before its actual deployment. This involves updating personnel on the political and military situation within the country, on the UN Mandate for the Mission, as well as epidemiological and medical intelligence of the Mission area. Training continues following deployment, with the need to conduct familiarization training of the Mission area, rules of engagement and Mission SOPs, as well as standardization of procedures and coordinating measures with other medical units. Medical personnel may also need to be familiarized with medical equipment and supplies from other countries that they may be required to use.

C. **Continuation Medical Training.**
Medical skills, if not used or practiced regularly, may deteriorate, and it is not uncommon for medical personnel deployed for long

duration in peacekeeping operations to lose these skills through relative professional inactivity. This is particularly so in the relatively long- standing missions where there is no active armed conflict or where there are less environmental and work-related hazards. It is, therefore, mandatory for core medical skills and procedures to be regularly practiced by paramedics, and for a continuing medical education program to be conducted for doctors. The FMedO and SMedOs are responsible for the coordination of such programs, which should be included in the Medical SOP for the Mission. Medical unit commanders are required to ensure that their personnel remain current in medical knowledge and attend such programs.

D. **First Aid Training for Military Observers and Civilian Police Monitors.**

As highlighted earlier, there is a need for Military Observers and Civilian Police Monitors to have a working knowledge of First Aid as they are required to operate in small groups, often with no immediate access to medical care. Initial treatment provided at the point of injury may be critical in saving a life, organ or limb, and such knowledge is a pre-requisite in the training of such individuals. It is also strongly recommended that all Mission personnel and military contingent members have basic knowledge of First Aid. This training should take place prior to deployment in the Mission area and is the responsibility of the respective TCC. It is recommended that such training focus on practical aspects of First Aid, covering only the bare essentials of theory. Components of such training are outlined in *Annex 11-2.*

E. **Health Education for Military Contingents.**

Regular health education is to be conducted for military contingent personnel within the Mission area. The FMedO and SMedO are responsible to oversee this program, which is to be conducted by the medical unit overseeing health care for the respective contingent. This should focus on prevention of common health problems including vector-borne diseases, HIV/AIDS, accident prevention and stress management.

Annex 11-1 PRE-DEPLOYMENT TRAINING FOR PEACEKEEPING OPERATIONS

S/N	TOPIC	SPECIFIC OBJECTIVES
1	The United Nations HQ	Role and functions of the UN Structure and organization of UN HQ Structure and organization of DPKO, its planning and administrative processes
2	Peacekeeping Operations (PKO)	Peacekeeping Mandate Types of peacekeeping operations Problems encountered in peacekeeping operations Key players: UN agencies, NGOs and Governmental agencies
3	Field Missions	Structure and organization of field missions, including civilian and military components Key Appointment Holders
4	The MSD and MSU	Structure and organization of MSD and MSU Roles and functions of MSD and MSU
5	Medical Support for PKO	Medical support planning Organization of medical support Levels of medical support Roles of key medical appointment holders: FMedO, SMedO, Medical Unit Commander
6	Health Care Policies and Procedures	UN Medical standards and policies Entitlement to medical care, compensation and reimbursement for medical expenses
7	Tropical Medicine	Common infectious diseases encountered in PKO
8	Preventive Medicine	Immunization policy Disease prophylaxis and vector control HIV/AIDS and sexually transmitted diseases Food and water hygiene and sanitation Prevention of accidents Stress Management Health Education
9	Medical Survey	Conduct of medical technical survey / reconnaissance
10	Casualty Treatment and Evacuation	Triage, treatment and holding policy Casevac, Medevac and Medical repatriation NOTICAS Mass casualty and disaster preparedness

S/N	TOPIC	SPECIFIC OBJECTIVES
11	Humanitarian Assistance	Principles of disaster medicine Initial assessment and planning Program objectives and strategy Program evaluation
12	Medical Records and Reporting	Medical documentation Medical confidentiality Concepts of medical epidemiology and health statistics UN medical reporting
13	Medical Logistics	Categories of medical logistics support UN Catalog of Medical Items for PKO Sustainment and reimbursement arrangements for troop-contributing countries Medical logistics management Requisition procedure for medical items Blood and blood products
14	Medical SOP for Mission	Developing Medical SOP Sample of Medical SOP for PKO
15	Medical Training	Training requirements Techniques of medical instruction Health education programs
16	International Humanitarian Law	Aspects of International Humanitarian Law and their implications to PKO Geneva Convention and its Protocols Privileges and Immunities of UN peacekeepers
17	Security Issues	Basic and essential field security measures Mine awareness
18	Personal Skills	Good public relations, liaison and negotiation skills Working with interpreters Dealing with media

