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MEDICAL SUPPORT

CHAPTER 7

of

UNITED NATIONS

OPERATIONAL SUPPORT

MANUAL

GENERAL INTRODUCTION

7.0.01 UN operations are complicated by a number of peculiar characteristics as described also in chapter 1, which impact fundamentally upon the provision of medical support.

7.0.02 Medical support plans must be purpose-built for each operation, meet the demands of geographic, individual national needs, different national medical standards, language and communication difficulties. Plans must be capable of speedy initial reaction and flexible enough to manage rapidly changing operational demands.

7.0.03 UN medical support planning and management of operational medical support must be acceptable to HQ UN and to participating nations as well.

7.0.04 **Aim.** The aim of this chapter is to provide:

a. Basis for the production of UN medical operational doctrine, training, organizations and equipment.

b. Planning tool for future operations.

c. Management tool for the audit od medical support of current operations.

d. Basis for future UN operational medical support development.

7.0.05 **Scope.** The chapter will examine 6 areas:

a. Section 1 - Medical Support Precepts and Principles.

b. Section 2 - Medical Support Concept.

c. Section 3 - Medical Support Planning Process.

d. Section 4 - Medical support Policies and Procedures.

e. Section 5 - Terms and Definitions.

f. Section 6 - Catalogue of Medical items for PKO.

7.1 OPERATIONAL MEDICAL SUPPORT PRECEPTS AND PRINCIPLES

7.1.01 Whilst the general logistic support precepts apply equally to medical support, medical staffs face unique problems affecting the health of UN personnel deployed on operations. The overall objective of medical support is the conservation of manpower, preservation of life and the limitation of residual physical and mental disabilities. Operational medical support therefore requires clearly defined and distinctive guidance.

7.1.02 **Aim.** The aim of this Section is, to lay down operational medical precepts and principles which will underpin all UN medical support planning.

7.1.03 **UN Medical Precepts.** UN medical support will comply with the following precepts:

a. International Conventions for the Treatment of the Sick and wounded. Medical support for UN operations will comply with rules laid down under the Geneva Conventions. In circumstances where the provisions of the Conventions are not directly applicable, the standards set out therein will be the minimum acceptable level of treatment.

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. Operational medical support to UN forces must meet standards that are acceptable to all participating nations. The aim must be to provide a standard of medical care as close as possible to prevailing peacetime medical criteria.

d. Maintenance of Health and the Prevention of Disease. Medical support plans must include detailed measures for the prevention and control of disease and non-battle injury to deployed UN forces.

e. Establishment of Medical Risk. Medical resources must watch the assessed risk to the deployed forces, from disease, non-battle and combat injury. The estimation of risk and production of predicted casualty rates is the responsibility of UN operational staffs.

f. Capability of Medical Support. The medical capability deployed in support of UN forces must be in balance with the force strength and the exposure to risk of disease, non-battle and combat injury. Medical resources must be capable from the outset of an operation, of meeting the demands of predicted casualty rates and be designed to expand progressively as force strength and risk increase.

g. Readiness, Availability and Flexibility. Medical resources and staff must be at the same state of readiness and availability as the forces they are to support. They must also have the flexibility to meet the demands of evolving operation scenarios.

h. Levels of Medical Care. The 4 fundamental levels of medical care must be available to all UN forces, organized on a progressive basis:

(1) First Aid.

(2) Resuscitation and stabilization of vital functions.

(3) Life and Limb saving surgery, including post-operative care.

(4) Definitive treatment and rehabilitation.

i. Provision of Life and Limb Saving Surgery. Modern medical protocols are predicated on the need to provide immediate advanced trauma life support, to stabilize a patient prior to transportation and to provide life and limb saving surgery as soon as possible, normally no longer than 6 hours after

injury. This imperative will determine the overall structure of in-theater operational medical support.

j. Continuity of Care. Patients moving through the levels of medical care must be given treatment which is continuous, relevant and progressive. When a number of casualties occur simultaneously, they must be managed using the standard criteria for triage, in order of priority according to the urgency of clinical need for treatment.

k. Interdependence of Evacuation and Treatment. The size and capability of medical treatment assets at intermediate levels will be determined by the operational environment, length of evacuation routes, type and availability of evacuation assets.

l. Means of Evacuation and In-transit Care. The means of evacuation must be compatible with the need to sustain the patient during the journey. In-transit care must be available throughout evacuation.

m. Fitness for Evacuation. Clinical condition will be the key criterion in determining the timing and means of evacuation.

UN Medical Support Principles

7.1.04 Nations retain ultimate accountability for the health of their forces, but on the assumption of authority, the UN Force Commander will share the responsibility for the health of assigned forces. To meet this requirement, the Force Commander needs appropriate medical staff. They shall plan and execute the medical support plan in accordance with the precepts laid down in the preceding paragraphs and the following policies:

a. Medical Health Standards. In order to qualify for UN resource medical treatment, evacuation and where applicable, compensation for personal disability, national contingents and individuals allocated or contracted to UN operations must achieve the basic standards of individual health and physical fitness laid down by the UN medical policy staffs, prior to

deployment.

b. Contingency Planning. Planning for medical support must be part of contingency planning. Where and when planning staff cells form, they must include appropriate numbers of experienced medical staff to undertake medical support planning. Medical planning staffs must be supported by an operational medical information system.

c. Provision of Resources. Contributing nations bear ultimate responsibility for ensuring the provision of medical support to forces and individuals allocated to UN Operations. This may be discharged in a number of ways, including agreements with other nations or the appropriate UN planning staffs and force commanders.

d. Statement of Requirement. Medical support requirements are to be determined by the appropriate UN Force Commander in consultation with contributing nations and UN medical planning staff. Medical resources will be specified as those necessary to prevent and control disease and to collect, evacuate and treat casualties occurring at agreed daily rates.

e. Levels of Support. Levels of medical support will be provided appropriate to a particular operation. Policy for national contributions, established by UN medical planning staffs, will generally be:

(1) Level 1 - National Responsibility,

(2) Level 2 - UN,

(3) Level 3 - UN

(4) Level 4 - National.

f. Evacuation. Evacuation resources will be provided, appropriate to a particular operation. Overall evacuation policy, both intra-theater and inter-

theater, will be established by UN medical planning staffs in concert with the operational, logistics staffs and contributing nations.

g. National Structures. National medical systems of care and evacuation should be retained as much as possible, however, medical planners must seek to take advantage of economies of scale which may be achieved from multinational concepts such as Lead Nation Responsibilities, Role Specialization and Mutual Assistance.

h. Treatment of Entitled UN Personnel. From the outset of an operation, policy must be established regarding the entitlement of UN non-military staffs and other authorized personnel in-theater and for all medical treatment other than emergency measures.

i. Medical Liaison. Medical planning staffs are to ensure that methods are established to provide regular and efficient liaison between national contingents and theater medical resources, particularly the monitoring of in-patients at Levels 3 and 4, and for all intra-theater and inter-theater evacuation.

j. Definitive Treatment. Provision of definitive treatment, so far as Level 4 treatment is requested, is a national responsibility and will generally be undertaken outside the theater of operations.

k. Medical Material Rates and Standards. National medical support contingents must deploy into theater with a standard quantity of medical material, as laid down by UN medical planners. This will be based upon estimated consumption at UN predicted casualty rates. Nations must use medical material which meets internationally recognized quality assurance standards for the treatment of non-National patients.

l. Resupply Policy. Policy and planning for the resupply of medical material is a medical matter and

is inter-related directly with patient treatment. Medical planning staff must aim to achieve as much standardization as possible and establish an effective means of auditing usage and repayment.

7.2 Medical Support Concept

7.2.01 The complex nature of UN operations and the factors which govern them, as outlined in the beginning of chapter 1 are further complicated by financial and resource limitations and by reaction time of a highly complex UN decision cycle.

7.2.02 In order to overcome these limitations, there is a need for a concept of medical operational support which can react rapidly and with flexibility. This concept must not be considered a template, but should act as a basis for planning and as a means of obtaining a coherent medical support structure, which can be applied by all contributing countries.

7.2.03 **Mission Statement.** The UN mission is to provide medical support to a standard acceptable to all participating nations, across the spectrum of UN deployment and in all phases of operations.

7.2.04 **Tasks.** Analysis provides 3 specified tasks:

a. Maintenance of Health and the Prevention of Disease.

b. Treatment and Evacuation of Sick and Wounded.

c. Resupply of Medical Material.

7.2.05 **Medical Planning Responsibilities.** The task of planning, executing and controlling operational medical support is complex and needs so much specific expertise, that it must lie properly with a medically trained planning staff who must have an established organization of sufficient, experienced manpower, communications and Information Technology.

7.2.06 However, medical staffs do not operate in isolation and there is a very close interface with the personnel, operational and logistics staffs to provide the operational basis for, and to resource and support medical plans. The extent of this interface is shown in diagrammatic form at Figure 1, on the following page.

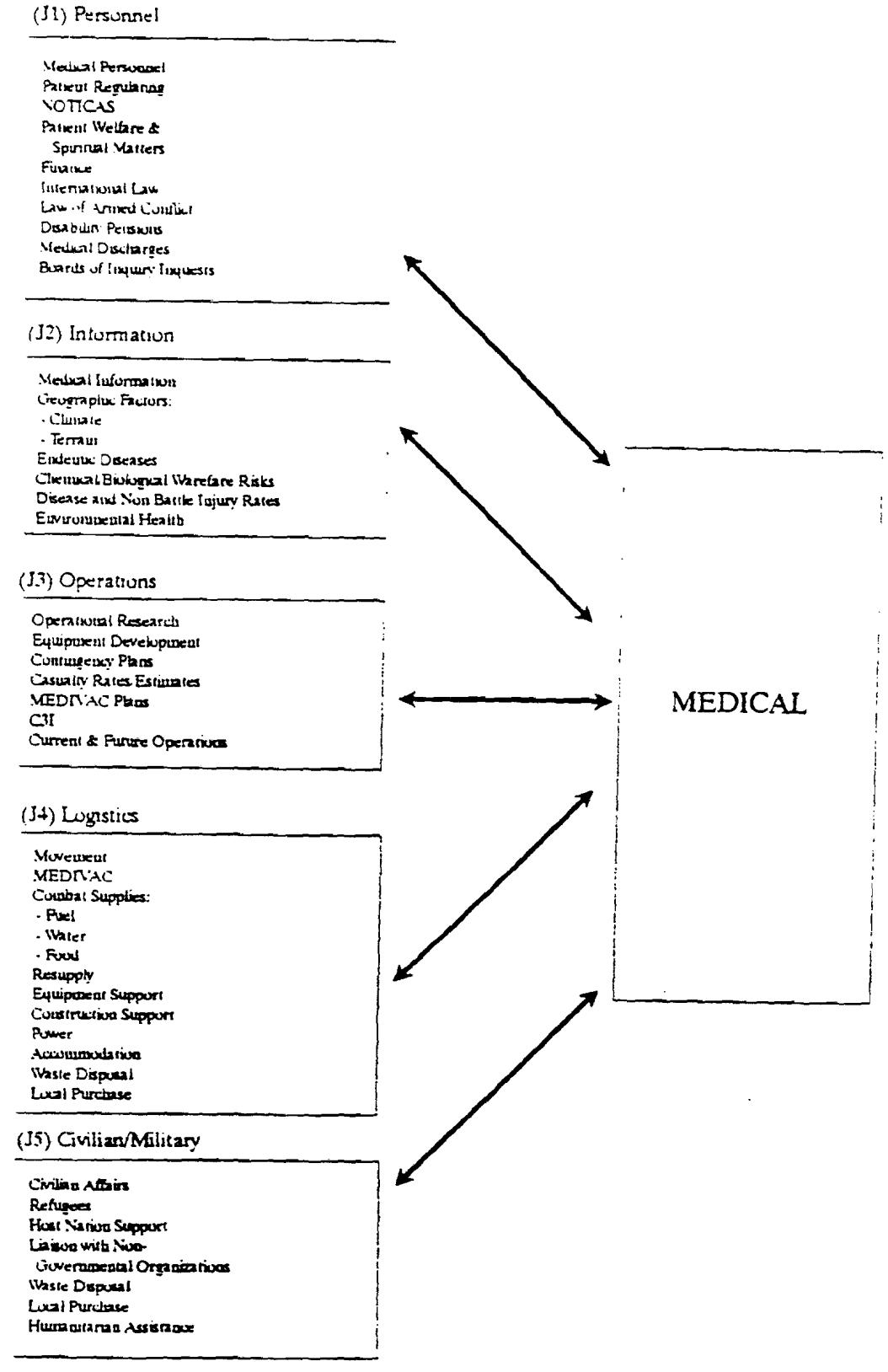

Figure 1: Interface Between Medical and Staff Functions

Medical Resources and Capabilities

7.2.07 The resources and capabilities required to meet the demands of the medical tasks can be fully described as 7 functional elements simply demonstrated in diagrammatic form at Figure 2. An examination of these functions offers a coherent and comprehensive medical concept of operations which can be applied to the range of UN potential operational scenarios.

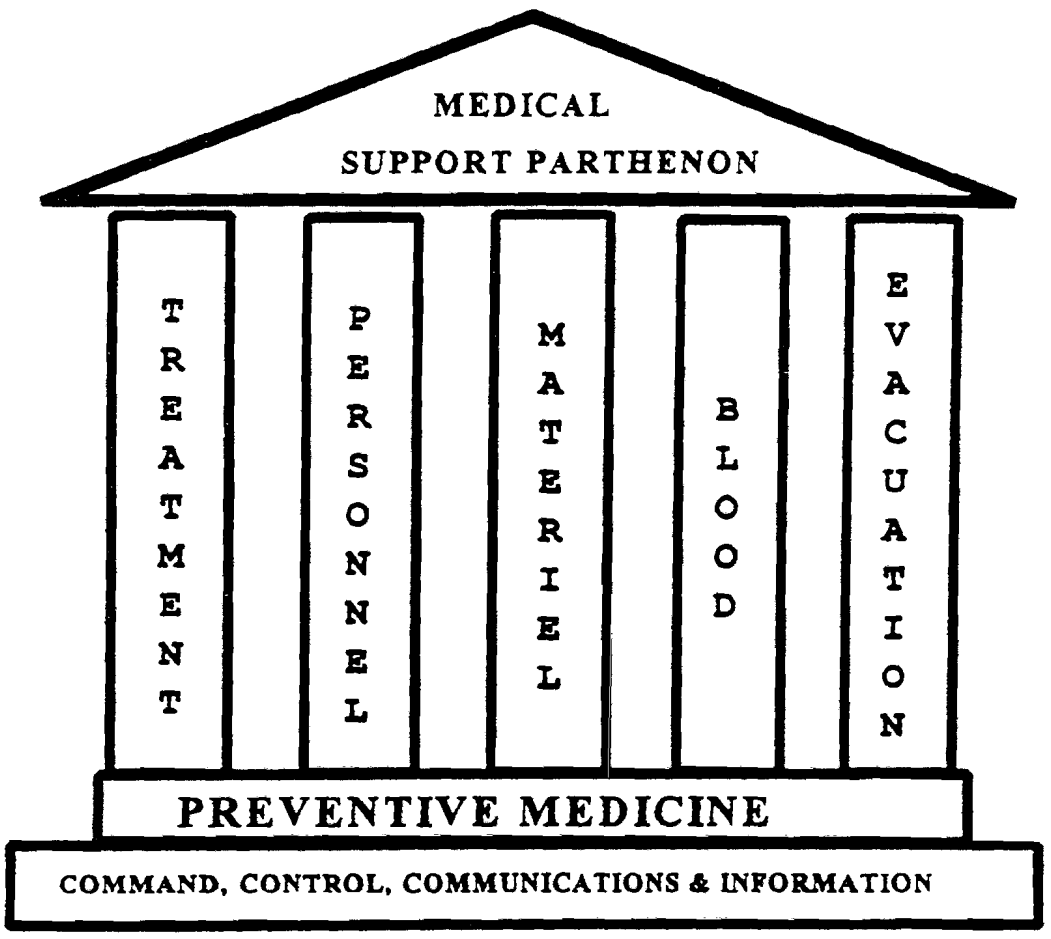

Figure 2: "Parthenon" of Medical Support Functions.

7.2.08 **COMMAND, CONTROL, COMMUNICATIONS & INFORMATION (C3I)**

a. **Requirement.** A dedicated and structured medical C3I organization is the essential foundation of an efficient medical support concept. It begins before the operation is launched and will inter alia crucially depend on:

(1) Good reconnaissance information

(2) Accurate, timely medical information system.

(3) Careful selection and briefing of a suitable CMedO and national contingent SMedOs.

(4) Clearly established lines of accountability and control.

(5) Clearly understood policy directives and orders, issued promptly.

(6) Liaison at every level including HNS and any Non Governmental Organization (NGO) in theater.

(7) Comprehensive and capable medical communication and information management system, allowing CMedO to pass and receive information rapidly; both intra-theater, down to SMedOs and inter-theater, to HQ UN and other HQs as appropriate.

(8) Prompt and accurate passage of medical information at every level.

(9) Prompt and comprehensive after-action analysis of operational medical data, to provide a basis for future planning.

b. **Capability.** The medical C3I organization must be capable of planning, executing, controlling, supporting and auditing the full range of medical support functions. It must be capable of providing a seamless system of control of treatment,

evacuation and passage of information from initial point of injury or sickness throughout evacuation to definitive treatment. It must also be capable of passing prompt and accurate medical information to operational commanders and on to superior HQs.

c. **Organization.** Medical C3I must be so organized that each level of operational command has a Senior Medical Officer, directly accountable to the operational commander. SOPs must state functional responsibilities, lines of accountability and the methods used to achieve these, including the passage of directives, orders and the return of information. For UN operations the following levels of medical C3I will be established where appropriate:

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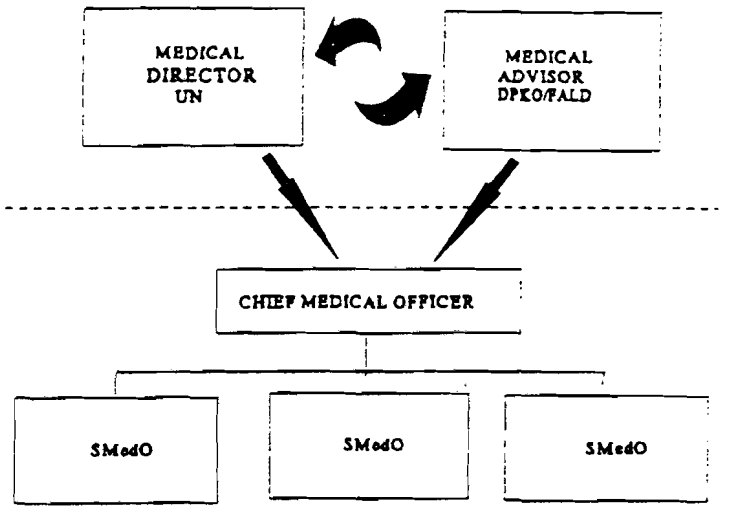

Figure 3

d. **Resources.** The designated senior medical officer at each level must be supported by an appropriate number of experienced and expert medical staff. They in turn, must have the full range of equipment support for their task, including transport, communications and Information Technology.

7.2.09 **PREVENTIVE MEDICINE**

a. **Responsibility.** In the majority of UN operations, the most likely risk to UN personnel will be from disease and non-battle injury. Therefore the primary responsibility of medical support is the maintenance of health and the prevention of disease. Medical support plans must include provision for preventive medical measures and the means to implement them effectively.

b. **Capability.** Preventive measures must be capable of:

(1) Identifying the risks and threats to the health of all UN personnel deployed in a specific theater of operations, from terrain, climate, endemic disease and special environmental and occupation hazards.

(2) Identifying necessary preventive and controlling measures and advising commanders on their implementation; including the production of theater policy on vaccination and prophylaxis measures and the appropriate training of all personnel.

(3) Auditing and in some cases training in and supervision of implemented measures. This will include gathering of epidemiological and other technical statistics and information.

(4) Advising commanders on the overall risks and threats and the limitations they may place on the operational plan; including estimating the rates of disease and non-battle injury that may result.

c. **Organization.** Preventive health measures are an essential element of planning. Implementation begins with pre-deployment stage and continues throughout, irrespective of overall changes in the conduct of the operation. They involve every individual in the operational theater, who must be

aware of necessary personal protective measures and trained accordingly. The organization to undertake them must therefore be in place from the outset and must extend from UN HQ down to the unit and below. Its shape and size will be mission dependant but will include, at least, individual advisors at every level of operational command.

d. **Resources.** The single most essential requirement of preventive medicine is a source of prompt, usable medical information, available to UN planning staffs at the outset of an operation. This information must be accurate and its source sufficiently dynamic to inform the user quickly of threat changes. Other preventive medical resources will include provision for vaccination against specified diseases, prophylactic medical material and a spectrum of mission dependant, field support measures.

7.2.10 **Treatment.** To produce a concept of medical support that implements them, it is necessary to apply the precepts and principles of medical care to each of the 4 fundamental levels in a progressive manner; from point of injury or sickness throughout evacuation to definitive treatment and rehabilitation. The key is to achieve a balance between medical capability at each level and the ability to evacuate between them. Evacuation and treatment are inextricably linked and should not be planned in isolation. The aim should be to ensure that medical treatment at every level is of a standard acceptable to all national contingents and UN employees and that over-resourcing or duplicating medical effort is avoided.

a. Level 1:

(1) Roles. Level 1 medical support is that which is integral to a unit. Its roles are the provision of:

- Triage and immediate life saving measures and first aid.

- Implementation of disease, non-battle injury and combat stress preventive measures.

- Casualty collection.

- Routine sick calls and the management of the minor sick and injured.

- Patient Reporting.

(2) Responsibility The provision of Level 1 Treatment resources is a national responsibility and national contingents should expect to deploy with their own integral medical support at this level.

(3) Capability. Medical capabilities and standards at Level 1 will vary considerably, depending upon mission and national resources. The minimum acceptable standard is every individual to be capable of undertaking basic First Aid. National contingents must have a nominated, medically trained individual to be the Senior Medical Officer (SMedO), responsible to the Force Chief Medical Officer (CMedO) for the implementation of Force medical policy. Each national contingent must also have the collective capability to:

- Undertake first aid on and prepare for evacuation of the seriously injured and sick.

- Diagnose, treat and hold the minor sick and injured, for a minimum time period as laid down by the CMedO of those who can quickly return to duty (RTD).

- Maintain a patient tracking and audit system and report to CMedO.

(4) Resources. The size of Level 1 organizations and the resource required, will be mission dependant but the minimum would be sufficient equipment to enable individuals to undertake

life saving first aid. Sub-units would require appropriately trained and equipped medical personnel. National Contingents of battalion size, must be expected to deploy with the minimum of one medical officer, with supporting medical staff, medical stocks as laid down by the medical planning staff and to be self-sufficient in transport for unit evacuation.

b. Level 2:

(1) Roles. Level 2 medical support is normally provided at formation level. Its roles are primarily:

- Evacuation from Level 1.
- Triage and skilled resuscitation of the seriously injured.
- Sustaining treatment of those sick and injured requiring further evacuation.
- Management of those minor sick and injured who can quickly RTD.
- Provision of additional support and reinforcement to Level 1 organizations as necessary.
- Centralization of medical resources as appropriate. These might include dental support, hygiene support and medical resupply.

(2) Responsibility. National contingent forces should deploy with their integral medical and evacuation assets. Where national contingents are of formation-size, responsibility for Level 2 will normally lie with the nation. Where deployments involve national contingents of unit size and Level

2 support is required, UN planning staffs and the CMedO will organize it.

(3) Minimum Capability. When deployed in support of UN operations, Level 2 medical organizations will be task-organized. At minimum, they must be capable of:

- Evacuation from and support to Level 1.

- Triage, resuscitation and stabilization of the seriously injured, prior to evacuation.

- Diagnosis, treatment and holding of minor sick and injured, for the minimum time frame laid down by the CMedO.

- Maintaining records on and reporting the treatment and evacuation of the sick and injured to CMedO.

(4) Additional Capability. Dependent upon mission, Level 2 organizations might also require the capability to provide:

- Emergency dental treatment.

- Implementation and monitoring of hygiene and preventive medicine measures, including the management of combat stress reaction.

- Medical resupply to formation Level 1 organizations.

- To meet a particular operational and medical imperative, Level 2 capability on an exceptional basis may be enhanced to provide Life and Limb saving surgery and post-operative management. This will require the addition of field surgical resources together with diagnostic and

nursing support.

(5) Resources. The resources required to undertake Level 2 missions are usually found in medical companies, medical battalions and other national equivalents such as field ambulances.

c. Level 3:

(1) Roles. Level 3 medical support is normally provided at formation level and will be mission-dependant. The key medical precept, which dictates the location, capability and numbers of Level 3 units, is the need to ensure that a casualty receives Life and Limb-saving surgery as soon as possible, normally no longer than six hours after injury. Principal Level 3 roles are:

- Evacuation from Levels 1 and 2.

- Triage, resuscitation and stabilization of the seriously injured prior to further evacuation.

- Life and Limb-saving Surgery of the injured who could not tolerate further evacuation without immediate treatment or for whom further evacuation would be problematic or inappropriate i.e. detainee, refugees and other civilians.

- Stabilization for evacuation and where possible, diagnosis and treatment of those suffering from serious and life-threatening diseases.

- Diagnosis, treatment and holding of those sick and injured who can receive total treatment and RTD within the time-frame

laid down by the CMedO.

- Patient Reporting.

- Medical resupply to Levels 1, 2 and 3.

- Centralization of formation-level medical capability as appropriate. These might include, diagnostic resources, specialist surgical and medical capability, dentistry, stress reaction management and preventive medicine.

(2) Responsibility. Level 3 support will usually be deployed in support of UN operations where relatively large numbers of personnel are involved and where Host Nation Support (HNS) resources are inadequate or inappropriate to meet the medical mission. Responsibility for the provision of Level 3 support lies with UN medical planning staff, who may utilize HNS hospitals, National or Lead Nation facilities (including hospital ships), Non-Governmental Organization (NGO) hospitals or a combination of these.

(3) Capability. Whichever resource or combination of resources is provided, Level 3 medical support must be capable, at a minimum of:

- Evacuation from Levels 1 & 2.

- Triage, resuscitation and stabilization for further evacuation, of the seriously injured and sick.

- Life and Limb-saving surgery of those who could not tolerate further evacuation without immediate treatment or for whom further evacuation would be problematic or inappropriate.

- Diagnosis, treatment and holding of those injured and sick who can expect to RTD within the time-frame laid down by CMedO.

- Emergency dental treatment (if not available at Level 2.)

- If not undertaken at Level 2, implementation and monitoring of hygiene and preventive medicine measures, including the management of stress reaction.

(4) Resources. The resources necessary to undertake Level 3 support are found in hospitals, hospital ships and the transport system units at formation level and above (particularly for helicopter and fixed wing ambulance aircraft). These assets are expensive to operate and are in short supply. Therefore:

- The numbers, size and overall capability of Level 3 units will be predicated upon the estimates of daily injury and sickness rates in theater made by the operational and medical staff.

- Maximum use will be made of HNS resources, where present and of a standard acceptable to UN medical planners.

- Maximum efforts will be made to achieve economies of scale and effort, by applying Lead Nation and similar concepts at Level 3.

d. Level 4:

(1) Roles and Capabilities. In the context of UN operations, Level 4 resources provide definitive care of the injured and sick. This embraces specialist surgical and medical

procedures, reconstruction, rehabilitation and convalescence.

(2) Responsibilities. Level 4 treatment is usually highly specialist, expensive, time consuming and of limited availability. It is therefore normally provided nationally, in the country of origin. Inter-theater transfer is normally arranged by the UN and for reasons of financial, compensation, pension etc., retains UN administrative interest until care is complete. UN medical planning staff will organize Level 4:

- Where distance from theater of operations to country of origin is excessive.

- When patient requires only short-term specialist treatment and is expected to RTD rapidly.

- Contributing nations are unable to provide appropriate definitive treatment.

- UN receives appropriate offer to provide definitive care from a specific nation.

- Patient is a non-UN personnel and no acceptable Level 4 treatment facility exists. This is particularly important for the definitive care of detainee, Prisoners of War and refugees.

7.2.11 Evacuation. The overall shape and capacity of treatment resources required in theater will be determined by evacuation capability. The more problematic evacuation is between levels of care the greater the treatment capability required at each. Evacuation will in turn be determined by operational environment, length and quality of evacuation routes and the availability of suitable evacuation assets.

a. Planning Determinants. Key determinants in establishing a comprehensive and capable medical

evacuation system are:

(1) Theater Evacuation Policy. From the outset of an operation, a theater evacuation policy must be established by the operational and medical planning staff working in concert with the Force Commander (FC) and CMedO. This policy will dictate the maximum length of time (normally expressed in days) a patient may be held at a particular Level of care. This in turn dictates the treatment capability required at each Level and the supporting Evacuation system necessary, both intra-theater and inter-theater.

(2) Fitness for Evacuation. Despite the discipline of an Evacuation policy, the clinical condition of a patient will be the key criterion when determining the timing of evacuation between Levels. Clinical condition will where possible, also determine the means of evacuation.

(3) Time to Life and Limb-Saving Surgery. Evacuation must enable the stabilized patient to reach life and limb-saving surgery as fast as possible and no longer than six hours, after injury.

b. Roles. In the context of UN operations, evacuation of the sick and wounded falls into 2 roles:

(1) Intra-theater Evacuation. This describes the evacuation from points of injury, through the levels of care established in-theater.

(2) Inter-theater Evacuation. This describes the evacuation from in-theater care, usually Level 3, to definitive treatment at Level 4. Inter-theater evacuation falls into 2 categories:

- Medical Evacuation. Describes evacuation

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of a patient who is expected to RTD in theater.

- Medical Repatriation. Describes evacuation of a patient not expected to RTD in theater.

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c. Responsibilities. The overall responsibility for planning and executing an effective medical evacuation system, lies with the UN medical planning staff and, in theater, the operational, logistic and medical staffs working in concert. The provision of resources will be coordinated by UN medical planning staff but will comprise assets from a number of sources, including HNS:

(1) Evacuation from point of injury to Level 1.
- National responsibility.

(2) Evacuation from Level 1 to Level 2 or 3
- National/UN/Lead Nation.

(3) Evacuation to Level 4
- UN/Lead Nation.

d. Capability. To achieve its mission, a medical evacuation system must have the following capabilities:

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(1) Be able to evacuate casualties 24 hours a day, in all weather and over all terrain.

(2) Evacuate from point of injury to Life and Limb-saving surgery as rapidly as possible and normally within 6 hours.

(3) Enable critical sustainment of the casualty throughout the journey.

(4) A C3I system that can regulate the flow of patients when circumstances require and enable frequent and accurate patient tracking throughout evacuation.

e. Resources. To meet the evacuation demands, a spectrum of evacuation assets will be required:

(1) Intra-theater. Evacuation assets, appropriate to the mission, including helicopters and fixed wing aircraft, high mobility wheeled ambulances (perhaps armored) coach ambulances, trains and boats/ships.

(2) Inter-theater. Inter-theater transport will also be mission dependant, the most likely option will be fixed wing aircraft. Aeromedical evacuation requires:

- An aeromedical organization, either in theater or travelling in on evacuation aircraft, to prepare patients for evacuation and to manage them on route.
- Aircraft that are appropriate for the task, particularly the need to carry stretchers securely and to enable medical management on route.

7.2.12 Material

a. Requirement. An efficient, well-regulated and cost-effective medical material logistics system is fundamental to UN medical support. The characteristics of medical material set it apart from other commodities and produce unique requirements:

(1) Medical stores are afforded protected status under the terms of the Geneva Conventions. It is necessary to store and distribute medical material separately for it to be considered protected.

(2) The complex inter-dependence between treatment capability and the availability of medical material gives medical logistics a key role in patient care management. It must

be able to respond rapidly to urgent clinical demands.

(3) The highly technical nature of medical stores and their extensive national and international regulations, require tight controls and highly specialized management.

b. Limitations. The complexity of multinational UN operations generates a number of peculiar medical logistic difficulties which arise principally from:

(1) A lack of commonality, and often compatibility, of national medical material, particularly drugs and consumables.

(2) Disparity between national clinical treatment regimes.

(3) Lack of an established, standardized and coherent resupply and accounting system.

c. Capabilities. The establishment of a medical logistics system for UN operations will be mission dependant and the resources necessary to undertake the tasks will be designed to meet the needs. It must however, have the following capabilities:

(1) Enable national contingents to be self-sufficient for the majority of commodities, from deployment and from a period of time specified by UN planning staff.

(2) Enable those elements providing centralized support such as hospitals, to be self-sufficient in the majority of commodities for the time specified by UN planning staff.

(3) Provide the user with a straight-forward and guaranteed demand system.

(4) Provide a theater-wide supply system, capable of delivering rapidly.

(5) Establish a resupply system equal to supply.

(6) Provide an audit system which is cost-effective, straight forward and does not constrain demand or supply.

d. Responsibilities. The overall responsibility for planning and executing an effective medical logistics system, lies with the UN medical planning staff and, in theater, the operational, logistics and medical staffs working in concert.

e. Supply of medical material to the theater of operations and the method for audit and payment, will be established and coordinated by UN medical planning staff. The options available are detailed in Section 4 of this chapter.

f. The establishment of in-theater demand and distribution systems will be the responsibility of the CMedO.

7.2.13 Blood. The supply of blood and blood products to multinational operations is a complex and sensitive issue, stemming from the wide disparity of standards between nations and the legal constraints incumbent upon some. Consequently it is considered as a separate function from general medical logistics. The availability of blood and blood products is essential for the management of the seriously injured and sick. For the majority of UN operations this will require its provision at Level 3.

a. Requirement and Capabilities. For the majority of UN operations, the requirement will be for an in-theater system with the minimum capability of:

(1) Receiving liquid blood and blood components of a standard acceptable to all participating national contingents and individuals.

(2) Moving, storing and distributing liquid blood components in accordance with acceptable standards.

(3) Collecting, processing and testing blood on and as needed in an emergency basis.

b. The general principle is that for UN operations, national contingents should be responsible for the supply of blood to their own injured and sick. In reality this is not always a practical proposition. The requirement must therefore be for all blood and blood products used in theater to comply to internationally agreed standards. Where a particular nation cannot accept this as a policy they must organize their own system of supply, at national expense.

c. The most cost-effective and rational approach would be for UN medical planning staff to coordinate supply through the Lead Nation concept; using supplies from a nation whose blood and blood products are acceptable to all contingents.

7.2.14 Personnel. The spectrum of personnel issues which impact upon or are generated by the medical support function, is extremely wide. They emerge during the initial planning stages and continue long after an operation is finished. Consequently, the working relationship between medical and personnel staffs must be well developed and relevant personnel concerns detailed in medical plans. Personnel issues are developed in detail in Section 4. The following paragraphs consider, in outline those issues which impact most obviously on the overall medical concept of operations.

a. Medical Manpower. The size, shape and capability of medical organizations are dictated by the numbers and quality of individual personnel. Medical personnel issues must detail:

(1) The physical and personal health standards of individuals contracted or allocated to serve on UN operations and the method of auditing them.

(2) Professional medical capability and standards required by UN and the means of ensuring

them.

(3) Training and information in medical matters.

b. Legal. Legal issues will concern both international and national law:

(1) Medical obligations under international law will be particularly crucial to the management of non-UN personnel such as prisoners of war, civilian refugees, detainee and non-UN combatants. Medical plans must detail the degree of care to be offered to these groups and how continuity of care is to be provided, when needed. In general terms:

- Only urgent medical treatment, not available in appropriate non-UN medical facilities, will be offered to civilian refugees.

- Detainee and non-UN combatants will receive urgent medical treatment in UN medical organizations, but are unlikely to remain in Level 3 or be evacuated to UN Level 4 for definitive treatment. An alternative source of definitive treatment must be organized as part of the overall medical support plan.

(2) National law will concern a range of issues, particularly regarding the provision of medical evidence for inquiries into deaths and severe injury.

c. Medical Information Management. The efficient management of medical information, particularly regarding patients, is a vital element of competent medical support planning. This information must be standardized and distributed rapidly to all who need it. Principal areas of concern will be:

(1) Provision of statistics, for both epidemiological and administrative purposes.

(2) Patient tracking depends upon the passage of timely and accurate medical information, the key is the maintenance of medical records at every level of care and the use of clear and comprehensive patient documentation procedures. Medical Documentation must be standardized throughout the theater of operations and all national contingents. Most importantly, copies of patient documents must move with the patient throughout evacuation to each level of definitive care.

(3) Notification of serious sickness and injury to be rapid, accurate and dynamic, using standardized procedures and a chain of command and control. Failure to establish a competent system for patient tracking will produce much national political disquiet, unnecessary administrative effort and distress for both patient and relatives.

(4) Accurate production of clinical evidence for official national or international inquiries; this include post-mortem evidence of deaths in theater.

d. Financial. Financial issues will impact on:

(1) The size and shape of medical resources available to support the medical concept of operations.

(2) Terms of Service, particularly pay, allowances, pensions etc.

(3) Maintenance costs, particularly the provision of medical material, resupply and evacuation.

(4) Final costs, particularly disability pensions and compensation for injury.

e. Welfare and Spiritual. The general welfare of patients is an important element of medical care and therefore support planning. Particular issues will be personal mail, contacting relatives, management of personal effects and most importantly, spiritual welfare. The latter could be a complex problem in a multinational operation. Religious and cultural customs may impact upon aspects of medical care, for example, diet and feeding of patients.

7.2.15 Outline Concept for Operational Medical Support. outline concept of operational medical support is sh diagrammatic form, at Figure 4 (next page).

The capability of an
one system is
Aim in concept b
not provided in
practicality.
Probably needs to
expand upon a patient
tracking system from
level 3-4 → onwards

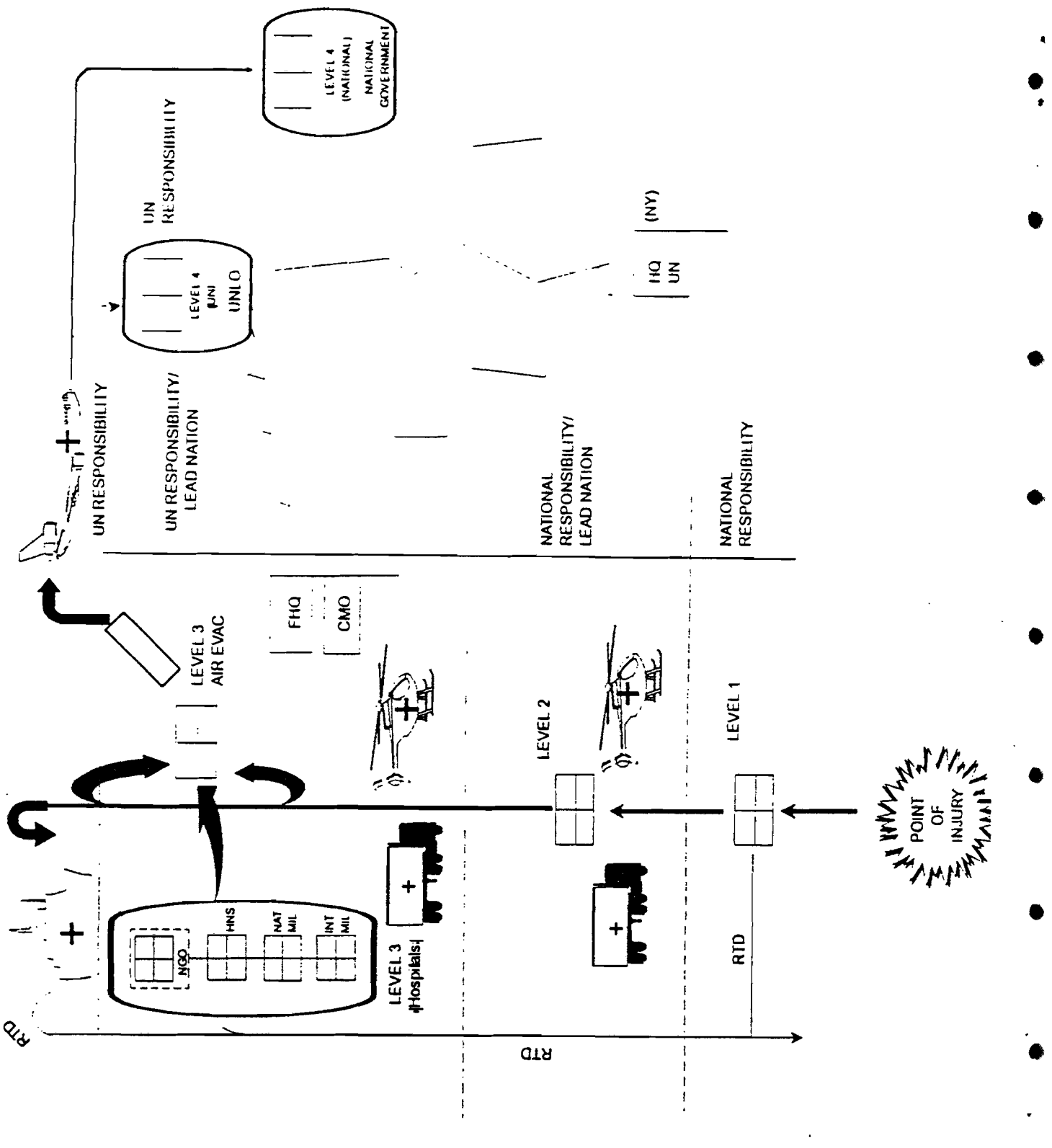


Figure 4: UN Medical Support Concept

7.3 MEDICAL SUPPORT PLANNING PROCESS

7.3.01 The disparate nature of UN operations dictate that a Medical Support Plan be purpose-built for each operation and that rarely will two plans be identical. Although every plan will differ, the process of achieving it should follow a standard planning process. This process should be progressive, comprehensive and understood at every level.

7.3.02 The characteristics of UN contingencies make it essential that outline planning is done rapidly, often with limited information and rarely with the benefit of reconnaissance. Planning at this stage, should aim to produce no more than an operational estimate. However, it must be sufficiently comprehensive and accurate to allow for a reasonable estimate of resources and particularly funding.

MISSION ANALYSIS

7.3.03 The first and most essential step in the medicine planning process is to have a clear understanding of the medical mission. Analysis should follow a progressive path.

7.3.04 Operational Scenario. This will be no more than a general outline of what the UN intends to do. It will however, provide medical planners with some key points:

a. Where the operation is to take place (Geographic factors).

b. What type of operation (Rough guide to size and intensity).

c. When it is to begin (Time available to plan).

7.3.05 Medical Precepts/Concepts. In applying the medical precepts and outline medical concept, the key issues to emerge will be the need to:

a. Access all available medical intelligence on the theater of operations.

b. Deploy a properly briefed and competent medical

representative on reconnaissance.

7.3.06 Medical Intelligence. The information required for medical planning must be comprehensive, rapidly available, accurate and most importantly, up to date. Ideally it should be available from a single source data base. It must be able to provide information on:

a. Geographic factors - Effects of climate and topography on general health.

b. Endemic diseases - Types, prevalence, current prophylaxis measures, resistant strains, treatment etc..

c. Special environmental and occupational hazards - Chemical/Biological warfare capabilities of protagonists, radiation hazards, road movement hazards, pollution etc.

d. Medical resources available in the theater of operations (HNS) - transport for ambulances (air, land and maritime), treatment capability and standards at every Level of care.

7.3.07 Disease and Non-Battle Injury (DNBI) Rate

a. A detailed analysis of this information will enable medical and operational staffs, to produce an initial DNBI Rate for the operation. It is a technical estimation of the probable rate of disease and injuries not resulting from combat, which can be expected once deployment begins.

b. DNBI-rate is expressed as a daily % rate or as two separate rates, one for diseases and one for non-battle injuries. It is mission dependant and dynamic, often rising and falling with the level of activity, acclimatization and skill of deployed personnel. Though DNBI-rate depends for example on region, climate and specific health threats, a common average is 1,35 % of all deployed personnel per day.

c. The factors which result in the DNBI-rate must be assessed and translated into preventive medicine measures, including policy on vaccination and prophylaxis. It will also be a determinant in the size and capability of treatment resources required in theater.

7.3.08 Total Battle Casualty Rate (TBC rate)

a. The next key stage in the medical planning process is the determination of a Total Battle Casualty Rate for the operation. This is the operational estimate of how many casualties and Battle Stress Cases will result from combat. It will vary considerably depending on the overall concept of operations.

b. Total Battle Casualty rates are expressed as daily % rates of combat-troops. They are dynamic, rising or falling as operational imperatives change and depend on the command level as well as shown below.

Battalion	24.6 %
Brigade	8.3 %
Division	3.6 %
Corps	1.7 %
Army	1.2 %

c. TBC rates include the Killed in Action (KIA), Captured and Missing in Action (CIA), Wounded in Action (WIA) and Battle Stress Cases (BS) applying in the following percentages:

KIA	17 %
CIA	8 %
WIA	58 %
BS	17 %

d. For most UN Peace-keeping and even for UN Peace-making operations, the battle casualty rates will likely be significantly lower than in combat between conventional forces.

e. Although TBC rates are even more dependant on the specific nature of operation than DNBI rates, by neglecting KIA, CIA and BS a first rough estimate may be provided for UN Field Missions being between 2.1 and 14.27 %.

7.3.09 The overall shape and capability of the medical support plan is decided by a combination of DNBI and Battle Casualty Rates. It is therefore essential that they are determined as early as possible.

7.3.10 Casualty Estimate

a. Once the rates have been established, they can be compared against the overall size of the force to be deployed in theater of operations, to produce a Casualty Estimate.

b. Casualty Estimates are expressed in numbers per day. These numbers are a determinant in the overall size of the operational medical organization required.

7.3.11 HNS Capability. The medical resources available in the theater of operations is a key issue in determining the size and capability of the medical organization the UN must establish. The more HNS available for UN use the less has to be found from contributing nations. Overall HNS capability is assessed by a mixture of medical information analysis and reconnaissance. A key issue will be the standards of medical care available, compared to UN and national contingent criteria. Resources required will include:

a. Transport for ambulances (air, land and maritime), for both intra-theater and inter-theater evacuation.

b. Treatment capability at every Level of care but particularly at Level 3.

c. Medical logistics support, including the provision of drugs and consumables.

d. Essential non-medical logistic support, including buildings, water, power, disposal of waste, communications, laundry, labor, etc..

7.3.12 Alliance Capability

a. In planning to provide medical support to the standards to contributing nations, it is vital that every effort is made to achieve economies of scale and effort, because:

(1) Medical assets are expensive to procure and difficult to obtain. In many nations, the majority of military medical personnel are contained in the military reserves and are more difficult to deploy for support missions.

(2) Medical assets under-employed in one theater of operations are not available for another.

(3) All medical assets, but particularly Level 3 organizations require a large logistic effort to sustain them, even when they are not functioning.

b. Maximum effort must be made to tailor medical support to the predicted demand. Some contingents may have an abundance of assets whilst others may lack all but the fundamentals. UN medical planners must aim to find a balance of capabilities. Often the most cost-effective means will be to organize for one nation to provide a particular function for all contingents, for example aeromedevac.

POLICIES

7.3.13 Two key policy issues must be addressed at this point.

7.3.14 Prophylaxis Policy. Policy must be issued as early as possible regarding the prophylaxis measures, including vaccinations, that must be taken by all individuals deploying into the theater of operations. Instructions will cover measures to be

taken prior to deployment, those to continue in theater and post operations. Details are to be found in part 4.

7.3.15 Evacuation Policy

a. Theater Evacuation Policy, known in some nations as Holding Policy, is the key to balancing the treatment capability available at each level of care, against the medical evacuation assets required.

b. This is achieved stating the maximum period, in days, a patient may be held for medical treatment at each level of care. If a patient cannot return to duty within the specified time he/she must be evacuated as soon as possible. This limitation is expressed in days.

c. It has a number of purposes:

(1) To balance the medical capability and limit the need for unnecessarily sophisticated resources, at each Level of in-theater care.

(2) Ensure that while the minor sick and injured are managed and RTD at the correct Level, the seriously injured/ill are evacuated to appropriate treatment as rapidly as possible.

(3) Ensure that all in-theater medical support Organizations, remain capable of reacting rapidly to operational imperatives.

d. The following factors influence the creation of a theater Evacuation Policy:

(1) Must be mission dependant, shaped by the assets available to undertake the medical task, both treatment and evacuation. It will be influenced by constraints on movement, particularly operational imperatives, weather and topography.