S/N	TOPIC	SPECIFIC OBJECTIVES
1	Cardio-Pulmonary Resuscitation	Positioning of unconscious individual "Mouth-to-mouth" resuscitation Use of Venti-mask Cardiac or chest compression
2	Control of Hemorrhage	Importance of universal precautions Pressure dressing and bandaging Preventing further bleeding
3	Wound Dressing	Dressing common wounds in various parts of body
4	Fracture Immobilization	Immobilization techniques Handling casualties with neck injuries
5	Casualty Transport and Evacuation	Preparing casualty for transport Casualty transport by stretcher Improvised techniques for transporting casualty
6	Communications and Reporting	Reporting procedure for accidents Activating procedure for ambulances and air evacuation

CONTENTS

A

ABCC	Advisory Board on Compensation Claims
AD	Africa Division
ADC	Aide de Camp
AE	Aeromedical Evacuation
AMED	Asia and Middle East Division
ASG	Assistant Secretary-General

B

BOI	Board of Inquiry

C

CAO	Chief Administrative Officer
CASEVAC	Casualty Evacuation
CI	Command, Control, Communication and Information
CCEO	Chief Civilian Engineering Officer
CCO	Chief Communications Officer
CCPS	Chief Civilian Personnel Section
CEO	Chief Engineering Officer
CFO	Chief Finance Officer
CGS	Chief General Services
CIA	Captured in Action
CISS	Chief Integrated Support Services
CIVPOL	Civilian Police Monitor
CLO	Chief Logistics Officer
CMO	Chief Military Observer
CMPO	Chief Military Personnel Officer
COE	Contingent-Owned Equipment
COO	Chief Operations Officer
COS	Chief of Staff
CPO	Chief Procurement Officer
CTO	Chief Transportation Officer

D	
DAM	Department of Administration and Management
DFC	Deputy Force Commander
DHA	Department of Humanitarian Affairs
DNBI	Disease and Non-Battle Injuries
DNCI	Disease and Non-Combat Injuries
DOA	Director of Administration
DOW	Died of Wounds
DPA	Department of Political Affairs
DPKO	Department of Peacekeeping Operations
DMA	Daily Meal Allowance
DSA	Daily Subsistence Allowance

E	
ECHO	European Community Humanitarian Office
ELAD	Europe and Latin America Divisions

F	
FALD	Field Administration and Logistics Division
FAO	Food and Agriculture Organization
FC	Force Commander
FFM	Field Fire Marshall
FHO	Force Hygiene Officer
FMedO	Force Medical Officer
FMSS	Finance Management and Support Service
FMT	Forward Medical Team
FRC	Federation of Red Cross

H	
HCC	Headquarters Committee of Contracts

HNS	Host Nation Support
HQ UN	Headquarters, United Nations
HQ Field	Headquarters, Field Missions
HR	High Commissioner for Human Rights

I

ISS	Integrated Support Services
ICRC	International Committee of the Red Cross

K

KIA	Killed in Action

L

LA	Legal Adviser
LCC	Local Committee on Contracts
LCS	Logistics and Communications Service
LOA	Letter of Assist

M

MAO	Military Adviser's Office
MAS	Mine Action Service, DPKO
MEAD	Medical and Employee Assistance Division
MEDEVAC	Medical Evacuation
MIA	Missing in Action
MILOB	Military Observer
MIP	Medical Insurance Plan
MPS	Mission Planning Service
MOU	Memorandum of Understanding
MSA	Medical Staff Aid (*Also*: Mission Subsistence Allowance)
MSD	Medical Services Division
MSF	Medecins Sans Frontieres
MSU	Medical Support Unit

N	
NBC	Nuclear, Biological and Chemical
NBI	Non-Battle Injury
NGO	Non-Governmental Organization
NOTICAS	Notification of Casualty
O	
OGS	Office of General Services
OHRM	Office of Human Resource Management
OIC	Officer in Charge
OLA	Office of Legal Advice
OO	Office of Operations
OPS	Office of Planning and Support
P	
PD	Planning Division
PIO	Press Information Officer
PKO	Peacekeeping Operations
PMSS	Personnel Management and Support Service
PTSD	Post-Traumatic Stress Disorder
R	
R&I Report	Receiving and Inspection Report
RTD	Return to Duty
S	
SA	Senior Adviser
SC	Situation Center
SMedO	Senior Medical Officer
SRSG	Special Representative to the Secretary General
SG	Secretary General
SOP	Standard Operational Procedure

STD	Sexually Transmitted Diseases

T

TCC	Troop-Contributing Country

U

UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCHS	United Nations Center for Human Settlements
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Program
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNITAR	United Nations Institute for Training and Research
UNSC	United Nations Security Council
UNSCOM	United Nations Special Commission
UNV	United Nations Volunteer
USG	Under-Secretary General

W

WFP	World Food Programme
WHO	World Health Organisation
WIA	Wounded in Action