(2) Must be dynamic, able to respond to rapidly changing operational imperatives. Normally, the outset of an operation sees a short Evacuation Policy, dictated by the medical assets in-theater. As operations build-up and medical assets are in place, the holding time lengthens. The evacuation policy then fluctuates, both up and down as the medical capacity dictates. In anticipation of casualties which may exceed the medical capacity of the treatment facilities, the evacuation policy would be shortened.

(3) Establishing evacuation policy is a command decision. Medical and logistic staffs will advise. CMedO will promulgate and monitor.

(4) Despite the existence of a definitive Evacuation Policy, the decision to evacuate must remain a clinical responsibility based on the patient's clinical condition.

(5) The dynamic effect of factors influencing the creation of a theater Evacuation Policy is shown in Figure 5 (next page).

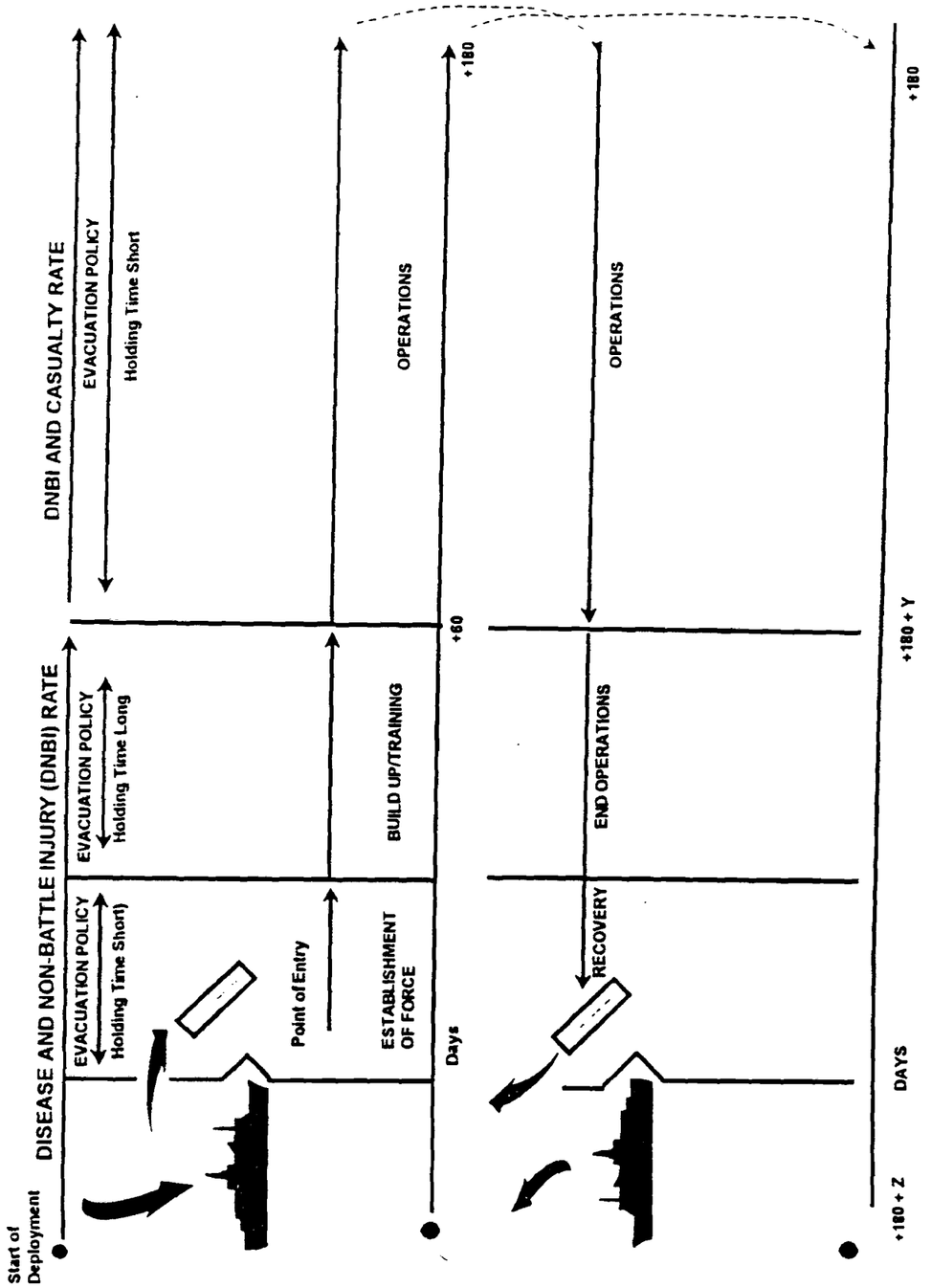


Figure 5: In-Theatre DNBI Rates and Evacuation Policies

7.3.16 Medical Operational Concept. At a later stage in the planning process the medical concept of operations should be refined, particularly by input from the reconnaissance. It should now be clear how the medical staff intend to undertake the mission; the next stage is to decide on resources.

7.3.17 Medical operational concepts have to follow all factors of influence using the data accumulated from mission analysis, reconnaissance and policy decisions. Each of the 7 functional areas of the "Medical Parthenon" should be examined permanently to decide the size and capability required of each function.

7.3.18 All factors listed in part 2 of this chapter will influence and be influenced by Medical operational support planning. Therefore constant auditing and permanent medical information is essential.

Flowchart for Operational Medical Support Planning

7.3.19 A flowchart for the estimation of operational medical support requirements, is at Figure 6 (next page).

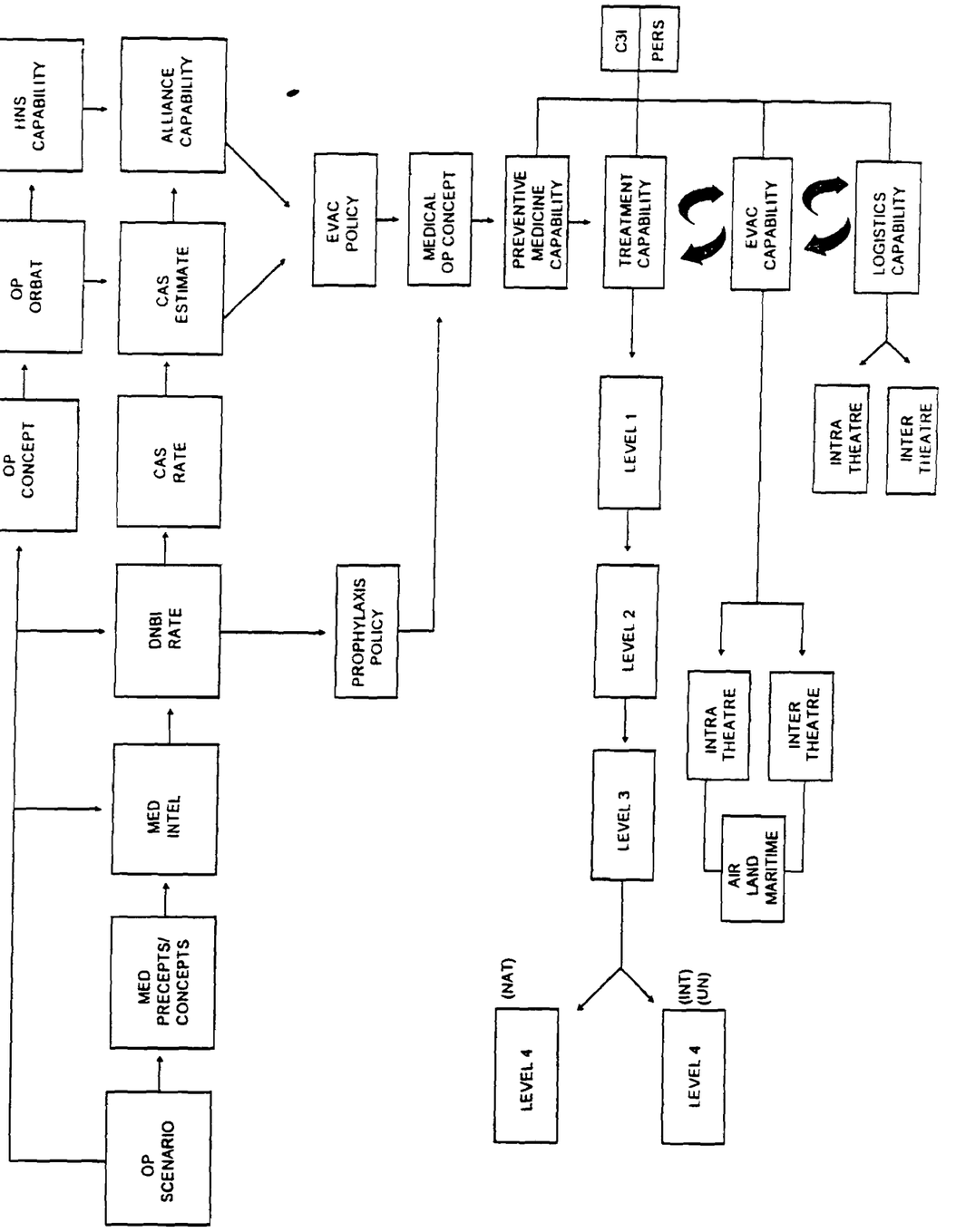


Figure 6: Flowchart Estimation of Operational Medical Support

7.4 MEDICAL SUPPORT POLICIES AND PROCEDURES

7.4.01 Within the context of the parthenon of medical support, detailed policies and procedures exist which apply to all UN operations. This section provides the policies and procedures which will lay out the inter-working relationships between Headquarter UN in New York, the Force Commander (FC), the Chief Medical Officer (CMedO) and the Senior Medical Officers (SMedOs) as clinical heads of their respective organizations.

7.4.02 **Command, Control, Communications and Information.** Within the C3I foundation are interrelationships and responsibilities which are important for all UN participants to understand. The Medical organizational relationship within UN HQ NY is shown as Annex A on page 77.

7.4.03 **Responsibilities.** Medical Director UN, Medical Advisor DPKO/FALD, Chief Medical Officers and Senior Medical Officers must work closely together to guarantee continuously sufficient medical support in theater. The following shows the different responsibilities of these persons:

a. Medical Director UN (in connection with UN Field Missions only):

(1) Reviews and coordinates UN Medical Policies with Department of Peace-keeping Operations at UN Headquarters, New York and with the various Chief Medical Officers in the missions.

(2) Reviews and updates chapters on medical and health related matters in the Guidelines for Governments contributing Personnel/Troops to the UN Peace-keeping Operations.

(3) Establishes UN Medical Standards for members being assigned to Peace-keeping/Special Missions.

(4) Provides medical clearances for mission assignment of:

- UN staff members
- Military observers
- Civilian police

(5) Assesses local medical facilities and those of predesignated regional medical evacuation centers for advising on the levels of UN facilities to be established or making alternative arrangements.

(6) Provides initial medical threat information and mission area assessment to Medical Advisers of DPKO.

(7) Advises on necessary immunization for each mission and any changes thereafter.

(8) Provides medical briefings at UNHQs for designated CMedOs, FC and Contingent Commanders from various troop contributing countries.

(9) Provides on-going technical support for smooth operations of military and UN medical facilities of the mission.

(10) Analyses medical statistics submitted by CMedOs from the missions to make necessary changes in recommended immunizations and/or in evacuation policies.

(11) Advises on repatriation of UN Staff Members, Military Observers, Civilian Police and Military Contingents, on medical grounds in accordance with the holding policy of the mission.

(12) Approves overseas or regional medical evacuations for UN Staff Members, Military Observers and Civilian Police, in accordance with the Directives on medical evacuations.

(13) Advises UN on medical questions of

compensation claims, in her capacity of a Medical Adviser to ABCC, UN NY, submitted by or on behalf of UN Staff Members, Military Observers and Civilian Police for Service incurred injury, illness or death.

b. Medical Adviser DPKO/FALD:

(1) Advisor to the UN Military Advisers Office and FALD on all military medical operational matters.

(2) Recommends improved logistic support policies and procedures.

(3) Coordinates with Medical Director UN and with the mission reconnaissance party for essential elements of medical information required to conduct initial operational planning and budgeting.

(4) Prepares initial military medical estimates for planned UN missions.

(5) Advises on organization and equipment of military medical support elements, the level and structure of military medical facilities to be established in a mission area, and the estimated costs for medical support.

(6) Provides initial briefings to designated CMedOs and appropriate staff members of the deploying force.

(7) Responsible for verification and processing of requests from the UN field missions for medical consumable and non-consumable goods.

(8) Is the validator of all medical operational requests from UN field missions.

c. Chief Medical Officer (CMedO), UN Field Mission:

(1) Plans, directs, advises and supervises all activities related to the medical support plan. Provides medical expertise to the Force Commander (FC) and to all contingent Senior Medical Officers (SMedOs) of the mission.

(2) Conducts initial and on-going deployment medical assessments and surveys. Gathers and distributes information of general medical situation in the operational area and of medical threats in particular.

- Assesses the local medical facilities and advises on their suitability.

- Evaluates and coordinates medical support received from Host Nation Support.

- Evaluates the possibilities for local purchase of medical supplies and medical consumables.

- Provides guidance and coordinates preventive health measures/field hygiene including food and water inspections and disposal of medical waste.

(3) Oversees medical standards of all medical care functions depicted in the parthenon of medical support as shown in Figure 2 of this chapter. This will also include inspections of military medical facilities in-theater.

(4) Ensures all military medical units extend their services to the UN civilian support staff, and other UN staff members assigned to that particular mission.

(5) Recommends Holding/Evacuation Policies to FC, and to HQ UN.

(6) Provides guidelines for MEDEVACS and coordinates inter and intra-theater MEDEVACS.

x comment d. Who co-ordinates out of theatre - The

(7) Responsible for tracking evacuated personnel within the theater of operation.

(8) In concert with UN HQ, and the FC, provides guidance in the treatment of non-UN force personnel.

(9) Responsible for coordination of medical matters with Non-Government Organizations (NGOs), Private Organizations (PVCs), and with local medical authorities.

(10) Establishes in concert with national Senior Medical Officers, policy and standards for supply of medicine, blood and blood products.

(11) Responsible for collection of medical information/statistical reporting as required by HQ UN.

x comment e. Clarify & pers br responsibility

(12) Establishes a system of notification of sick, wounded or deaths. Audits these reports prior to submission to national authorities.

(13) Coordinates and certifies requisitions for medical equipment, supplies and medical consumables. Coordinates the mission's medical formulary.

(14) Plans and coordinates for an integrated medical warehouse if necessary.

(15) Resolves clinical differences between national contingencies.

(16) Responsible for the economic considerations for all of the above.

d. Senior Medical Officer (SMedO)

(1) Is CMedO's national point of contact on medical matters. Senior clinician for clinical decisions.

(2) Responsible for implementing UN medical policies and CMedO's regulations and advises international procedures.

(3) Responsible for medical information, training, and education of contingent personnel, and contingent medical personnel.

(4) Responsible for hygiene and preventive measures for national contingent's area of operation.

(5) Coordinates evacuations on a national level.

(6) Ensures medical resupply to national contingent.

(7) Prepares reports as required by HQ UN and CMedO.

e. Although in UN Field Missions contributing countries may always have a final approval, the CMedO must have the necessary authority to implement medical policies and to communicate and audit these policies with each of the force contingents.

(1) It is recommended that the CMedO is designated from the national contingent providing the majority of medical forces.

(2) The CMedO is the header of the Med Unit in Field HQ and the Medical Advisor to the FC as well. An example of a basic organization chart for PK HQs is shown as Annex B on page 78.

(3) CMedO must be a physician with sufficient experience and rank to exert influence on other medical contingents.

(4) Force commander should prescribe the authority and coordinating limitations of the CMedO.

(5) The CMedO must have the necessary staff to fulfill his tasks. Although the shape and number of personnel of his unit depend on several circumstances varying from mission to mission the recommended structure at least necessary for medium and large UN Field Missions are outlined in Annex C on page 79.

(6) To ensure an uninterrupted chain of responsibility in medical matters between the CMedO and national contingents, each national contingent with medical forces must have one designated chief medical representative as the Senior Medical Officer (SMedO) which the CMedO may communicate with and obtain clinical decisions.

f. Medical reports, statistical reporting and patient status reporting is an important element of medical support in UN operations. It is necessary for command and control and combines communication and information as well.

(1) To provide expertise to the FC the CMedO has to have certain information about organizations and utilization of medical units participating and of the health status of all personnel.

(2) To provide necessary information for UN HQ CMedO has to forward at least 4 regular medical reports. A "Medical Location, Level and Capability Report" as shown in Annex D/1 and D/2 on pages 80 and 81, and a "Medical Flash Report" as shown in Annex E, page 82.

Medical flash report is considered confidential and is to inform UN HQ of specific incidents that have resulted in, or are likely to result in, significant casualties, or other incidents of a medical nature which are likely to attract higher staff, public, political or media attention (such as assassination, mass casualties, infectious disease outbreak, food poisoning, etc.).

(3) He also has to provide monthly "Treatment Reports - DIAGNOSES' and "Treatment Reports - PER CAPITA" showing diagnosis' and the number of treated personnel to Medical Director UN and Medical Advisor DPKO/FALD. "Medical Treatment Report - Per Capita" is also needed to state a possible reimbursement on a per capita per day basis. Though the CMedO is free to establish different forms within the Mission Area it is recommended to use the forms shown as Annex F and G on pages 83 and 84.

(4) Patient regulating and patient reporting system must be instituted. The CMedO is responsible for this system and is responsible for tracking patient status and condition throughout all levels of care until medical repatriation takes place.

(5) Special requirements exist when the patient is a UN civilian employee or non-military eligible beneficiary for medical care. These special requirements are necessary due to legal aspects of claims for insurance and compensation. Reports to cover these purposes will be mentioned in Part labelled "Personnel".

(6) Recommended Reports for MEDEVACS and repatriation are mentioned within this part. Other necessary medical forms will be

mentioned either in "Treatment- Piller" or within "Personnel-Piller".

(7) **Medical status/information combined with identification of a patient is regarded as being confidential and is to be released to authorized medical personnel only.**

(8) The CMedO is charged with gathering the medical information for epidemiological reporting and analysis, and to validate all outpatient visits, inpatient care, Medical Evacuations and Repatriations. National contingents must comply with CMedOs guidance in reporting matters.

g. The success of medical support will rely heavily on effective communications.

(1) Compatible communications must be established between all medical elements to support the rapid decision making requirements, such as medical evacuations and search and rescue. An often forgotten aspect of communications is the requirement for interpreters as part of the medical provider's team to ensure communication with foreign patients as well as between contingents of different nationalities.

comment f X

(2) There must be a dedicated medical communications network established that includes at a minimum, a medical response element. CMedO is responsible to coordinate for an emergency medical frequency with the communications network administrators and the air service administrators.

comment g. X

(3) Experience has shown that field aeromedical evacuation functions most effectively and reliably when these assets are dedicated to their medical mission and are under direct medical command and control. CMedO should

coordinate with Chief Air Services for this type of arrangement.

(4) Each nation has a mandatory right to liaise with their national personnel when in a patient status in foreign medical units. While a nation has the right to access, they do not have the right to medical supervision/evaluation of the patient.

(5) Each national contingent shall provide a point of contact for medical liaison purposes to the national contingent providing the medical treatment facilities. Medical treatment facilities or the respective national contingent will, through the designated national points of contact, report patient information as may be required. In all cases, illnesses and injuries which are clinically determined to be serious, very serious, or will result in death will be reported to the national points of contact as expeditiously as possible. Any changes within these conditions will also be expeditiously reported.

h. Information about the overall situation in a planned mission areas well as specific information about medical care, medical threats, possibilities of Host Nation Support is most important for initial planning and ensuring sufficient medical care during and after deployment. Gathering the utmost information during all phases of a UN Field Mission is essential and therefore medical expertise should be already implemented in a very first UN reconnaissance party as outlined in Chapter 1. HQ UN N.Y., CMedO and SMedO must permanently gather all available information and ensure the permanent input in a UN medical planning and operation unit.

7.4.04 Preventive Medicine. Preventive medicine transcends each of the five medical pillars of medical support discussed

above. Its importance cannot be stressed enough. It includes matters dealing with vaccinations and immunization as well as matters of hygiene, including inspection, control, and advice on water and food, kitchen operations, camp facilities, garbage and waste disposal, sewage control as well as action against insects, vermin, rodents and stray animals. The medical threat must be fully evaluated prior to, during and following the UN operation.

a. It is a national responsibility to ensure personnel are prepared and appropriately trained in field preventive medicine measures prior to deployment to a UN operation. This must include the necessary vaccination and immunization.

(1) Medical Director UN will make recommendations for vaccinations and chemoprophylaxis.

(2) Although the country contributing forces to a UN mission ultimately must decide what vaccines should be given to its personnel, because the immune status of individuals varies from one country to another, failure to follow UN recommended policies on chemoprophylaxis and immunizations could result in denial of medical claims and compensation.

(3) The UN has responsibility for immunization and chemoprophylaxis sustainment once personnel are under UN command. CMedO in coordination with the Medical Director UN will adjust guidance as necessary during the conduct of an operation.

(4) In theater it is the CMedO's responsibility to monitor, audit and advise on all aspects of preventive medicine carried out in the UN operation.

b. It is a national responsibility to maintain international standards in regards to the provisioning of food and water as well as the standards for sanitation, epidemiology and

entomology.

(1) CMedO will inspect and audit national measures to ensure international standards are maintained in these areas.

(2) CMedO/Force Hygiene Officer will provide advice to national contingents on training programs and procedures to follow improved standards.

(3) In the case of medical facilities/activities, international recognized minimum standards must be maintained if the medical facilities are to be used to support personnel outside the respective national force.

c. The CMedO/Force Hygiene Officer is responsible to coordinate for mission dependant preventive medicine services such as regional spraying or vector control.

d. Education of prevention of medical diseases is a national responsibility.

(1) Each UN participant must have basic training in field hygiene measures to aid in the control of diseases.

(2) Sexually transmitted diseases which include the HIV infection, have always been, and always will be a major medical and command problem when personnel are deployed throughout the world in support of operations. National education programs must place extra attention on the prevention of sexually transmitted diseases.

(3) HIV infection is not the most likely cause of ill health in the tropics; other diseases are both more common and more difficult to avoid. However, HIV infection is avoidable and also nearly all people infected with HIV

eventually develop AIDS, for which there is still no cure.

(4) Sexual transmission is by far the most common route of HIV infection. Therefore, practicing safer sex and using condoms is vital for prevention of this infection. All contingents must bring their estimated supply of latex condoms and water-based lubricant, along with other medical supplies, for an initial period of 3 months. Further replenishing of these should be requested from FALD/UN. Contingent commanders must enforce proper and regular use of condoms by their contingent personnel.

e. After phase initial deployment and establishment in-theater food and water acquisition and handling is a responsibility of the Chief Logistics Officer. The CMedO will ensure medical expertise available to support the supply personnel in the acquisition and handling of foods.

f. Medical waste will only be disposed of in accordance with recognized international standards. Although disposal of medical waste is the responsibility of UN administration, CMedO/Force Hygiene Officer have to provide the necessary expertise and have to advise in methods and standards.

7.4.05 Treatment. Medical treatment of personnel is evidently one of the most important issues for the success of every UN mission and is usually defined as treatment at certain levels. Capacity and minimum capability are described in 7.2.10. Providers at each level must be capable and able to provide the medical care as described there.

a. Nations offering forces to UN operations must deploy the medical support that is integral to those formations.

b. Medical units deploying to a Mission Area must

carry an estimated initial medical supply (including consumables) for treatment during the first three months.

c. UN civilian personnel as well as military observers, UN civilian police and locally hired UN personnel are eligible to receive medical care from all UN medical treatment facilities.

d. Many national contingents will include female personnel in their staffing. All medical personnel and medical facilities with the potential of providing care to females, will be appropriately staffed, trained and equipped to provide for their medical needs.

e. Dental support during UN operations normally will be planned for emergency and pain support therapy only. The first level which may provide further treatment should be level 3.

f. The capability to provide for psychiatric /stress control crisis intervention should be included, at the minimum at level 3 facilities in each UN operation.

g. Each level of care must have a sufficient laboratory equipment. However, laboratory work up to level 2 should be limited to routine work such as complete blood count, urine analysis and gram stains.

h. Wherever the possibility and capability for blood transfusions are intended there must be the capability for pre-transfusion cross-matching.

i. All patients must be in a stabilized condition prior to evacuation to other, or between levels of care. The decision for suitability for transfer is a clinical decision and it and the arrangements for transfer will be the responsibility of the holding nation. Levels of care may be skipped if necessary and if the patient is stabilized to withstand the

transport.

j. Evacuation policy/holding period within the theater of operation is set by the UN Force Commander who is advised by the Force Chief Medical Officer. This policy is to be established based on the in-theater medical capabilities.

(1) Although holding policy may vary, level 1 and level 2 should have a holding capability of up to five days, level 3 up to 30 days.

(2) Treatment for more than 30 days should usually cause repatriation at the soonest possible time.

(3) All medical care provided must be documented properly and forwarded with patients as they are evacuated between facilities and levels of care. Documentation must begin at the initial point of injury/illness.

k. Providers of level 1 and level 2 care must be as mobile as the forces they are supporting and they must be capable and able to provide the care prescribed at that level.

(1) Level 1 care will normally be a national responsibility. Covering day-to-day illnesses and injuries in the force is no minor undertaking and should be the responsibility of each contingent/unit using their own medical personnel and facilities. Minor units, numerically in numbers, should be supported by neighboring units with a medical capability.

(2) Medical personnel at level 1 must be able to treat patients for minor injuries and diseases and hold patients pending medical evacuation. They must be able to provide emergency medical care and to convey the casualty directly to the next level of care

as necessary. This care must include beginning of intravenous fluids, control of haemorrhage, application of field dressings, administration of analgetics and establishment of an airway.

(3) Level 2 care should be provided by a national contingent when the size of respective national force structure warrants it.

(4) Level 2 provides resuscitative care as provided by medical units such as a clearing station, medical company, medical platoon or dispensary. Here the patient is examined and the injuries and general status are evaluated to determine the priority, as a single casualty among other casualties, for return to duty or continued evacuation to higher levels of treatment. This level continues previously initiated emergency care, including beginning resuscitation. Depending on the capability of the medical unit, initial surgery to save life or limb may be available. This level has the capacity to hold, treat and return to duty the less seriously injured/ill personnel that will recover in 1-5 days.

1. Level 3 care will initially be coordinated by the UN, through evaluation and deliberate planning of area assessments, world health reports, mission requirements, hosts nation capabilities, etc. Continued refinement of the Level 3 medical support will occur throughout the operational mission.

(1) Medical Director UN will provide initial medical threat information and mission area assessment to Medical Advisor, DPKO/FALD.

(2) Medical Advisor, DPKO/FALD, utilizing UN Medical Directors guidance, and estimations of Disease and Non-battle injuries, along with an evaluation of potential battle

casualties, will provide initial determination of medical support requirements or HQ UN to source.

(3) CMedC, after initial on the ground evaluation, will coordinate with the Medical Advisor, DPKO/FALD torefine medical support requirements.

- Casualty rate estimation to be determined by the Force Commander.

- Force structure adjustments may have to be made to compensate for the varying standards and capabilities of medical support by contributing nations.

(4) This level provides medical care in a facility staffed and equipped to provide resuscitation, initial wound surgery and post-operative care. These facilities may provide additional surgical support, additional laboratory and radiological support. This is the first level of actual hospitalization for statistical purposes.

(5) At level 3, physiological monitoring devises and techniques must be available and employed. Equipment and appropriately trained personnel must be available at these levels to monitor and assess patient conditions.

m. At level 3 medical facilities, dietary requirements must be planned with special consideration to cultural/religious factors of those being fed. Special requirements for acquisition will be coordinated with the Force Chief Logistics Officer.

n. Level 4 provides medical care in a facility staffed and equipped for full definitive care which includes follow-up surgery and other rehabilitative therapy for patients in the recovery phase.

o. Level 4 care is normally provided in facilities outside the theater of operations; i.e., outside the regional area that is directly supporting the (UN-termed) "in-theater" mission. However, level 4 care can be provided within the supporting region when it is likely the individual patient will return to UN duty.

p. National contingents will be expeditiously notified through the designated national liaision points of contact, individuals that become critically injured/ill or die.

q. Any pathological materials/tissues taken in the course of conducting an autopsy or preparing a death certificate must be turned over to the decendent's national representative.

r. Documentation is an important tenant of medical care throughout the various levels of medical care. Charting of provided care is a mandatory requirement and provides a trail for any subsequent medical claims that may arise.

(1) CMedO is responsible to ensure that all medical documents pertaining to medical care of the non-military personnel of a UN operation are provided in a timely manner as prescribed by HQ UN.

(2) On each level must be an adequate documentation of all treatment measures. Documentation must begin at the initial point of injury/illness.

(3) All personnel participating in a UN operation are required to have copies of their relevant health records with them at their supporting medical care facility.

(4) When their UN mission is over, personnel are to take their own health records with them and turn them over to their new supporting

medical facility.

s. Additional Treatment Policies:

(1) Initial resuscitation, when required, should be prompt, adequate and at the site of injury or as far forward as possible. These resuscitation efforts should follow or be comparable to Advanced Trauma Life Support/Advanced Cardiac Life Support standards to the extent that requirements can be achieved in the mission setting.

(2) Initial wound surgery will consist of those procedures necessary to stabilize a patient sufficiently to save life or limb as well as those required to stabilize neurological, vascular, bone and joint wounds and injuries. Time/distance from point of injury to initial required surgery will be six hours or less.

(3) Triage as used throughout this document, is the evaluation and categorization of injured/ill for treatment and evacuation and facilitate the intelligent use of available resources thus ensuring the greatest good for the greatest number. Sorting is accomplished by the medical personnel best qualified to make sound clinical judgements promptly and in a continuous action. Patients are clinically identified by a category title which indicates the urgency of his receiving treatment and likliehood of his survival based upon the clinical problems. This rapid sorting assures that the available treatment is directed, first towards the patients who have the best chance to survive. Although the nature of medical management changes to "the greatest good for the greatest number", at no time is the abandonment of a single patient contemplated. The 4 sorting/triage categories are:

- Minimal - Simple procedures will suffice and enable him to be returned to some form of duty.

- Immediate - Immediate, resuscitative treatment is required. This category has the highest priority for treatment. Generally, the procedures used are short in duration and economical in terms of medical resources.

- Delayed - For the patient whose condition is such that with the application of modest emergency procedure, the possibility of morbidity or mortality increases very little by delaying major definitive procedure until they can be performed under more ideal circumstances.

- Expectant - Injuries are so massive that the probablility of the patient's survival is miniscule, even if the total medical resources were to be concentrated upon him. The objective to provide the greatest good for the greatest number during the period of medical disparity, dictates that medical personnel manage this category of patients with an attidude of alertness to changes in the patient's condition and provide them symptomatic and supportive care until such time as as the medical workload permits a more intensive effort on their behalf.

t. Medical services to personnel outside the UN mandated mission is a matter of some delicacy, where legal commitments must be weighed against humanitarian principles. It must be planned carefully and fully coordinated in concert with the various non-governmental organizations that are present. The official UN policy is that a UN Force has no obligation to give, or to take responsibility for medical services to the local

population. However, emergency cases are always given priority regardless of person and party but must be transferred to HN facilities as soon as possible. Health care for the civilian population should be run by the host country, aided by national and international relief organizations.

u. Although the capacities and capabilities of the medical units always depend on existing national structures and the specific field mission, contributing nations often ask for rough guidelines concerning structure and numbers of personnel, certain basics are therefore given in Annex H/1 - H/4 on pages 85 - 88. The definitive guidelines on size however, will laid down by HQ UN for each UN field mission.

7.4.06 Personnel. Included is individual personnel policy as well as policies pertaining to those who are patients.

a. Every deployed UN force must have a Chief Medical Officer that has direct access to the UN Force Commander. This staff advisor must be a physician.

b. Each deployed national contingent that has medical personnel must have a single designated individual that has the clinical responsibility for all national medical matters. Being a physician, this person will become the national Senior Medical Officer.

c. All personnel being deployed on UN operations must be medically and dentally fit for duty.

(1) The UN medical standards for peacekeeping missions shown in Annex I/1 and I/2 on pages 89 and 90, are the minimum acceptable standards for UN duty.

- Prior to medically clearing an individual for UN duty, the clinician should consider the following: security situation, living conditions, endemic disease and the

physical hardships of the mission.

- Physical conditions which generally preclude UN duty are also listed in Annex H.

- The UN medical standards do not preclude national contingents/military services from establishing higher qualifying medical standards.

- In no cases, however, should an individual be unacceptable for national military duties, but be included in the UN military contingent force.

(2) UN civilian staff, including those hired locally, military observers, UN civilian police must be examined according to the UN medical guidelines and documents forwarded as outlined in Annex J/1 - J/5 on pages 91 to 95.

(3) Many troop contributing countries are testing their military personnel periodically for HIV infection, especially before sending them to overseas assignments. Although testing is not a mandatory requirement yet, it is highly recommended that military or police personnel with known positive HIV status should not be sent to UN peace-keeping missions. The required immunizations for those assignments as well as the endemic diseases of those countries could be detrimental to their health.

(4) Personnel with sexually transmitted diseases at the current time, are not generally precluded from duty with the UN. However, treatment for these diseases may usually not be adequate in-theater. Personnel being HIV positive should not be deployed to UN peace-keeping, observer and special missions.

(5) UN policy precludes medical claims for pre-existing medical conditions. Individuals with diseases outlined in Annex H should therefore generally be considered as precluded from service in a UN field mission.

d. All personnel participating in UN operations should be trained in field hygiene. Military personnel should also be trained in basic first aid care.

e. Medical personnel participating in UN operations must be appropriately trained to provide the required care commensurate with the level of care they are supporting and the medical skills they are said to possess.

f. Where a claim is to be filed, there are specific instructions that must be complied with:

(1) The guidelines for "possible Claims for Compensation for UN Staff Members" are outlined as Annex N/1 - N/5 on pages 102-106.

(2) The guidelines for "Possible Claim for Compensation for Military Observers/Civil Police, Monitors on Assignment" are outlined as Annex O on page 107.

g. The death of a UN staff member or another person assigned to UN duty must be reported immediately. The guidelines describing the responsibilities of Chief Medical Officer in the event of death of a United Nations staff member are outlined in Annex P at page 108.

7.4.07 Material. In this part there are only procedures mentioned which are different from the general supply regulations laid down in Chapter 2, Supply. Included are procedures for medical materials, their movement, medical maintenance and optical fabrication support.

a. Military contingents must be self-sufficient for medical material for an initial period on

deployment. The length of this period will be mission dependant , but should usually cover the first 3 months of deployment.

b. The provision, holding, issuing and accounting for all medical/dental/veterinary supplies (equipment, pharmaceutical and consumables) to a UN force is a major undertaking. It is a joint responsibility of the CMedO, the Chief Administrative Officer and the Chief Logistics Officer, whose offices must cooperate to create a system with the necessary reliablilty, flexibility and speed.

c. Standard UN procedures reflected in Chapter 2, Supply, of this manual are valid also for medical items. Experiences in the past showed however, that the UN procurement system as to invite tenders on the world market and then settle for the most favourable offer, is frequently unacceptable in the context of medical sustainment supplies.

d. Processing a requisition through the UN procurement system is extremely time consuming and is unable to react immediately to urgent requests sue to changing operational threats, mass casualties and changing health threats in-theater.

e. UN procurement has to be sufficient not only for routine requests, but it is imperative that procurement of medical items has to react in an adequate time frame . Therefore, medical supply should use national resources and trained national personnel whenever possible.

f. To improve UN procurement system given the necessary flexibility there are four possibilities for supply of medical items laid down in Annex Q/1 and Q/2 at pages 109 and 110.

(1) **Requisitions are raised by every medical unit seperately for procurement of medical items through the UN procurement system.**

This possibility uses the existing UN procurement system and must remain for not urgent requisitions and requisitions from participating countries without material and financial resource for an own national resupply.

(2) **Every unit will organize their resupply using their own national resources and their own national transportation. Reimbursement will be by UN on a per capita per treatment per day basis for each medical unit. Continuous certified reports of per capita per day treatment are essential.**

In cases where countries are participating with their own resouces for a national resupply, the medical unit has toreport their numbers of treated outpatients and inpatients per level of treatment through CMedO whohas to audit and certify these reports. CMedO will forward the reports to Chief Administrative Officer who will onforward them to FALD.

Based on estimated costs for outpatients and inpatients on the different levels of treatment, UN will reimburse each requesting nation on a per capita, per day basis. The nation itself becomes responsible for a sufficient national resupply including transport of medical items in theater. This national resupply will be financed by the per capita per day payment by the UN.

(3) **A lead nation will take over responsibility for medical resupply in theater, but will raise a collective requisition for central procurement through the procurement system of the UN.**

In cases where there is a designated lead nation for medical supply without national

resources, this nation will collect the requisitions raised by allmilitary medical units and will raise a collected requisition through DOA/CAO using the existing procurement system of UN.

Shipment of medical items will only be to this nation which has the responsibility to run a pharmaceutical warehouse and to support all military medical units in theater.

(4) **A lead nation will take over responsibility for medical resupply in theater by running a medical pharmaceutical warehouse and will use their own natural resources and own national transportation.**

Reimbursement will be by UN on a per capita per day basis of each medical but only to the nation providing the warehouse. Continuous certified reports of per capita per day treatment are essential.

The fourth possibility uses national resources of a lead nation willing to resupply medical items for all participating military medical units. All medical units will report their number of inpatients and outpatients to FALD as described in e. 2. above. The per capita per day reimbursement for all military medical units will however be only to the lead nation providing a central pharmaceutical warehouse in theater.

(5) The needed form to report per capita per day treatment is shown in Annex F on page 83.

(6) Although per capita per day reimbursement and a responsible lead nation seems to be the most sufficient way to improve medical resupply for UN operations, flexible enough to respond to rapid changes in theater, this concept is not yet approved by United Nations

Secretariat New York.

(7) For each particular mission, HQ UN must determine the methods to have medical sustainment supplies acquired for UN use. Concurrence from participating nations must be obtained prior to implementation.

(8) Experiences from recent UN missions and nations in expenses on a per capita per day treatment lead to an initial estimate of:

- 5 US$ per outpatient on all levels including inpatient treatment on level 1 and 2.

- 35 US$ for inpatients on level 3 (and 4 if existing intheater of operation).

f. National contingents are encouraged to use pharmaceuticals which are internationally known generic drugs. Pharmaceuticals must come from sources that comply with internationally recognized standards. Only internationally registered generics should be used. In no cases are "unique to an area" pharmaceuticals to be used on personnel of another contingent's force unless internationally recognized quality standards are assured.

(1) UN HQ's listing of pharmaceuticals and consumables that are to be used as a guide for standardization throughout the theater of operations is attached as Section 6 to this chapter.

(2) Brand name drugs tend to be considerably more expensive than generic drugs and will not be used unless absolutely necessary.

g. Requisitions for medical items have to be extremely precise to ensure an identification of drugs and comsumables without any doubt.

Requisitions should be raised seperately for:

(1) Human medicines

(2) Human consumables

(3) Dental medicines

(4) Dental consumables

(5) Laboratory items

(6) Hygienic items

(7) Veterinary medicine

(8) Veterinary consumables

The requested requisition form for medical supply is shown as Annexes R/1 and R/2 on pages 111-112.

h. Disposable medical supply products will be used as much as possible. UN reimburses medical sustainment costs that include the use of disposable products.

i. Sterilization of reusable medical products must be in accordance with internationally recognized standards.

j. CMO in coordination with the force Chief Logistics Officer is responsible for the destruction of medical material (such as outdated pharmaceuticals, needles and syringes) and the disposal of contaminated medical waste.

k. It is a national responsibility to ensure personnel are optically prepared for deployment to UN operations. It is the CMO's responsibility in coordination with the DOA/CAO to coordinate for optical support when it is required during the conduct of the UN operation.

l. It is a national responsibility to maintain and repair contingent owned medical equipment.

m. Medical equipment is usually not provided by the UN and has to be taken out of national resources only. However, in a case to case decision, the UN may agree in providing medical equipment on special requests.

n. The reasonable and customary bills for the replacement of service-incurred loss or damage of spectacles and hearing-aids may be reimbursed by submitting those bills to the DOA/CAO. These bills are usually settled by the local boards and provision for that is made in the budget for troop costs.

10.4.08 Blood. Blood and blood products are perhaps the most sensitive of national contingent concerns in UN operations. The quality assurance of blood and blood products begin at the time of collection and continue all the way to the time of transfusion. Some national contingencies have requirements for a quality control system that continues beyond the time of transfusion in regard to documentation policies.

a. Blood not meeting international standards for collection, processing, testing, transporting and storage will not be used unless a clinical decision is made that it is necessary to save life.

b. Blood in storage must be maintained at a temperature range of +1 degrees centigrade to =6 degrees centigrade. During transport, blood products must be maintained at a temperature range of +1 degree centigrade to +10 degrees centigrade.

c. Blood and blood products are only to come from sources that meet international testing standards. Testing is required at least against:

(1) Erythrocyte antibodies

(2) GPT

(3) Treponemal agglutination test

(4) HIV 1 and 2

(5) Hepatitis C virus

(6) Hepatitis B surface antibodies

d. Because provision and transport of blood and blood products is a matter of such high importance, a lead nation's designation for sourcing of blood and blood products is encouraged.

e. The CMO, in concert with national contingent medical officers, will establish the blood support plan to the UN operation.

f. Blood and blood products must be available at level 3 and level 4 medical facilities.

g. Transfusions will only be performed after compatible cross matching which is to be done in accordance with international standards. Transfusions are not to be done based on records or verbal indications of blood types.

h. Nations desiring a national supply of blood and blood products will do so at no additional expense to the UN.

7.4.09 Evacuation. The CMedO plans and coordinates the medical evacuation plan which will be dependant on the evacuation resources available to support the operation. In general, when using means of ground evacuation, it is a national responsibility to evacuate rearward to higher levels of care, versus a higher level of care collecting from the lower levels.

a. Intra theater evacuation will be planned to support the tenant that initial surgery is no more than 6 hours away from the point of initial wounding/injury.

b. Physicians are ultimately responsible for decisions

concerning casualty evacuation. The evacuation policy establishes the maximum number of days that a patient should be hospitalized/held in theater of operations.

c. The medical welfare of the patient must be the paramount consideration. Evacuations will not take place unless the patient has been clinically determined to be stabilized to withstand the duration of the movement to the next care facility with a high probability of not incurring complications requiring invasive treatment or intervention during evacuation beyond the scope of general supportive care during the evacuation.

d. Medically dedicated means of transport are preferred in support of UN operations. If available, they will conspicuously be marked as medical assets. In the absence of dedicated transport, specific ground and air assets will be designated with the additional mission of medical evacuations.

(1) Each ground evacuation vehicle will be accompanied by medical personnel and equipment/supplies to provide enroute medical care to the patient.

(2) Designated aircraft with an aeromedical support mission, whether they are military and/or chartered civil aircraft, will be configured to support a patient and will be accompanied by medical personnel, equipment and supplies to provide inflight sustainment medical care to the patient. The decision to fly casualties directly to hospitals depends on 5 variables:

- the clinical status of the casualty,
- the flying time,
- the weather conditions,

- the casualty generation rate or load,

- the mission situation.

e. The CmedO, with the force Aviation Control Center, isresponsible for coordinating aeromedical evacuation. The decision to evacuate will be based primarily on clinical decision. Economy of transportation resources is encouraged.

f. Requirements for attendants and necessary additional equipment/supplies to accompany patients during evacuation will be based on a clinical decision.

g. The CMedO is responsible to coordinate for appropriate attendant care and support items.

h. Equipment exchange of like items between medical forces transferring patients will be employed whenever possible. This is to be doneto minimize inconvenience to the patient.

i. Patients will be transferred to their own national organization at the earliest practical opportunity when:

(1) A medical facility of their own nation is within reasonable proximity of the facility of the holding nation and,

(2) The patient is determined to require hospitalized in excess of the holding policy, or

(3) There is any question as to the ability of the patient to perform duty upon release from the hospital, or

(4) There is any question as to the capability of the medical unit performing adequate-

treatment.

j. When any national desire to evacuate its own personnel is contrary to the clinical opinion of the medical officer in charge, especially in the cases mentioned above in i. 3. and i. 4. the decision whether an evacuation has to be executed or not will be made by the CMedO. His decision is binding for all parties. However, when a nation insists on evacuation of it's personnel against the clinical opinion of the Medical Officer in charge and the CMedO it becomes a national responsibility and may affect future claims against the UN.

k. It is essential that adequate documentation of the patient's pre-movement and inflight course maintained and accompany the patient so that continuity of medical care is ensured. All clinical documents, including X-rays related to the patient will accompany him/her on transfer to the designated point of evacuation.

l. Procedural guidance for the medical evacuation/repatriation of military observers and civilian police is contained at Annexes K/1 and K/2 on pages 96 and 97. In most cases, prior approval of the evacuation is required from HQ UN. UN staff members have a seperate personnel directive for medical evacuation, as outlined in Annexes L/1 and L/2 on pages 98 and 99 that should be followed when the need arises.

m. Medical repatriation is a medical evacuation normally back to the patient's own country.

(1) Medical repatriation on medical grounds applies to all those who are unlikely to be fit for duty within the evacuation/holding policy established, or those requiring treatment not available in the mission area. In general, 30 days is provided as a guideline for this evacuation policy.

(2) Generally, any inter-theater medical evacuation where there is not the intent to immediately return the patient to the UN operation is a medical repatriation.

(3) Coordination of this is a responsibility of the CMedO working with the respective country and the UN HQ.

(4) Once an individual is medically repatriated, continuing medical care is a national responsibility.

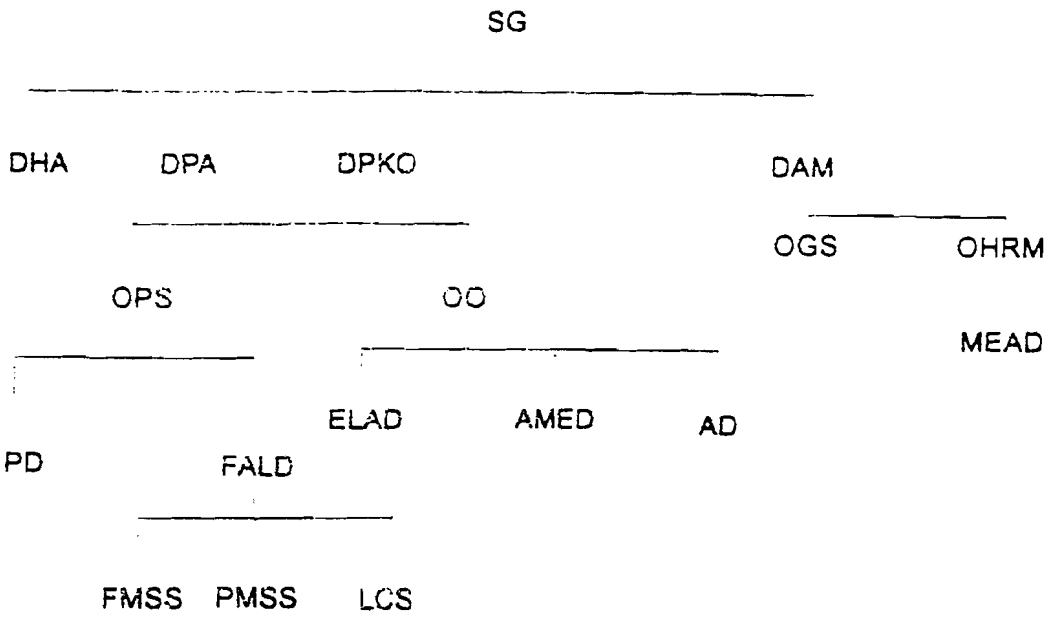
(5) All military personnel arriving in theater not fit for duty shall be repatriated immediately when one of the illnesses listed in Annex H are found and no definitive treatment is possible within the timeframe laid down by the CMedO in his evacuation policy guideline.

(6) Pregnant women should be repatriated at the end of their fifth month of pregnancy at the latest.

(7) All personnel diagnosed as having AIDS will be repatriated as well.

(8) Although in many cases national military or commercial airplanes will be primarily used for repatriations there are several possibilities to perform a fixed wing MEDEVAC/REPATRIATION using commercial air ambulances. Effective January 1989, the Swiss Government as part of its contribution to UN Peace-keeping activities made available the services of an air ambulance called REGA. Necessary information requested by UN HQ to be able to approve and assist in performing MEDEVACS/REPATRIATION is listed in Annexes M/1 and M/2 on pages 100 and 101. REGA's address,telephone and fax number are also provided in Annex L.

MEDICAL ORGANIZATIONAL RELATIONSHIP WITHIN UN HQ N.Y. (Secretariat)



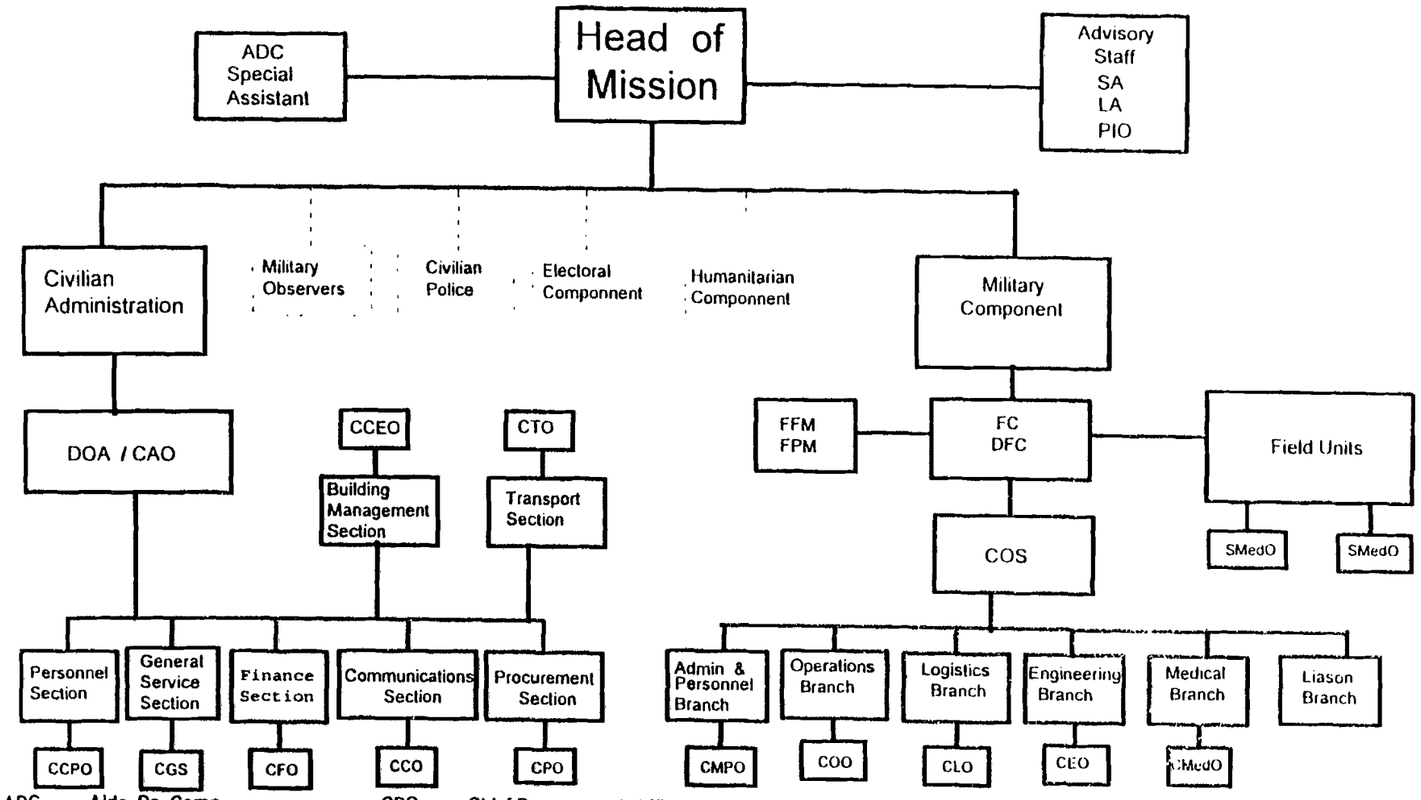
Abbreviations:

AD	Africa Division
AMED	Asia and Middle East Division
DAM	Department of Administration and Management
DHA	Department of Humanitarian Affairs
DPA	Department of Political Affairs
DPKO	Department of Peace-keeping Operations
ELAD	Europe and America Divisions
FALD	Field Administration and Logistic Division (former FOD)
FMSS	Finance Management Support Service
LCS	Logistics and Communications Service
PMSS	Personnel Management and Support Service
MEAD	Medical and Employee Assistance Division
OGS	Office of General Services
OHRM	Office of Human Resources Management
OO	Office of Operations
OPS	Office of Planning & Support
PD	Planning Division
SG	Secretary-General

Notes: Medical Director UN is leader of MEAD
Medical Advisor DPKO / FALD is located in FALD / LCS

EXAMPLE OF A BASIC ORGANIZATION CHART

FOR PKO HQ



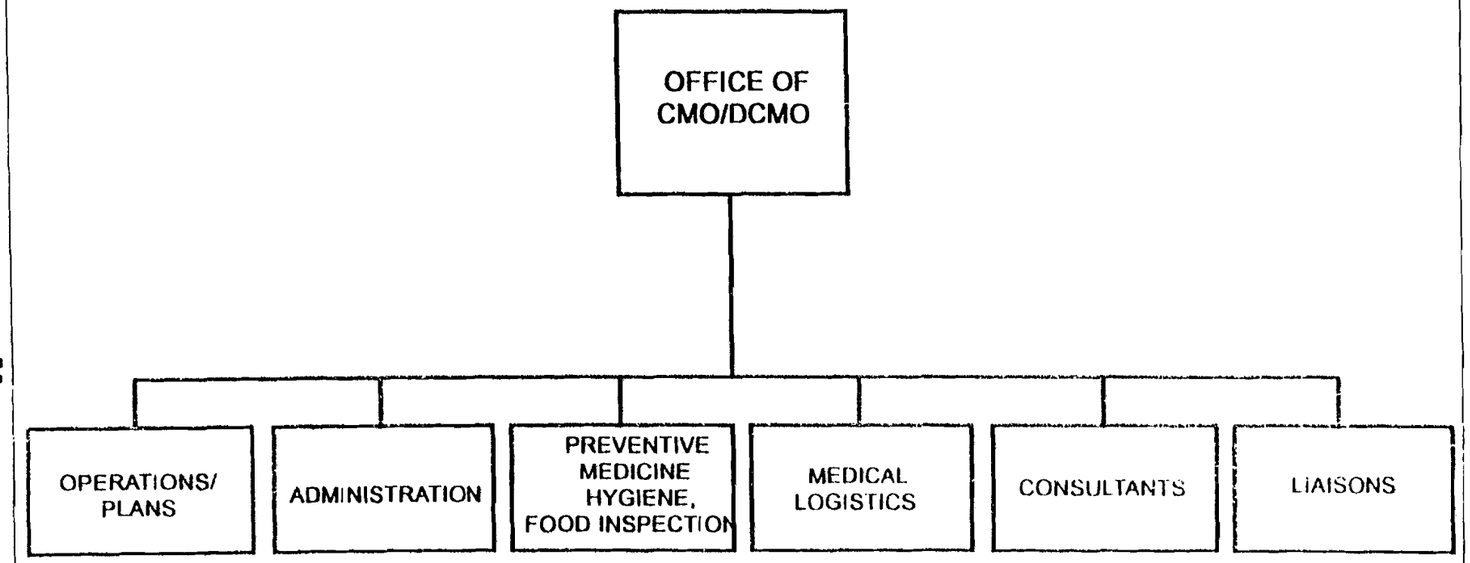
ADC	Aide De Camp	CPO	Chief Procurement Officer
CAO	Chief Administrative Officer	CTO	Chief Transportation Officer
CCEO	Chief Civilian Engineering Officer	DFC	Deputy Force Commander
CCO	Chief Communications Officer	DOA	Director of Administration
CCPS	Chief Civilian Personnel Section	FC	Force Commander
CEO	Chief Engineering Officer	FFM	Field Fire Marshall
CFO	Chief Finance Officer	FPM	Field Provost Marshall
CGS	Chief General Services	LA	Legal Advisor
CLO	Chief Logisitic Officer	PIO	Press Information Officer
CMedO	Chief Medical Officer	SA	Senior Advisor
CMPO	Chief Military Personnel Officer	S MedO	Senior Medical Officer
COO	Chief of Operations	SRSG	Special Representative Secretary General
COS	Chief of Staff		

Note:

(1) This is a basic organisation chart containing elements which will be found in most PKO. Civilian Administration and Military Componentare essential, other elements such as Military Observer, Civilian Police, Electoral and Humanitarian Component supplemental.
(2) Expansion of Civilian and Military Staff Elements to include constituent sections can be done if necessary.
(3) Head of Mission can be SRSG, Special Envoy, or FC.
(4) CMedO is also Medical Advisor to Force Commander.

EXAMPLE OF A FUNCTIONAL ORGANIZATION CHART

FOR HQ MEDICAL STAFF SECTION FOR UN FIELD MISSIONS



LOCATION, LEVEL, CAPABILITIES - level 2 and up only
(Report is requested on the first of every month during the first 6 months of a new UN Field Mission. After that on the first of January, April, Juli, October, or on special request)

Date of report:

Name of Mission medical unit:.....

Change location, level, capabilities: ☐ NO - see former reports
☐ YES - see report below

1. Organization:

Name, rank, title of header:.....

Location:.....

Point of contact:.....

Phone number.....

Other communication system (numbers, radio frequencies, call sign, etc):.....
.....

Next airfield or heliport/distance:.....

2. Personnel: physicians/specialists:.....
nurses:.....
medics:.....
other:.....
total:.....

3. Beds and/or cots: total:.....
surgical:.....
maximum number in case of mass casualty:.....

4. Medical capability: specialities:.....
.....
isolation ward:.....

5. Intensive care unit:	ICU beds:..... equipment:..... .....
6. Surgical capability:	specialities:..... .... operating rooms:..... operating teams:.....
7. Labaratory capability:	microbiology:..... virology:..... parasitologie:.....
8. X - RAY:	skeleton:..... ..... abdominal:..... others:..... ultrasound:.....
9. Blood bank:	screening .methods:..... .....
10. Dental capability:.....	
11. Other special capabilities:.....	
12. Preventive medicine assets:.....	
13. Veterinarian service:.....	
14. Medevac capability:	ground, (number of ambulances):..... air: (number of aircraft (capacity and location):..... .... request procedures incl. phone number or requencies: ....

Medical Flash Report

(Report must submitted immediately, with follow-up reports as soon as additional information is available)

Mission Unit:.....Date of report:☐☐/☐☐/☐☐

Type of incident:.....
Place of incident:.....
Time of incident:.....

DEAD	DNBI	DOW	KIA	TOTAL
Military UN				
Civil UN				
Local hired UN				
Military Observers				
Civil Police				
Civilians				

WOUNDED, INJURED, SICK	DNBI	NBI	WIA	TOTAL
Military UN				
Civil UN				
Local hired UN				
Military Observers				
Civil Police				
Civilians				

DNBW = dies as result of non-battle wound/injury
DOW = died in hospital as result of battle wound/injury
KIA = killed in action (dies out of hospital)

DNBI = disease and non battle injury
NBI = non battle injury
WIA = wounded in action

Diagnoses of infectious disease outbreak or other illnesses:.....
.....
Verified:.....
Decisions made:.....
.....
.....
Additional information:.....
.....
.....

DATE OF REPORT

MEDICAL TREATMENT REPORT - PER CAPITA

(Monthly - for previous month)

MISSION : / UNIT	OUT PATIENT							IN PATIENT						
	MILITARY UN PERSONNEL *	CIVIL UN PERSONNEL *	LOCAL HIRED UN PERSONNEL *	MILITARY OBSERVER *	CIVIL POLICE *	FAMILY MEMBERS OF *	CIVILIANS	MILITARY UN PERSONNEL *	CIVIL UN PERSONNEL *	LOCAL HIRED UN PERSONNEL *	MILITARY OBSERVER *	CIVIL POLICE *	FAMILY MEMBERS OF *	CIVILIANS
LEVEL 1														
LEVEL 2														
LEVEL 3														

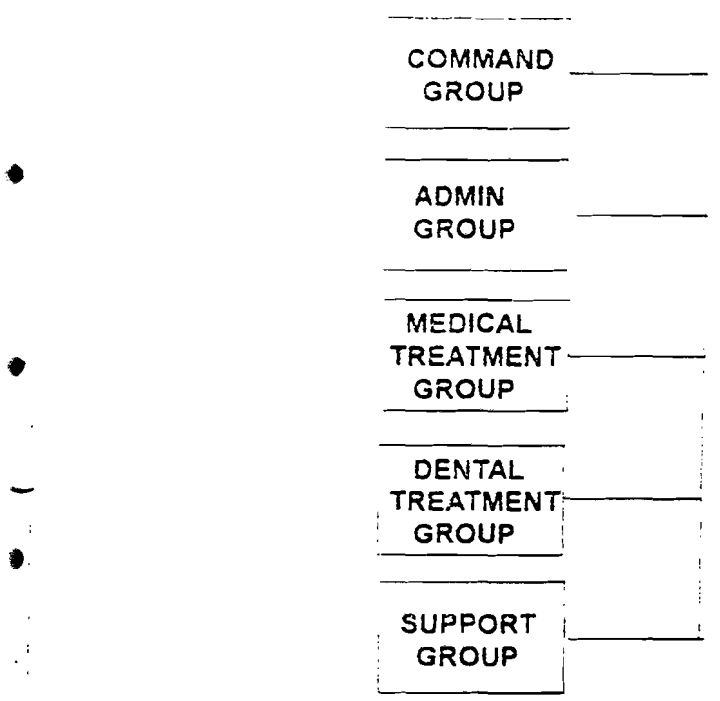
MEDICAL TREATMENT REPORT - DIAGNOSES (Monthly - for previous month)

DATE OF REPORT

MISSION UNIT	OUTPATIENT	INPATIENT	MEDICAL EVACUATION	REPATRIATION	DEATH
Injuries					
- Weapons, mines, etc					
- Traffic					
- Sport/other accidents					
Non-infectious Diseases					
- Cardiovascular					
- Pulmonary (except TBC)					
- Gastrointestinal					
- Uro-genital (except Venereal)					
- Arthritis & Musculoskeletal					
- Neurological					
- Eye					
- ENT					
- Skin					
- Abuse (alcohol & drugs)					
- Tumors					
Infectious Diseases Bacterial & Viral					
- Upper Respiratory Infection					
- Diarrhoea					
- Dysentery					
- Tuberculosis					
- Influenza					
- Typhoid Fever					
- Hepatitis (A,B,C)					
- Dengue Fever					
- Cholera					
- Poliomyelitis					
- Meningitis					
Infectious Diseases: Protozoal & Parasitic					
- Malaria					
- Amoebiasis					
- Giardiasis					
- Leishmaniasis					
- Pediculosis					
- Scabies					
- Ascariasis					
- Enterobiasis					
- Anchylostomiasis					
- Taenia					
- Echinococcus					
- Bilharziasis					
- Filariasis					
Sexually Transmitted Diseases					
- Gonorrhoea					
- Syphilis					
- Chancroid					
- HIV/AIDS					
Gynaecological					
- Vaginitis					
- PID					
- Pregnancy					
- Other					
Poisonings					
- Accidental					
- Chemical/Biological Agents					
Bites					
- Dog					
- Snake					
- Scorpion					
Consultations					
- Vaccinations					
- Examinations					
Dental					
- Fillings					
- Other					

STRUCTURE AND PERSONNEL OF MEDICAL FIELD UNIT

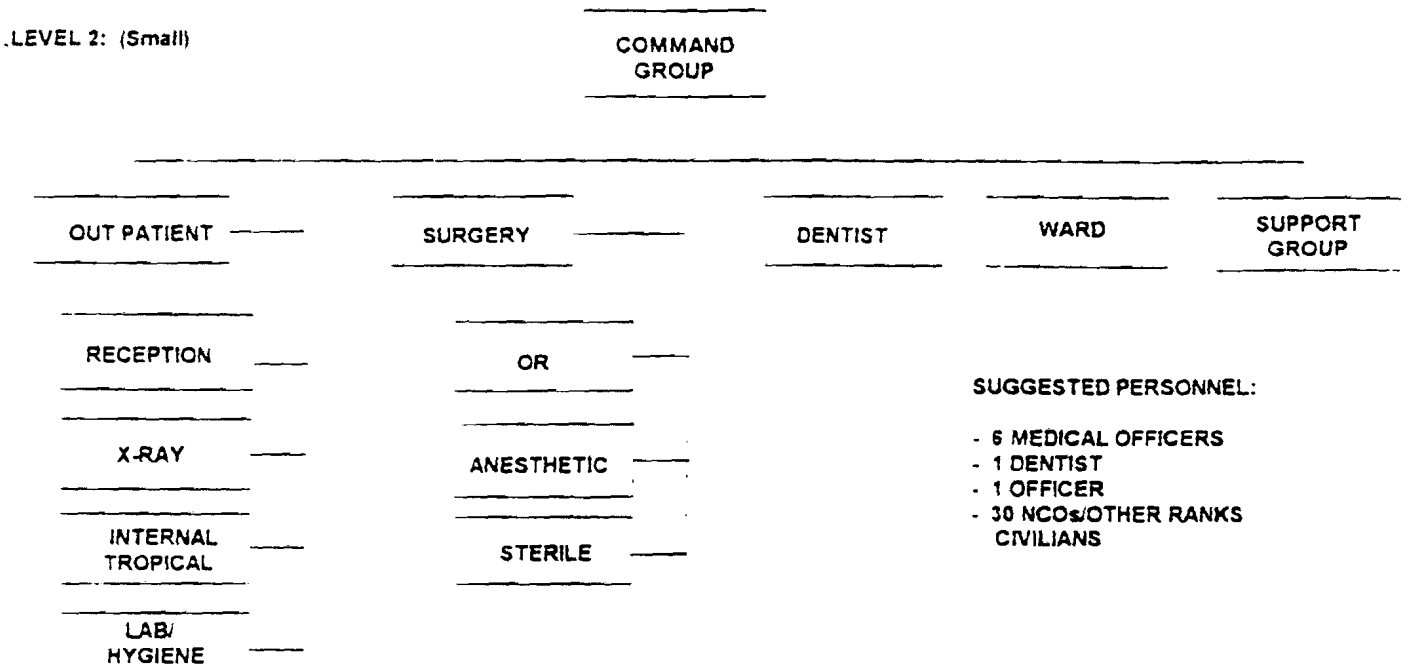
LEVEL 1:



SUGGESTED PERSONNEL:

- 2 MEDICAL OFFICERS
- 1 DENTIST
- 10 NCOs/OTHER RANKS/CIVILIANS

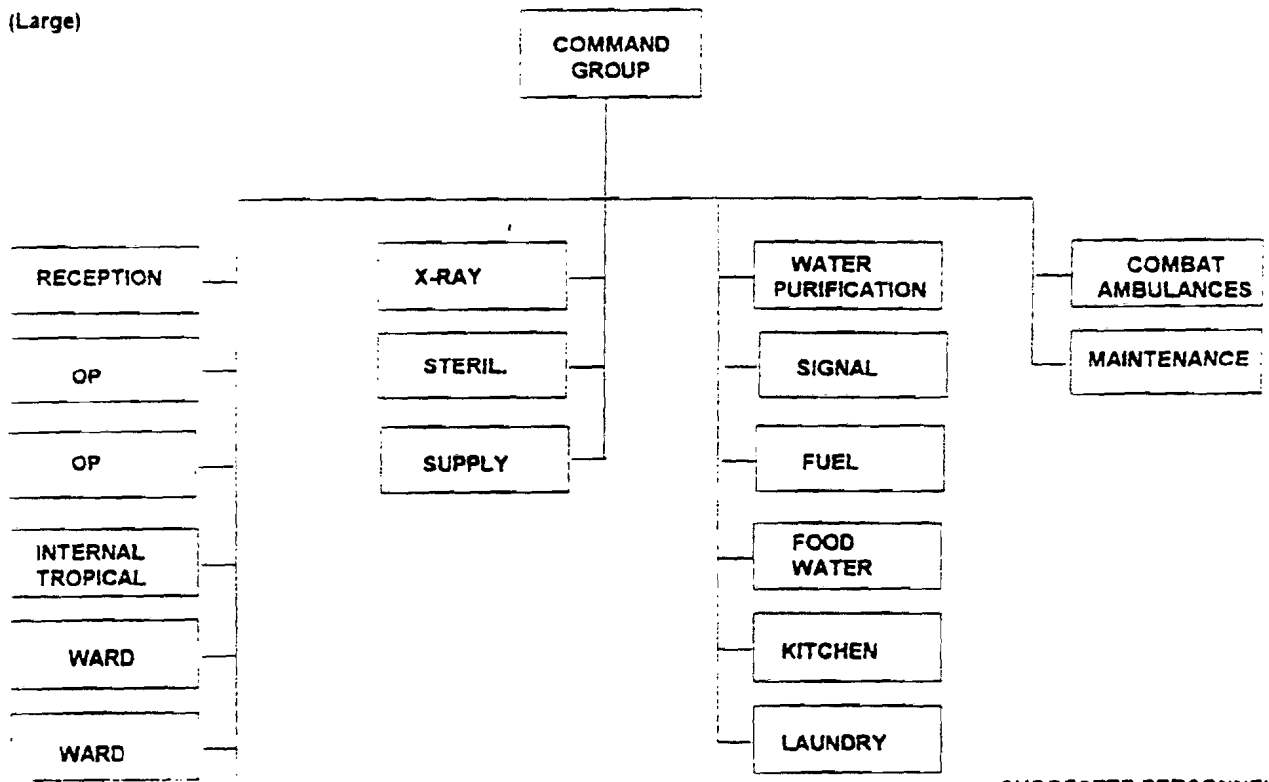
LEVEL 2: (Small)



SUGGESTED PERSONNEL:

- 6 MEDICAL OFFICERS
- 1 DENTIST
- 1 OFFICER
- 30 NCOs/OTHER RANKS CIVILIANS

LEVEL 2: (Large)

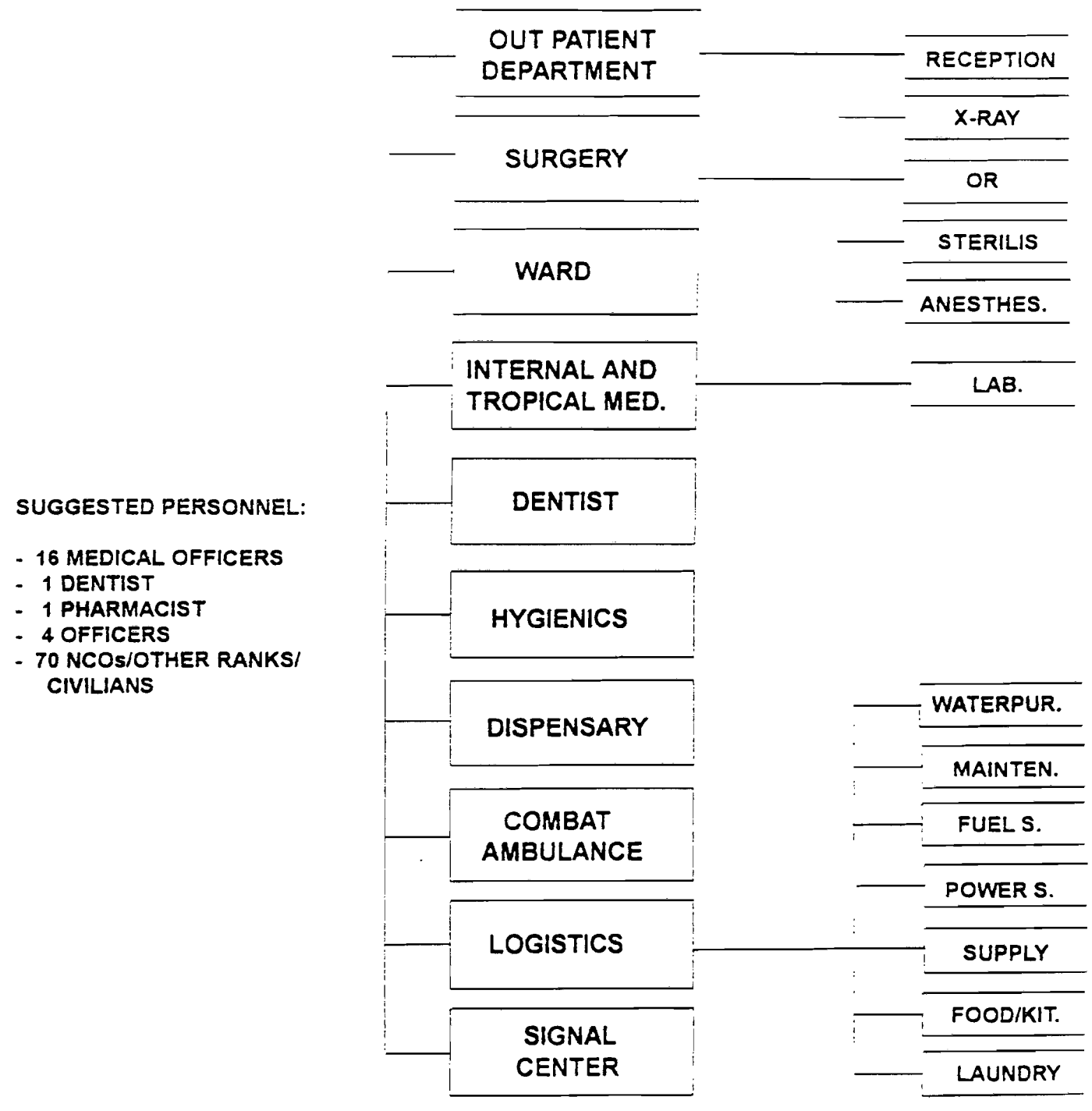


SUGGESTED PERSONNEL:

- 16 MEDICAL OFFICERS
- 1 DENTIST
- 5 OFFICERS
- 55 NCO/OTHER RANKS/ CIVILIANS

STRUCTURE AND PERSONNEL OF MEDICAL FIELD UNIT

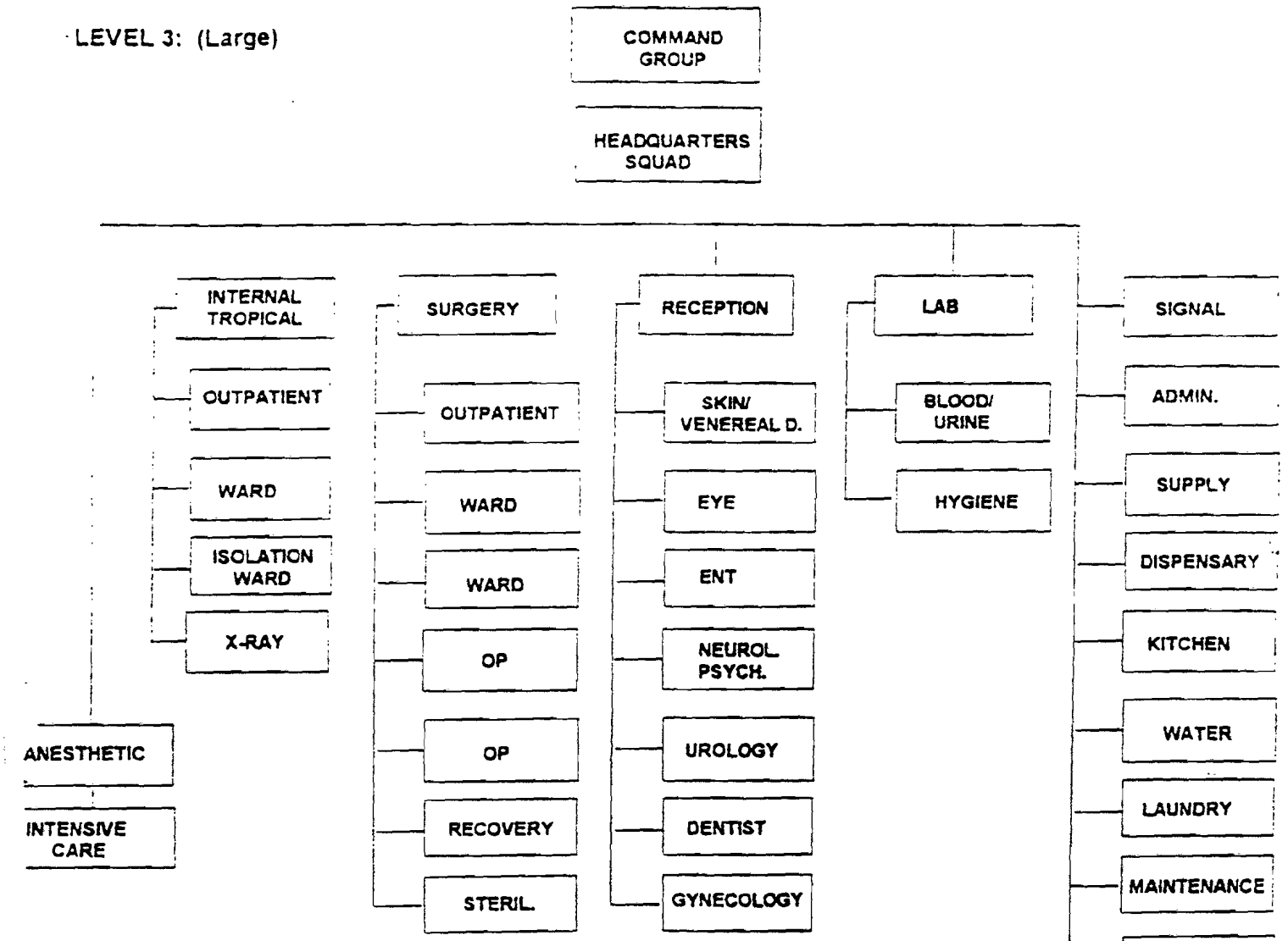
LEVEL 3: (Small)



SUGGESTED PERSONNEL:

- 16 MEDICAL OFFICERS
- 1 DENTIST
- 1 PHARMACIST
- 4 OFFICERS
- 70 NCOs/OTHER RANKS/ CIVILIANS

LEVEL 3: (Large)



SUGGESTED PERSONNEL:

- 30 MEDICAL OFFICERS
- 1 DENTIST
- 3 PHARMACISTS
- 15 OFFICER
- 140 NCOs/OTHER RANKS/ CIVILIANS

UN MEDICAL STANDARDS FOR
PEACEKEEPING/SPECIAL MISSIONS

1. Staff assigned to peacekeeping/special missions are exposed to hazardous conditions not normally associated with peace-time service. Moveover, due to stressful and changed working environment, there is a potential of aggravation of any pre-existing medical condition. Therefore, special consideration should be given to staff with a history of certain chronic medical problems.

Medical Standards

2. When examining members for service in a peace-keeping special mission area, it must be borne in mind that they may be required to serve where unfamiliar diseases are endemic, where sanitation may be sub-standard and amenities few. They may be required to travel on foot and live in primitive conditions. Recreational facilities may be scarce.

3. Physicians shall make their assessment on the basis of medical history, physical examination, laboratory and X-ray results, and an estimate of personality characteristics.

4. Special considerations shall be given to members with a history of the following conditions, who may function well in a relatively sheltered service environment, but may prove to be a medical liability in a peacekeeping mission assignment:

a. Physical Conditions - The following conditions are generally considered as precluding service in peacekeeping areas, but must be carefully assessed on an individual basis, taking into account the severity of the condition and the particular area for which the member is being examined;

(i) ischemic heart disease;

(ii) hypertension requiring medication;

(iii) diabetes;

(iv) malignancies;

(v) history of gastro-duodenal ulcers - a single instance of duodenal ulcer in the past history of a member should not preclude service in these areas;

(vi) ulcerative colitis;

(vii) asthma, chronic bronchitis and emphysema;

(viii) chronic nephritis and urinary lithiasis;

(ix) low back condition;

(x) skin diseases, such as extensive eczema, cystic recurrent acne, and skin cancer;

(xi) allergies requiring sustained supportive treatment;

(xii) members on special continuing medication such as steroids; anti-tuberculous treatment, chemotherapy, anti-depressant and anti-psychotic drugs;

(xiii) endocrine disturbance such as hyperthyroidism;

(xiv) members with known allergies to antimalarial medication;

(xv) members with any immuno-compromised medical conditions such as HIV/AIDS.

b. Psychiatric Conditions - Members, who in the past have had episodes of situational maladjustment, anxiety neurosis or neurosis with somatization should be very carefully evaluated. Members who have been known to require minor tranquilizers for relatively long periods of time, should also be screened carefully.

c. Alcohol - The stress of deployment in these special areas and the environment of such areas create conditions favouring excessive alcohol consumption. Members who have a history of problems related to the use of alcohol or are known to be heavy drinkers should be screened carefully for service in these areas.

Immunization

5. Immunization programme shall be carried out in accordance with WHO's recommendation for that particular special mission area.

6. Anti-malarial medication for members proceeding to a malarious area shall be prescribed in accordance with WHO and UN guidelines.

MEDICAL EXAMINATION AND DOCUMENTATION

A member selected for service in a peace-keeping area will be medically examined in accordance with the UN Medical Standards, to determine his/her fitness for the duty.

The following documentation will be required for UN Mil Obs, Civ Pols and UN Staff Members but not for military contingents:

a. A complete physical examination shall be completed and recorded on forms MS-2.

b. Chest X-ray, haematology, blood chemistry, urinalysis and Venereal Disease Research Laboratory tests shall be completed.

c. An electrocardiogram (EKG) will be done on everybody if they require chemoprophylaxis for Malaria, Mefloquine, Quinine and Halofantine.

d. The completed original MS-2 form with chest x-ray film and report, laboratory results and EKG tracing are to be forwarded all together to the UN Medical Service, New York. Failure to comply with these instructions will result in undue delays in providing medical clearances. A copy of the MS-2 form is being enclosed.

A copy of the MS-2 form is being attached.

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)

. . . . . .

. . . . . .

. . . . . .

TELEPHONE

BIRTHPLACE

DUTY STATION

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:

MS.2 (1-88) - E.

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	N
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 neuralogist, 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? _____

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.)

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 : _____

DIRECTIVE FOR MEDICAL EVACUATIONS

MEDICAL EVACUATION OF MILITARY OBSERVERS AND CIVILIAN POLICE

1. This directive establishes conditions for the authorization of travel expenses on medical grounds in respect of Military Observers and Civilian Police and also sets out the procedure to be followed for arranging medical evacuation.

Who may be medically evacuated

2. **Military Observers, Civilian Police and UN staff members serving in the peacekeeping and Observation missions** may be evacuated at the United Nations expense for the purpose of securing essential medical care or treatment which cannot be secured locally because of the inadequacy of medical facilities in relation to the particular injury or illness. There is a separate personnel directive available for the UN staff members.

3. In appropriate cases, travel of an accompanying doctor, nurse or a colleague may be authorized.

When medical evacuation is justified

4. Medical evacuation may be authorized for any severe injury or illness requiring medical intervention locally unavailable or inadequate. Medical evacuation for a chronic pre-existing condition will be reviewed on a case by case basis.

Procedure for medical evacuations

5. Authority to approve medical evacuation is delegated to the heads of peacekeeping and Observation missions, in consultation with the UN Medical Director. In an extreme medical emergency, in respect of all Military Observers, Civilian Police and UN staff members, the decision to evacuate will be taken directly by the head of mission in consultation with Chief Medical Officer, or the UN Examining Physician/UN Dispensary Physician in the area of the duty station. The prior approval of the UN Medical Director in New York is required for all the non-emergency medical evacuations.

6. In cases where the prior approval of the UN Medical Director is required, requests for medical evacuation should contain patient's **current clinical condition, tentative diagnosis, latest lab results, treatment initiated and the specific purpose of the evacuation.** It is essential that correct and complete information be communicated to the Medical Director to avoid unnecessary delays. Each request for medical evacuation will be reviewed individually, taking into consideration the recommendations of Chief Medical Officer of the mission, or of the local UN examining Physician/UN Dispensary physician, and any other medical information at hand.

7. In the emergency situations, when the head of mission will take the decision to evacuate, he/she will inform Field Personnel Section/Field Operations Division at headquarters of the circumstances involved and send all the medical information directly to the office of the UN Medical Director.

8. Since many of these injuries or illnesses could be recognized as service-incurred, UN Medical Director in her capacity of a Medical Advisor to ABCC, based on the available medical information, advises on the entitlement of the injured or sick for compensation under **the Notes for the Guidance of Military Observers in case of a military observers/civilian police monitors, or under Appendix D to UN Staff Rules for UN staff members.**

9. The Medical Service at Headquarters is available for consultation and assistance in all cases, and may be reached by telephone, fax or telex at the numbers listed in Annex A.

10. Medical information is confidential and should be treated as such, whether within offices or in the transmission to the Medical Director.

ANNEX

The UN Medical Director at Headquarters could be reached as follows:

Telephone: (212) 963-7082, during office hours;

(212) 963-6666, after working hours, through UN Security

FAX: (212) 963-4925

DIRECTIVE FOR MEDICAL EVACUATION

MEDICAL EVACUATION OF CIVILIAN COMPONENT OF PEACEKEEPING MISSION

1. This directive establishes conditions for the authorization of travel expenses on medical grounds in respect of civilian component of peacekeeping missions and also sets out the procedure to be followed for arranging medical evacuation.

Who may be medically evacuated

2. Internationally recruited staff members may be evacuated at United Nations expense for the purpose of securing essential medical care or treatment which cannot be secured locally because of inadequate medical facilities in relation to a particular illness or injury.

3. Locally recruited staff members, their spouse and dependent children in situations of great emergency where medical risk is very high or where a life-threatening condition is present, medical evacuation will be considered when the available local facilities do not offer, in the opinion of the Medical Director, an adequate response to the medical emergency.

4. In appropriate cases, travel of an accompanying doctor or nurse may be authorized.

Procedure for medical evacuations

5. Authority to approve medical evacuation is delegated to the heads of departments and offices, in consultation with the UN Medical Director. Except in the cases described in subparagraphs a. and b. below, the prior approval of the Medical Director is required for all medical evacuations. The decision to evacuate will be taken directly by the head of office in consultation with Chief Medical Officer without prior approval of the Medical Director under the following circumstances:

a. In an extreme medical emergency, in respect of all staff and their eligible dependents;

b. In non-emergency cases, one medical evacuation for a particular medical condition, in respect of internationally recruited staff assigned to those missions (prior approval of the Medical Director will be required for follow-up evacuations).

6. In case where the prior approval of the Medical Director is required, requests for medical evacuation should contain patient's current clinical condition, tentative diagnosis, latest lab results, treatment initiated and the specific purpose of the evacuation.

7. In the situations described in paragraph 4. a. and b. above, the head of office will take the decision to evacuate following consultation with the Chief Medical Officer. In such cases, the head of the office shall inform the relevant administrative service at Headquarters of the circumstances involved and send all the medical information directly to the office of the Medical Director. In all cases of medical evacuation, a medical report from site of evacuation shall also be forwarded to the United Nations Medical Director.

8. The Medical Service at Headquarters is available for consultation and assistance in all cases, and may be reached by telephone, fax or telex.

9. Medical information is confidential and should be treated as such, whether within offices or in the transmission to the Medical Director.

Place to which medical evacuation could be authorized

10. Where medical evacuation is justified, it shall be authorized, as a general rule, to the place nearest the duty station where adequate medical facilities are available bearing in mind the particular nature of illness or injury involved, the type of treatment required, and the language spoken.

11. For deliveries, psychiatric conditions and for illnesses requiring a prolonged recuperation period, medical evacuation to the place of home leave or repatriation to parent duty station should be encouraged.

12. If the staff member prefers medical evacuation to his/her place of home leave, such travel may be authorized as advanced home leave or family visit.

13. Normally the staff member should return to the duty station when the attending physician at the authorized place certifies that he/she is fit to do so. This certificate should in due course be forwarded to the Medical Director. In cases of serious illness or injury, the Medical Director has the authority to approve the return of the patient to the duty station, and the patient may not return to the duty station at the expense of the organization before such approval is given.

The complete Personnel Directive on Medical Evacuation document (PD/1/1992) is available from the Chief Administrative Officer/Peace-keeping Operations.

Information required by UN HQ, NY, prior to approving of MEDEVAC/REPATRIATION

The following information should be submitted to FPS/FOD/DPKO and MEAD/ OHRM/DAM, in accordance with the Directives outlined in Annexes J and K, for requesting approval of a planned MEDEVAC/REPATRIATION:

Internationaal UN staff. ☐, Locally recruited staff: ☐, MO: ☐, CivPol: ☐, Soldier: ☐.

Name (last, first, middle):.....

Date of birth: ☐☐/☐☐/☐☐ Passport/VISA:.....

Rank/Title:.....Service-/Index-Number:.....Nationality:.....

Duty station/contingent:.....

MEDEVAC:☐, Repatriation: ☐,

due to Illness ☐, Accident ☐, Injury ☐, Death ☐, other reasons ☐.

Home adress:.....

Home Telephone Number:.....

MEDEVAC/Repatriation requested from:.....

Name of the hospital:.....

Adress of the hospital:.....

Telefon and fax-number:.....

Name of Contactperson:.....

Airport:.....

MEDEVAC/Repatriation requested destination:.....

Name of the hospital:.....

Adress of the hospital:.....

Telefon and fax-number:.....

Name of Contactperson:.....

Airport:.....

MEDEVAC/Repatriation means:.....

Date of requested MEDEVAC/Repatriation:.....

Accompanying personnel by REGA ☐

Accompanying personnel/profession requested:.....

Expected return to duty:.....

The following aditional information should submitted to DAM/OHRM/MRAD only:

How, where and when did accident, injury or illness occur:
.....
.....
.....

First hospitalization:

From:□□/□□/□□ Until:□□/□□/□□ Where:.....

Diagnoses:.....

Treatment:.....

Present hospitalization:

From:□□/□□/□□ Until:□□/□□/□□ Where:.....

Diagnoses:.....

Treatment:.....

Current diagnoses:.....

Current therapies.....

Current health-status:.....

Special treatment and equipment necessary during transport:.....
.....

SWISS AIR AMBULANCE
REGA
Telefon : 011-41-1-385 85 85
Telefon, Alarm: 011-41-1-383 11 11
Fax : 011-41-1-385 83 15

COMPENSATION FOR SERVICE-INCURRED INJURY, ILLNESS OR DEATH FOR UN STAFF MEMBERS

I. Who are entitled?

UN staff members - if covered by Appendix D to the UN Staff Rules.

II. Procedures for submission of possible compensation claims

1. Pursuant to Appendix D to the United Nations Staff Rules (ST/SGB/Staff Rules/Appendix D/Rev. 2, when a staff member sustains an injury or suffers an illness which he or she considers to be attributable to the performance of official duties and whishes to claim compensation (reimbursement of medical expenses, etc.), the staff member should observe the following procedure:

a. Refer to Appendix D to the United Nations Staff Rules (ST/SGB/Staff Rules/Appendix D/Revision 1, dated 1 January 1966 and Appendix D/Revision 1/Amend.1, dated January 1976) for information on the conditions under which compensation may be granted;

b. Submit the attached "Claim for Compensation" form and all supporting documentation to the Secretary, Advisory Board on Compensation Claims, Room S-3034, United Nations, New York, N.Y. 10017. The claim and related documentation must be submitted within four months from the date of the injury, or the onset of illness (see article 12 of Appendix D), unless it can be proven that exeptional circumstances prevented the staff member from taking such action within the four-month time limit. The claim must be submitted even if all medical bills are not redily available within the prescribed four-month time limit;

c. Report the accident as soon as possible to his/her supervisor and to the Security and Safety Service, Safety Section, Room c-106, Secretariat Building, if applicable;

d. All bills for medical, hospital and related services must be provided and listed. Reimbursement will be authorized only when original detailed bills with proof of payment (cancelled cheques, doctor's paid receipts) are submitted. All such bills are to be submitted to the Secretary, Advisory Board on Compensation Claims.
Do not send bills to the Medical Service.

2. Staff members are advised that they are personally responsible for the payment of all expenses incurred. Under no circumstances should the physician or hospital be told to send bills to the United Nations. Staff members are expected to pay all bills and claim reimbursement under the procedure outlined above.

3. Blue Cross, Aetna, Van Breda and HIP/HMO do not provide coverage for service-related injuries or illness as the insurance contracts exlude coverage of this nature. However, they will usually do so, on request, pending the outcome of the claim for compensation.

CLAIM FOR COMPENSATION UNDER APPENDIX D TO THE STAFF RULES

Submit to the Secretary, Advisory Board on Compensation Claims, Room S-2620, as soon as possible, but not later than four months from date of injury or the onset of illness. If you have failed to do so, please explain the reason(s) under item 8 below.

1. Full name		Index no.	Dept./Division
Functional title		Cat/Level	Type of appointment
Entry on duty date	Separation date	Date of birth	Marital status

2. Nature of injury/illness: _____

Date of injury/illness: _____

Where did injury/illness occur? _____

How did injury/illness occur? _____

Describe the extent of the injury/illness _____

3. Has the injury/illness been reported to the Medical Service? _____

[Please note that Form MS.15 (Report of Accident or Illness) is completed by the Medical Service.]

4. Nature of claim: Reimbursement of medical expenses _____; Other (please explain):_____

List actual bills attached on the reverse of this form and indicate the total amount being claimed.

If an outside physician has been consulted, please ensure that this person completes Form MS.16 (Medical statement to be answered by staff member's physician) in duplicate and return both copies to the Medical Service.

5. Has any hospital or medical bill been paid? _____ If yes, by whom? _____

6. Have you submitted a claim for this injury/illness through your health or (in the case of vehicular accident) automobile insurance company (Blue Cross/Aetna, HIP/HMO, or other medical insurance)? _____ If yes, give full details:_____

Does treatment continue? _____

Will bills be forwarded later? _____

7. Have you reported the accident to the Security and Safety Service/OGS? _____

8. Additional comments and/or explanations: _____

9. *I declare that the above is true and correct to the best of my knowledge. I hereby submit a claim for compensation as provided for under Appendix D to the Staff Rules of the United Nations.*

_____ _____

Signature of claimant Date of claim

LIST OF BILLS

Date of service	Name of physician/hosp./pharmacy etc.	Amount

Total: ______________________

I certify that the information given above is correct and authorize the release of any information necessary to process the claim. I further certify that no reimbursements have been received from any insurance carrier in respect of the above medical bills nor are benefits available under other group plans.

Name of Claimant	Signature	Date

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(s) of witness(es): _____

8. State nature of injury or illness: _____

9. Did you provide medical care? _____. If so, when? _____

What type? _____

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)

MS.16 (2-70)

UNITED NATIONS NATIONS UNIES

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 Mr. / Mrs. / Miss _____

   Home Address: _____

2. Place of accident, or onset of illness: _____

   Date: _____ Time: _____ a.m. / p.m.

3. Date of first treatment by you: _____

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? _____. If not, is the patient able to work? _____

8. If patient is not working and is unable to work, state probable duration of disability: _____

9. Was patient unconscious? _____. If so, for how long? _____

   Were X-rays taken? _____

10. Is patient in hospital? _____. If so, name of hospital: _____

11. In your opinion, was the accident, as above described, the cause of the injury sustained? _____

12. Is the injury or illness likely to result in permanent impairment? _____. If so, what? _____

13. Is patient still under your care? _____. If not, name and address of attending physician: _____

Date: _____ Signature: _____ *(Attending Physician)*

_____ *(Address)*

NOTE: The attending physician will issue itemized accounts to the patient who will be responsible for payment.

COMPENSATION FOR SERVICE-INCURRED INJURY, ILLNESS OR DEATH FOR MILITARY OBSERVERS/CIVIL POLICE MONITORS ON ASSIGNMENT

Procedures for submission of possible compensation claims

1. If it is intended to file a claim for compensation under the Notes for the Guidance of Military Observers/Civil Police Monitors on Assignment with regard to the incident, the following information and/or documentation is required by the Advisory Board on Compensation Claims in order to consider the claim:

(a) Submission of claim by the claimant or on his behalf by his/her Government;

(b) **Medical reports, one from the time of incident and the other after complete convalescence, from the claimant's attending physicians, for the UN Medical Director (the Medical Adviser to the Advisory Board on Compensation Claims) to advise on medical questions of compensation;**

(c) Board of Inquiry report; if not available: Administrative report from immediate supervisor(s) indicating in detail the circumstances of the incident;

(d) Statement(s) of witness(es);

(e) Medical Bills - In most cases, Military Observers/ Civil Police Monitors being military personnel are covered for all medical/hospital expenses by their own Governments. Claims submitted are normally for loss of function/death as covered under the Notes;

(f) Statement of earning, showing the monthly/annual base salary as certified by the Government;

(g) Birth, marriage certificates of claimant and dependent(s), and of claimant's death certificate, if applicable.

2. In addition, attention should be drawn to the time limit for entering claims as provided under the Notes:

"Claim for compensation by or on behalf of an MLO/ Police Monitor should be submitted through the Chief Administrative Officer to the United Nations Secretary-General by the MLO/Police Monitor, his dependents or his Government within four months of the MLO/Police Monitor's death, injury or onset of illness. In exceptional circumstances, the Secretary-General may accept for consideration a claim made at a later date."

PRODEDURE TO BE FOLLOWED IN THE EVENT OF DEATH OF A UNITED NATIONS STAFF MEMBER

The following guidelines are prepared in accordance with Personnel Directive on separation procedures in the event of death of a staff member

1. In the event of death of a United Nations staff member, when assigned to a Peace-keeping Operation, the Chief Medical Officer of that operation will notify the Chief Administration Officer, who in turn will notify the Director of Field Operations Division.

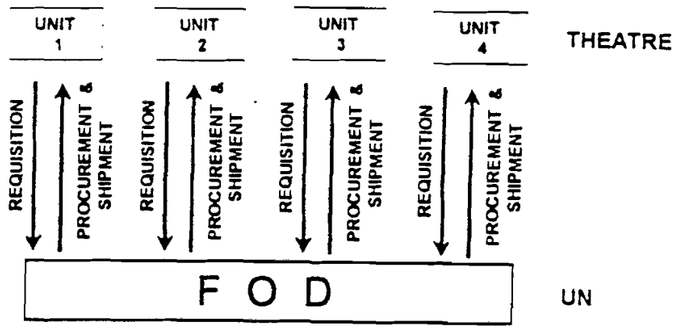
2. The Chief Medical Officer will obtain six (6) death certificates to be forwarded to different offices as listed under paragraph 13 of the Personnel Directive.

3. An autopsy will be performed only if it is considered necessary from the medical or legal point of view.

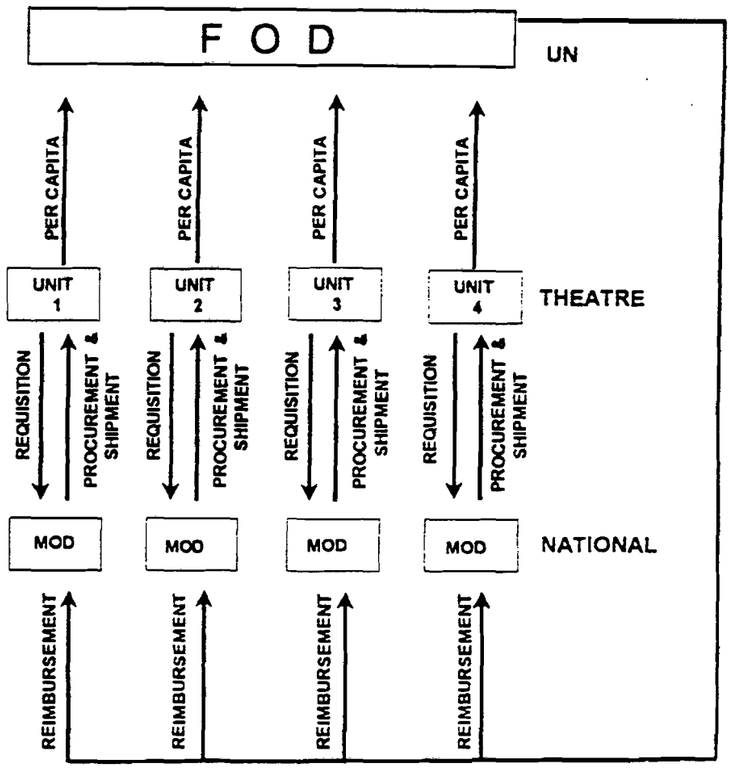
4. The Chief Medical Officer will provide assistance in preparation of the body (in accordance with paragraph 18 and 19 of the directive), although responsibility of transportation of the body rests with the Chief Administrative Officer.

This Personnel Directive could be requested through the Chief Administrative Officer/Peace-keeping Operations.

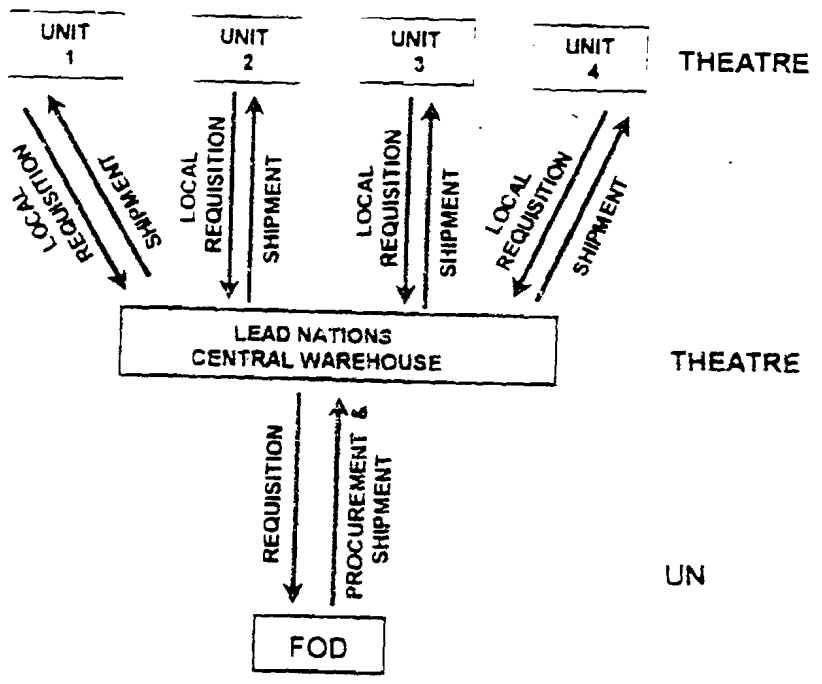
1) Requisition is raised by every medical unit separately for procurement of medical items through UN procurement system.



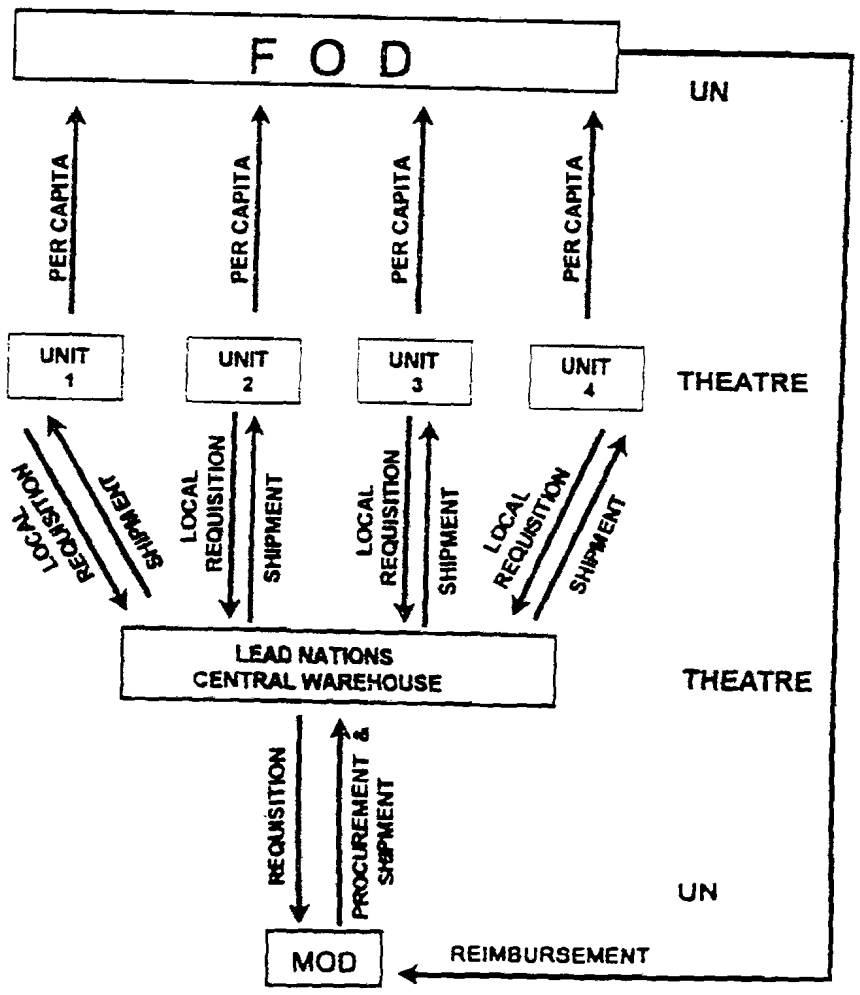
2) Every Unit will organize a resupply using own national resources and own national transportation. Reimbursement will be by UN on a per capita per day basis for each medical unit. Continuous certified reports of per capita per day treatment are essential.



3) A lead nation will take over responsibility for medical resupply in theatre but will raise a collective requisition for central procurement through Procurement System of UN.



4) A lead nation will take over responsibility for medical resupply in theatre by running a medical pharmaceutical warehouse and will use their own national resources and own national transportation. Reimbursement will be by UN on a per capita per day basis of each medical unit but only to the nation providing the warehouse. Continuous certified reports of per capita per day treatment are essential.



Essential Information for the Procurement of Medical Items (supplies and/or equipment)

Originator: Date of request: ☐☐/☐☐/☐☐

Suggested Vendor: Latest date of arrival: ☐☐/☐☐/☐☐
Shipment by: air ☐, sea ☐, road ☐

Designated for which unit:

Account code: Shipping adress:

INN CODE/GENERIC/ DESCRIPTION	TRADE NAME/ BRAND	PRESENTATION/ STRENGHT/SIZE	ADDITIONAL INFORMATION	QTY PER PACKAGE	PRICE PER PCKG US$	NO OF PCKGS REQUESTED	PRICE OF LOT REQUESTED US$)
TOTAL AMOUNT (US$)							

please note:

- All requests should be made in accordance with the **Catalogue of Medical Items for Peace-keeping Operations** as shown in part 6 of this chapter. The cataloque is intended to be the only reference for all requisitions made from the Field Missions, however the requests of national specialities or especially needed brands are generally not excluded.
- All requests must be in English language.
- Whenever possible INN Code or Generics should be used.
- Tra . Names/Brands should only be added, when this particular medicine is actually requested. In all cases however when a Brand is requested the land of origin and whenever possible the manufacturer must be identified in colum "additional information".
- Presentation/Strenght/Size is essential for exact identifikation.
- No. per Pckg. will determine whether packages of this particular size, or bulk-ware are requested.
- Additional information should be added if necessary to describe specific items. Additional information will always be imperative requesting consumables and equipment so that an identification by any vendor can be ensured without any doubt.
- Requisitions for:
  - medicine (human)
  - Consumables (human)
  - Medicine (dental)
  - Consumables (dental)
  - Laboratory
  - Hygienics
  - Medicine (veterinarian)
  - Consumables (veterinarian)

and for medical equipment should be raised seperately:

EXAMPLE:

INN CODE, GENERIC DESCRIPTION	TRADE NAME, BRAND	PRESENTATION, STRENGHT SIZE	ADDITIONAL INFORMATION	QTY PER PACKAGE	PRICE PER PCKG US$	NO OF PCKGS REQUESTED	PRICE OF LOT REQUESTED US$)
DIAZEPAM	VALIUM	AMP. 10 MG		10	3	5	15
...							
GLUCOSE		BTL 500 ML.5%		6	20	20	400
...							
MIRROR LARYNGEAL			215MM STEM AND FIXED HANDLE, CHROME PLATED, BOIL. SIZE 00, 8MM DIAMETER	1	27	2	54
..							
SUTURE, SKIN, BLACK SILK	ETHICON 684		SIZE 000 USP WITH 3/8 CIRCLE REV. CUTTING N. 24MM(FS1N.) LENGHT OF STRAND 45CM EACH STERILE IN FOIL PACK	20	17	3	51
..							
..							
..							
TOTAL AMOUNT(US$)							480,027.00

7.5 TERMS AND DEFINITIONS

7.5.01 A common approach by nations and HQNY is needed to achieve compatibility between medical services in the provision of support to multinational forces, operating in a unpredictable operational environment.

7.5.02 Previously, medical support has been a purely national and often single-service responsibility, and hence there was only a limited need for a common terminology for medical planning. With the introduction of multinational forces and consequent sharing of responsibilities between nations, Services and UN commanders, such a common terminology is now a necessity.

7.5.03 This Glossary of Medical Support Terms and Definitions is designed for use by medical planners at national and UN headquarters. It provides selected terms and definitions for use in medical staff work and correspondence within.

7.5.04 Nations are not being requested to change their own national medical support planning terminology, but to use these glossary terms when corresponding with other UN nations.

DEFINITIONS AND ABBREVIATIONS

Admission: Process of admitting an individual to a medical facility; also used to describe the individual admitted.

AECC: Air Evacuation Control Centre.

Aeromedical Evacuation (AE): The movement of patients under medical supervision to and between medical treatment facilities by air transportation.

Aeromedical Evacuation Conrol Centre (AECC): Control facility established in Field Missions HQs to operate in conjunction with the command movement control centre and coordinate overall medical requirements with airlift capability. It also assigns medical missions to the appropriate aeromedical evacuation elements in the system and monitors patient movement activities.

Aeromedical Evacuation Co-Ordinating Officer: Officer who coordinates aeromedical evacuation activities.

Aeromedical Evacuation System: An organized network of medical and non-medical functions designed to provide:

a. Control of patient movement by air;

b. Specially-trained medical staff to provide in-flight medical care;

c. Specialized equipment for in-flight medical care;

d. Aeromedical staging units;

e. Communication with destination and enroute medical facilities concerning patient airlift movements.

Aeromedical Evacuation, intertheatre: That phase of evacuation which provides airlift for patients over a long distance, normally outside the missions region of support area. Synonymous with Intertheatre Aeromedical Evacuation and Out-of-Theatre Aeromedical Evacuation.

Aeromedical Evacuation, intra-theatre: That phase of evacuation which provides airlift for patients from the point of injury or falling ill within the regional support area. Synonymous with Intratheatre Aeromedical Evacuation.

Aid Post/Aid Station: Medical facility fully integrated in a military unit at battalion/regimental level or corresponding units of the Air Force and Navy, and operated by the medical unit element under the command of the responsible medical officer of the unit. As a rule, the aid post/aid station is the first medical facility where a sick or wounded casualty receives medical treatment carried out by or under the supervision of a physician. Also called Level 1 medical facility.

Ambulance: A ground, air or sea conveyance, manned and equipped to provide in-transit care, for the sick, injured and wounded:

Ground: To include road/off road vehicles (wheeled/tracked) and railways.

Air: Fixed and rotary wing aircraft equipped and designated for medical evacuation.

Sea: Any vessel (ship, boat, hovercraft, but not hospital ships) intended for medical evacuation to a medical treatment facility. Compare Casualty Transport Ship.

Ambulatory Care Clinic: See Clinic, Outpatient.

Ambulatory Patient: See Patient, Walking.

Anaesthetist: Physician appropriately trained and licensed to administer local, regional, and general anaesthesia. Synonymous with Anaesthesiologist (US).

Anesthetic Assistant: Any medical personnel such as physicians, dentist and nurses trained and licenced to administer local, regional, and general anaesthesia under the supervision of an Anaesthesist.

Ancillary Services: Those services other than medical and dental, such as nursing, laboratory, radiology, pharmacy, nutrition care, and therapy services, that are provided to patients in the course of care.

Asset: Any resource (person), group, relationship, instrument, installation or supply) at the disposal of an organization for use in a specific role.

Aviation Medicine: The speciality of mediccine which is related to the biological and psychological problems of flight.

Battle Casualty: See Casualty, Battle.

Battle Stress Reaction: A disorder of psychological function which is a normal response to an abnormal situation experienced during combat. It may cause a temporary inability to perform duties. Also called combat stress, battle fatigue and battle shock reaction.

Bed, Available: An operational bed not currently assigned to a patient.

Bed, Intensive Care: A bed for patients requiring intensive care. See Care, Intensive.

Bed, Occupied: A bed assigned to a patient as of the census-taking hour, normally midnight, to include a patient on pass or liberty not in excess of 72 hours.

Bed, Operational: A bed in a fully supported medical facility in which a patient can receive medical treatment according to the role of the medical treatment facility. See also Bed, Available.

Bed Capability: The number of beds that a medical unit can fully staff and equip according to the role of the medical treatment facility.

Bed Capacity: Number of beds that a medical facility can accommodate.

Blood Donor Centre (BDC): Location for the collection and processing of blood products.

Buddy Aid: The initial aid provided by a serviceman to a sick, injured or wounded comrade (buddy). Also termed Buddy Care. See also Self Aid.

CAO: Chief Administration Officer. See there.

Capability, Medical: The aggregate of medical personnel and expertise, facilities, logistic sustainability and evacuation support that is available to provide a defined level of care to a determined number of casualties.

Capacity, Medical: The quantitative potential of the medical support system to collect, treat and evacuate patients. Capacity does not measure qualitative aspects of that support.

Care, Ambulatory: The examination, diagnosis, treatment and disposition of all categories of ambulatory patients.

Care, Continuity of: A medical support principle which states that a patient both in-transit and passing through the various medical echelons must be given care which is relevant, cintinuous and progressive irrespective of the organization providing the resources.

Care, Convalescent: Care rendered to patients who are mostly ambulatory. Complexity of care requires limited therapeutic intervention and administration of oral medications performed by

the patient. Patients are in the final stages of recovery and could be returned to limited duty. Emphasis is on physical reconditioning.

Care, Emergency: That care which requires immediate intervention to prevent the loss of life, limb, function, or body tissue, or to prevent undue suffering.

Care, Intensive: That degree of care which is extensive, highly technical and required because of the patient's actual or threatened inability to maintain vital functions.

Care, Intransit: Sustaining care during a evacuation

Care, Levels of: A medical support principle which states that medical care should be provided on a progressive bases ranging from frontline first aid to definitive specialized care as the patient is evacuated rearward. The three fundamental levels of progressive medical care include: Resuscitation and Stabilization of vital functions, life and limb saving surgery including post operative care, and finally definitive treatment and rehabilitation.

Care, Medical: A general term for all measures provided by medical personnel to a patient, including treatment and nursing.

Care, Minimal: That degree of care rendered to patients who require limited therapeutic and diagnostic services and are in the final stages of recovery. Complexity of care includes administering medications and treatments which cannot be done by the patients and providing instruction in self-care and post-hospitalization health maintenance.

Care, Self: Limited care provided by a patient for himself, such as the self-administration of oral medication. Synonymous with Self Aid.

Casualty: In relation to personnel killed in action, any person who is lost to his organization by reason of having been declared dead, wounded, injured, diseased, detained, captured or missing.

Casualty, Battle: Any casualty incurred as the direct result of hostile action, sustained in combat or relating thereto or sustained going to or returning from a combat mission. Synomymous with Total Battle Casualties.

Casualty, Died of Wounds Received in Action: A battle casualty who dies of wounds or other injuries received in action, after having entered the medical care system.

Casualty, Disease (D, DIS): Any person who is lost to his organization by reason of any deviation from, or interruption of, the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose ethiology, pathology, and prognosis may be known or unknown.

Casualty, Disease and NON-Battle Injury (DNBI): A grouping of casualties which are due to disease or injury not acquired in battle action.

Casualty, Killed in Action (KIA): A battle casualty who is killed outright or who dies as a result of wounds or other combat related injuries before entering the medical care system.

Casualty, Non-Battle: A person who is not a battle casualty, but who is lost to his organization by reason of disease or injury, including persons dying from disease or injury, or by reason of being missing where the absence does not appear to be voluntary or due to enemy action or to being interned.

Casualty, Non-Battle Injury (NBI): A person who is lost to his organization by reason of a trauma, such as a fracture, wound, sprain, dislocation, or concussion, not acuired in battle action.

Casualty, Wounded in Action: A battle casualty other than "killed in action" who has incurred an injury due to an external agent or cause. The term encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforated wound, or none, as in the contused wound; all fractures, burns, blast concussions, all effects of biological and chemical warfare agents, the effects of exposure to ionizing radiation or any destructive weapon or agent.

Casualty Category: The grouping of casualties used in medical planning, particularly included in this category are: Killed in Action (KIA), Missing in Action, (MIA), Captured in Action (CAI), Wounded in Action (WIA), Died of Wounds (DOW), Diseased (D, DIS), Non Battle Injured (NBI), Disease and Non Battle

Injuries (DNBI), Captured in Action (CIA), Battle Stress/Battle Shock Cases (BSC), Nuclear, Biological and Chemical Casualties.

Casualty Classification: The breakdown of raw casualty figures into clinical groups and/or origin if applicable, e.g., gunshot wounds of chest, burns, psychiatric patients.

Casualty Collection: The process of retrieving casualties to a place to facilitate further medical treatment and subsequent evacuation.

Casualty Evacuation (CASEVAC): Evacuation from point of wounding or accident to first point of medical treatment.

Casualty Evacuation Planning Period: Command decision for planning purposes, indicating the timeframe in which a unit at a specific level must be capable of evacuating the anticipated number of casualties at that level without delay.

Casualty Flow: The movement of patients through a system of treatment and evacuation. Usually referring to routing throegh levels of care.

Casualty Rate: The proportion of losses of personnel or materiel, normally expressed as a percentage, due to various causes within a specified period of time.

Chief Medical Officer (CMedO): Responsible officer for all medical and health matters within the Force.

Clinic, Outpatient: An entity or unit of a medical or dental treatment facility that is organized and staffed to provide health care for outpatients and holds regular hours in a designated place.

CMedO: See Chief Medical Officer

Combat Casualty: Synonymous with Battle Casualty.

Combat Service Support (CSS): The assistance provided to operating forces primarily in the fields of administrative services, chaplain services, civil affairs, finance, legal services, medical and health services, military police, supply, maintenance, transportation, construction, troop construction, aquisition and disposal of real property, facilities engineering, topographic and geodetic engineering functions,

food service, graves registration, laundry, dry cleaning, bath, property disposal, and other logistic services.

Combat Stress Reaction: See Battle Stress.

Consumable Supplies and Materiel: See Items, Expendable.

Continuity of Care: See Care.

Control, Functional: That sort of authority exercised by a senior medical officer over finctional areas such as general and special medical treatment, dental care, nursing care, veterinary service, medical laboratory service, patient evacuation, preventive medicine, dietetics, medical logistics, administration, managemant, education and training within that command.

Control, Professional: That sort of authority exercised by a senior representative of a medical service over medical staff with the same kind of state registration in order to supervise the compliance with professional standards.

Control, technical: See Control, Professional.

Convention: See Geneva Conventions.

Conventional Casualty: See Casualty.

Credentialed for: Having evidence of training, licensure, experience

Day of Medical Supply: The total amount of medical supplies needed at a specified echelon of medical support for the treatment of the planned number of battle and non-battle casualties for one day.

Definitive Treatment: The final level of comprehensive care provided to return the patient to the highest degree of mental and physical capability possible. It will be provided at an appropriate echelon of the medical evacuation chain. After the definitive treatment period the individual may undergo rehabilitation before being returned to duty or discharged from military service.

Dentist/Dental Officer: Person licensed to perform dental surgery or dental medicine.

Discharge: Leaving a Medical Treatment Facility.

Diseased: Individuals suffering from disease to include mental disability.

Diseased, Moderately: Individuals suffering from a second degree sickness, illness or disease. For planning purposes, four grades of clinical severity of disease, injury and wounding are used: Slightly, moderately, seriously and very seriously.

Diseased, Seriously: Individuals whose sickness, illness or disease is of such severety that there is cause for immediate concern but there is no imminent danger of life. For planning purposes, four grades of clinical severity of disease, injury and wounding are used: Slightly, moderately, seriously and very seriously.

Diseased, Slightly: Individuals suffering from a first degree sickness, illness or disease. For planning purposes, four grades of clinical severity of disease, injury and wounding are used: Slightly, moderately, seriously and very seriously.

Diseased, Very Seriously: Individuals whose sickness, illness or disease is of such severrety that life is imminently endangered. For planning purposes, four grades of clinical severity of disease, injury and wounding are used: Slightly, moderately, seriously and very seriously.

DNBI: Disease and Non-Battle Injury rate, see Casualty.

DOW: Died of Wounds, see Casualty.

DPO: Department Peace Keeping Operations (DPKO)

Disposition/Patient Disposal: The removal of a patient from a medical treatment facility (MTF) by reason of return to duty (RTD), transfer to another treatment facility, death or other termination of medical case.

Distinctive Emblems/Signs: According to The First Geneva Convention of August 12, 1949 the following heraldic emblems are retained as the emblem and distinctive sign of the Medical Service of armed forces: The red cross on white ground, the red crescent of the red lion and sun on white ground.

Echelon, Medical: One of three to five levels of medical care associated with casualty treatment in a combat or disaster situation.

Echelon of Medical Support: See Role, see Level.

Evacuation, Medical: The medically controlled process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities.

Evacuation Policy: Command decision, indicating the maximum period of non-effectiveness that patients may be held within the command for treatment. Patients who, in the opinion of the responsible medical officers, cannot be returned to duty status within the period prescribed are evacuated by the fastest available means, provided the travel involved will not aggravate their disabilities. Compare Holding Policy.

Evacuation, Fitness for: See Evacuation, Stabilized for.

Evacuation, Stabilized for: A medical support principle which states that an individual patient's condition should govern both the time and means of evacuation. Also Evacuation, Fitness for.

Expendable Items: See Items, Expendable.

FC: Force Commander

Fixed Medical Treatment Facility: A permanently established land-based medical facility excluding ships, field units, and air-transportable hospitals.

Force Hygiene Officer (FHO): Responsible for all hygiene matters within the theatre.

General Practitioner: Physician who practises primary medical care but is not specialized in a particular discipline such as surgery, internal medicine, obstetrics.

Generic Drug: Pharmacological basis of a drug, opposed to brand or manufacture name.

Geneva Conventions: Those four conventions of August 12, 1949 established for the Protection of Victims of War:

1. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field,

2. Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of Armed Forces at Sea,

3. Geneva Convention relative to the Treatment of Prisoners of War.

4. Geneva Convention relative to the Protection of Civilian Persons in Time of War.

There are two Protocols Additional to the Geneva Conventions of August 12, 1949: Protocol I, Relating to the Protection of Victims of International Armed Conflicts, and Protocol II, Relating to the Protection of Victims of Non-International Armed Conflicts. These Additional Protocols were adopted by the Conference on 8 June 1977 and submitted to Governments for consideration and signature. Not all of the NATO member nations have yet ratified them.

Health and Medical Services: See Medical and Health Services.

Health Record: A document which records the clinical history of and the provision of health services to an individual patient. Health records include both outpatient and inpatient files.

Health Services: Services intended directly or indirectly to contribute to the health and well-being of patients or a population.

HNS: see Host Nation Medical Support

Holding: Accommodating those patients waiting for return to duty or medical evacuation in a medical facility normally in other than fully supported hospital beds.

Holding Capacity: The quantitative potential of medical facilities to accommodate patients waiting for medical evacuation normally in other than fully supported hospital beds.

Holding Policy: Command decision for planning purposes, indicating the mean time required for the mean recovery of

patients in field medical facilities to become fit for evacuation. See also Evacuation Policy and Capacity, Medical.

Hospital: A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.

Hospital Bed: See Operational.

Hospital Ship: A mobile, flexible, rapidly responsive afloát medical treatment and hospitalization facility. Provides medical and surgical care in support of forward deployed troops in areas of hostility. Normally declared under the terms of the Geneva Convention.

Hospitalization Capacity: The quantitive potential for accomodating patients in fully supported beds.

Host Nation Medical Support (HNS): Civil and/or military medical assistance rendered by a nation to foreign forces within its territory during peacetime, times of crisis/emergencies, or war based upon agreements mutually concluded between nations or a NATO command and a nation.

HQ NY: Headquarter New York, sort of short form for Secretariat Building of UN in NY.

Hygiene: The science of health and of its preservation.

Hygienics: A system of principles for promoting health; hygiene.

Ill: Individual(s) suffering from disease to include mental disabilities.

Ill, Moderately: Individual(s) suffering from a second degree sickness, illness or disease. For planning purposes, four grades of clinical severity of disease, injury and wounding are used: slightly, moderately, seriously and very seriously.

Ill, Seriously: Individual(s) whose sickness, illness or disease is of such severity that there is cause for immediate concern but there is no imminent danger to life. For planning

purposes, for grades of clinical severity of disease, injury and wounding are used: slightly, moderately, seriously and very seriously.

Ill, Slightly: Individual(s) suffering from a first degree sickness, illness or disease. For planning purposes, for grades of clinical severity of disease, injury and wounding are used: slightly, moderately, seriously and very seriously.

Ill, Very Seriously: Individual(s) whose illness is of such severity that life is imminently endangered. For planning purposes, for grades of clinical severity of disease, injury and wounding are used: slightly, moderately, seriously and very seriously.

Incidence: An expression of the rate at which a certain event occurs, as the number of new cases of a specific disease, injury or wounding occurring during a certain pericd. Compare Prevalence.

Information, Medical: See Intelligence, Medical.

Injured: Individual(s) suffering from non-battle-related trauma, such as a fracture, wound, sprain, dislocation, concussion, or a condition resulting from extremes of, or prolonged exposure to temperature.

Inpatient: An individual, other than a transient patient, who is admitted by a member of the medical staff for treatment or observation to a bed in a medical facility.

Inpatient Care: The examination, diagnosis, treatment, and disposition of inpatients.

Intelligence, Medical: That category of intelligence resulting from collection, evaluation, analysis and interpretation of medical, bio-scientific, epidemiological and environmental information. It also includes the assessment of foreign medical capabilities in both military and civilian sectors.

Intensive Care: See Care, Intensive

Intensive Care Bed: See Bed, Intensive care

Intensive Care Unit: See Special Care Unit.

Internist: A physician appropriately trained and licensed to practise internal medicine.

Inter-theatre Aeromedical Evacuation: See Aeromedical Evacuation, Inter-theatre.

In-theatre: That geographical area which contains the imminent mission. Normally within the borders of a single country.

Intra-theatre Aeromedical Evacuation: See Aeromedical Evacuation, Intra-theatre.

Item, Expendable: Supplies that are consumed in use, such as surgical dressings, drugs, medicines, or that lose their identity, such as spare parts. Sometimes also referred to as expendable materiel, expendable property, expendable supplies, or consumable supplies and materiel.

Item, Non-Expendable: Supplies which are not consumed in use and which retain their original identity during the period of use.

Items, Recoverable: An item which normally is not consumed in use and is subject to return for repair or disposal.

Killed in Action: See Casualty.

Laboratory, Medical: A fixed or mobile facility run by a military medical service, capable of performing physical, chemical, pharmaceutical and biological analyses. Normally, medical laboratories are part of role 3 and role 4 medical support.

Letter of Assist (LOA): Letter authorized by UN to supplying nations so that these can make purchases directly through reliable national sources. The goods are paid for by the LOA nation and the expenses later reimbursed by the UN.

Level of Medical Support: A numeric designation which identifies the functions and levels of capability a medical unit can provide, see echelon, see role.

Level 1 Medical Support: Usually provided at the following level of command: Battalion (Army); Airbase (Air Force); frigates, destroyers and above (Navy). Apart from those measures

aimed at the conservation of the force strength, the following core functions will be provided:

a. Medical evacuation to level 1.

b. Physician managed measures for restoring and stabilizing vital functions in order to achieve fitness for further evacuation.

Level 2 Medical Support: Usually provided at the following level of command: Brigade and Division (Army); normally combined with role 1 Air Force and Naval facilities. Apart from those measures aimed at the conservation of the force strength, the following core functions will be provided:

a. Medical evacuation to level 2.

b. Collective facility for decontamination of Nuclear/Bacteriological/Chemical casualties.

c. Resuscitative capability for restoring and stabilizing vital functions in order to achieve fitness for further evacuation.

d. Resupply of level 1 units.

e. Medical personnel replacements.

Level 3 Medical Support: Usually provided at the following level of command: Division/Force/Corps ; local civilian or military hospital (Air Force); afloat in hospital ships or ashore in a civilian or military hospital (Navy). Apart from those measures aimed at the conservation of the force strength, the following core functions will be provided:

a. Medical evacuation to level 3.

b. Life and limb saving surgery.

c. Hospitalization.

d. Resupply of level 2 units.

e. Medical personnel replacement.

Level 4 Medical Support: (Army, Air Force, Navy: National logistic support command level, usually homebased; for Navy also

hospital ship possible). Apart from those measures aimed at the conservation of the force strength, the following core functions will be provided:

a. Medical evacuation to level 4.

b. Time consuming definitive treatment and rehabilitation.

c. Medical personnel replacement.

Line: See level

Litter Patient: See Stretcher, Patient.

Low/Minimal care bed: See bed.

Lying Patient: See Patient.

Mass Casualties: Any number of casualties produced in a relatively short period of time overwhelming the available medical and logistic support capabilities.

Medevac: see Evacuation, medical

Medical: Of pertaining to, or dealing with the healing art and the science of medicine, which includes services related to the diagnosis and treatment of illness, injury, pregnancy and mental disorders.

Medical Adviser: A medical officer (physician) with wide clinical, military and staff experience, assigned to a Command HQ staff in order to ensure proper consultation on, and recognition of, all matters affecting medical operational planning and the force's health. The Medical Adviser has the right of direct access to the commander.

Medical and Health Service: See Medical Service.

Medical and Health Services:

a. All professional, technical and related functions performed by medical services such as general and special medical treatment, dental care including prosthetic laboratory service, patient evacuation, preventative medicine (including

physical examinations), dietetics, medical logistics, administration, management, education and training.

b. Those branches of military organizations which provide the functions mentioned above. Synonymous with Medical Service.

Medical Capability: See Capability, medical

Medical Capacity: See Capacity, medical

Medical Care: See Care, medical

Medical Clinic: A treatment facility appropriately staffed and equipped to provide medical care that may include a wide range of clinical specialties.

Medical Documents: Medical records and reports, X-rays, ECG, Lab results, etc.. They are confidential.

Medical Emergency: A sudden, generally unexpected, event or set of circumstances demanding immediate medical action.

Medical Evacuation: See Evacuation.

Medical Evacuation Delay: The evacuation delay represents the number of days that a patient who has been identified for evacuation must wait before actually being evacuated. In determining evacuation delays, the planner should consider both patient stabilization requirements and the availability of evacuation transportation assets.

Medical Evacuation Policy: See Evacuation Policy.

Medical Information: See Intelligence/Information, Medical.

Medical Logistics: The science of planning and provisioning materiel required for effective medical support to a force. Medical Logistics comprise two main areas:

a. Inventory Management (determining the medical materiel requirement, codification, cataloguing, monitoring and tracking),

b. Provisioning (acquisition, storage, movement, distribution, maintenance).

Medical Logistics Support: Includes all measures and actions to provide medical supply corresponding to the requirements/needs of the medical situation, to control and manage medical materiel and to maintain medical materiel.

Medical Officer: Physician with officer rank.

Medical Other Ranks: Collective term for enlisted servicemen and Non-Commissioned Officers (NCOs) of the medical service. They are involved in direct and indirect support of patient care in all medical facilities and within units to provide medical support at all levels according to the Genenva Conventions of August 12, 1949. In addition, they may also work in logistic and administrative support of medical facilities and units. In some nations' forces enlisted servicemen and NCOs do not act as nurses.

Medical Personnel: All ranks of medically trained individuals required in either a military or civilian facility to accomplish the assigned mission. Medical personnel are protected by the Geneva Conventions.

Medical Planning: The process of designing, requiring and acquiring medical support capabilities in balance with the force strength and risk exposure in accordance with the politico-military requirement.

Medical Planning, Capability-Related: The process of designing a medical support system capable of dealing with a generic, non threat-related, casualty rate for peacetime planning. See Medical Planning.

Medical Planning, Scenario-Related: The process of designing a medical support system capable of dealing with a defined casualty rate based on specific threat assessments.

Medical Professional:

a. An Indidividual appropriately trained and authorized at state or national level to provide medical services.

b. Of or belonging to the skill or qualities of an individual appropriately trained and authorized at state or national level to provide medical services.

Medical Professional Supervision: See Control, Professional.

Medical Service: Branch of an organization, responsible for the establishment of medical policy, plans and the provision of medical support.

Medical Services: Activities related to medical care performed by physicians and/or other health care provided under the direction of a physician or another medical professional.

Medical Staff: Organized body or medical personnel, required in either a military or civilian medical capacity to accomplish the assigned mission.

Medical Support: A function encompassing the full range of medical planning and provision of medical and health services to maintain the force strength through disease prevention, rapid treatment of the diseased, injured and wounded, their recovery and return to duty.

Medical Support Capacity: See Capacity, Medical.

Medical Support System: An organized network of medical and non-medical functions designed to contribute to manpower sustainability of the employed force. The necessary functions include but are not necessarily limited to: Medical command and control (patient administration, management and reporting, medical personnel replacement, medical and other logistics resupply), preventive medicine (prevention/control of disease and NBC injury), and casualty care (self and buddy aid, casualty collection, treatment, hospitalization, evacuation).

Medical Sustainability: The ability of the medical support system to maintain the necessary quality and quantity of treatment and evacuation activities. This requires having on hand appropriate medical personnel, equipment, supplies and evacuation capacity as well as having the ability to resupply and to repalce personnel on a continuous basis.

Medical Team: A set of medical personnel working together for an assigned mission.

Medical Technician: Individual involved in technical services supporting patient care, e.g., laboratory technicians, radiology technicians.

Medical Treatment Facility (MTF): A facility established for the purpose of furnishing medical and/or dental care.

Medically Isolated Area: Any area, where evacuation of a patient can not be achieved within a reasonable timeframe or where professional medical advice is only, if at all, available by radio.

Mental Incapacitation: Condition resulting from temporary or permanent mental instability as a result of injury, disease, or mental condition.

MO: Military Observer

MTF: Medical Treatment Facility

NGO: Non Governmental Organization

Non-Battle Casualty: **See Casualty.**

Non-Expendable Supplies and Materiel: See Item, Non-Expendable.

Nurse: Person qualified by graduation from a formal nursing programme at an accredited school of nursing and licensed by a state to practise nursing.

Nursing Officer: Registered nurse with officer rank. Synonymous with Nurse Officer (US).

Nursing Attendant: A male or female, enlisted in the ranks of a nation's medical service or branch, who does not possess a nationally recognized general nursing qualification.

Nursing Personnel: Individuals involved in direct patient care, e.g., surgical nurses, nurses, nurse assistants.

Nursing Services: Activities related to nursing care performed by nurses and other professional technical personnel under the supervision of a registered nurse.

Operational Bed: See Bed.,

Outpatient: An individual receiving health care services for an actual or potential disease, injury, or life style related problem that does not require admission to a medical treatment facility for inpatient care.

Outpatient Clinic: See Clinic, Outpatient.

Paramedical Services: Medical services which are provided by specially trained/certified medical technicians.

Patient: An individual who was wounded in action, incurred a disease or a non-battle injury and has entered the medical care system.

Patient, Ambulatory: See Patient, Walking.

Patient Condition: A constellation of clinical states which requires medical care (e.g., broken leg, a wound perforating the abdomen).

Patient Decontamination: The process, performed in proximity of a medical facility and supervised by a physician, of making a patient safe by absorbing, destroying, neutralizing, making harmless, or removing chemical or biological agents, or by removing radioactive material clinging to or around him.

Patient, Emergency: Patient with potentially disabling or life-threatening condition who receives initial evaluation and medical, dental and other health-related service.

Patient, Litter: See Patient, Stretcher.

Patient, Lying: See Patient, Stretcher.

Patient, Sitting: See Patient, Walking.

Patient, Transient: A patient enroute from one medical treatment facility to another medical treatment facility.

Patient, Walking: A patient not requiring a litter while in transit. Also called Ambulatory Patient.

Patient Condition: A constellation of clinical states which require medical care.

Patient Flow: The movement of patients through a system of casualty care. Usually referring to routing through echelons of care.

Per Capita Reimbursement: Process of reimbursing based on average cost per outpatient visit and average of inpatient daycosts.

Personnel at Risk: Those members of a civilian or military service who are exposed to a casualty generating process.

Physician: An individual who practises the art of healing including medicine, surgery, and all other medical fields, who has graduated from a medical faculty of a university and is licensed by an appropriate board.

Physician Assistants: Person who provides health care services customarily performed by a physician under responsible supervision of that qualified licensed physician and who has successfully completed an accredited education program for physicians assistants and/or who has been certified, licensed, or registered by a recognized agency or commission.

Population at Risk: A group of individuals exposed to a casualty generating process.

Posture: The situation of a portion of the personnel or population at risk which is expected to generate different quantities and types of casualties

Prevalence: The total number of cases of a disease, injury or wounding in existence at a certain time in a designated area. Compare Incidence.

Preventive Medicine: The services that are concerned with identifying, preventing, and controlling acute and chronic communicable and noncommunicable diseases and illnesses with food and environmental hygiene, and vector control.

Psychiatrist: A physician appropriately trained and licensed to perform diagnosis and treatment of mental, emotional and behavioural disorders.

PVO: Private Organization

Recoverable Items: See Items.

Red Crescent: See Distinctive Emblems.

Red Cross: See Distinctive Emblems.

Red Lion and Sun: See Distinctive Emblems.

Repatriation: Leaving the mission and returning home.

Resource Determination (or Estimation): The process of using the results of casualty estimation to plan personnel, supplies, equipment and facilities.

Return to Duty: The administrative process of releasing patients from medical care to their unit.

Role: See Level.

Sanitary: Promoting or pertaining to health.

Sanitation: The establishment of environmental conditions favourable to health.

Sanitize: To clean and sterilize, e.g., eating or drinking utensils.

Sanity: Soundness, especially soundness of mind.

Self-Aid: Limited care provided by an individual, such as the self-administration of oral medication. Synonymous with Self Care.

Services, Other Resources: Equipment, supplies, and any other items or facilities necessary for health care services, but not including helth care personnel, whem such ither resources are used by or are needed to support a helth care provider under a partnership agreement.

Services, Support: Those services other than medical, dental, nursing, and ancillary services that provide support in the delivery of clinical services for patient care, including laundry service, housekeeping, purchasing, maintenance, central supply, materials management, and security.

Six Hours Rule: A medical support principle which states that emergency life and limb saving surgery must be provided as soon

as possible, but not later than 6 hours of wounding. This principle is used to determine the location of life and limb saving surgical facilities which will need to be sited no more than four hours from the point of wounding.

SMO: Senior Medical Officer

SOP: Standing Operation Procedure

Sorting: See Triage.

Special Care Unit: A medical care unit in which there is appropriate equipment and a concentration of physicians, nurses and others who have special skills and experience to provide optimal care to critically ill patients.

Stabilized Patient: A stable patient is one who, in the best judgement of the responsible physician, can withstand a planned evacuation.

Staged Wound Management: The surgical wound treatment of a war wound is a two stage operation. The first is concerned with the saving of life and limb and the prevention of serious sepsis by primary wound excision, leaving the wound open. The second stage, the closure of the wound, is carried out four or five days later, often after evacuation, and aims to procure initial soft tissue healing.

Standard Operating Procedure (SOP): are to standardize the methods of operation and administration in a mission.

State of the Art: The level of development (as of a device, procedure, process, technique, or science) reached at any particular time usually as a result of modern methods.

Strategic Aeromedical Evacuation: See Aeromedical.

Stretcher: A rigid frame with a flat horizontal surface on which a patient or casualty can be transported in a lying position. Synonymous with litter.

Stretcher Patient: See Patient.

Supplies: All materiel and items used in the equipment, support and maintenance of military forces. See also item.

Supply: The procurement, distribution, maintenance while in storage and salvage of supplies, including the determination of kind and quantity of supplies.

Support, Host Nation: See Host Nation.

Support Services: See Services.

Surgeon: A physician appropriately trained and licensed to perform general or specialized surgery.

Surgical Capacity: The quantitative potential for operations, determined by the number of available surgical teams and the number of operations per team and day.

Surgical Team: A group of medical personnel, led by a surgeon and supported by a medical facility, performing general or specialized surgery including anaesthesia.

Tactical Aeromedical Evacuation: See Aeromedical.

Theatre of Operation: That geographical regional area which is supporting a specific mission. See also In-theatre.

Total Battle Casualty: See Casualty, Battle.

Treatment, Definitive: See Definitive Treatment.

Treatment Protocol: A schedule of medical activities to be performed to handle a particular type of casualty.

Triage: The evaluation and classification of casualties for purposes of treatment and evacuation. It consists of the immediate sorting of patients according to type and seriousness of injury, and likelihood of survival, and the establishment of priority for treatment and evacuation to ensure medical care of the greatest benefit to the largest number. Triage is a continuous process. Also called "sorting".

a. Triage in a routine situation: Those casualties who require to be evacuated must be sorted into priorities based on their need for surgery and/or resuscitation. The following classification is used:

(1) PRIORITY ONE (P1): Cases requiring resuscitation and early surgery:

- Respiratory emergencies: asphyxia due to respiratory obstruction, maxillo-facial wounds with established or imminent asphyxia, sucking wounds of chest, tension pneumothorax.

- Shock due to: major haemorrhage from visceral injuries, cardio-pericardial injuries or wounds with massive muscle damage, multiple wounds and major fractures, severe burns over 20 per cent Body Surface Area (BSA).

(2) PRIORITY TWO (P2): Cases requiring early surgery and possible resuscitation: visceral injuries including perforations of the gastro-intestinal tract, wounds of the genito-urinary tract and thoracic injuries without asphyxia, major vessel injuries requiring repair, brain and spinal injuries, open or closed, requiring decompression, and burns under 20 per cent BSA of certain locations, e.g., face, hands, feet, genitalia and perineum.

(3) PRIORITY THREE (P3): All other brain and spinal injuries, soft tissue injuries requiring wound toilet, lesser fractures and dislocations, eye injuries, maxillo-facial injuries without asphyxia, and burns of other locations under 20 per cent BSA.

b. Tirage in a mass casualty situation: The magnitude of problems in a mass casualty situation will necessitate that the conventional treatment priorities must be abandoned. This means a radical departure from the traditional practice of providing early complete definitive treatment to each patient on the basis of his individual needs. For this new concept of treatment, priorities designed to assist in providing the greatest benefit for the largest number of patients, without wasting specialist skill and medical resources, the

following system of sorting (Triage) is to be used:

(1) IMMEDIATE TREATMENT (T1): To include those requiring emergency life-saving surgery. These procedures should not be time-consuming and should concern only those patients with high chances of survival.

Examples: Respiratory obstruction, accessible haemorrhage, emergency amputation.

(2) DELAYED TREATMENT (T2): To include those badly in need of time consuming major surgery, but whose general condition permits delay in surgical treatment without unduly endangering life. To mitigate the effects of - often critical - delay in surgery, sustaining treatment.

Examples: Stabilizing i.v. fluids and splinting, administration of antibiotics, catheterization, gastric decompression and relief of pain) will be required.

Examples: Large muscle wounds, fractures of major bones, intra-abdominal and/or thoracic, head or spinal injuries; also uncomplicated major burns.

(3) MINIMAL TREATMENT (T3): To include those with relatively minor injuries who can effectively care for themselves or who can be helped by untrained personnel.

Examples: Minor lacerations, abrasions, fractures of small bones and minor burns.

(4) EXPECTANT TREATMENT (T4): This group comprises patients who have received serious and often multiple injuries, and whose treatment would be time-consuming and complicated with a low chance of survival. If fully treated they make heavy demands on medical manpower and supplies. Until the mass casualty situation is under control, they will

receive appropriate supportive treatment. The extent of treatment will depend on available supplies and manpower and may involve the use of large doses of narcotic analgesics. These patients should not be abandoned, but every effort should be devoted to their comfort, and the possibility of survival with even alarming injuries always kept in mind.

Examples: Severe multiple injuries, severe head or spinal injuries, large doses of radiation, wide-spread severe burns.

UNNY: United Nations New York

Walking Patient: See Patient, walking

Wounded: Individual(s) suffering from battle-related trauma, including all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforated wound, or none, as in the contused wound; all fractures, burns, blast concussions, all effects of biological and chemical warfare agents, the effects of exposure to ionizing radiation, or any other destructive weapon or agent. Synonymous with Wounded-in-Action.

7.6 Catalogue of Medical Items for Peace-keeping Operations

7.6.1 The Medical Catalogue listed below is intended as a guidance to ensure correct description of the medical items requested. This is the only reference for all requisitions made from the Field Missions.

7.6.2 All requests should be made in accordance with this cataloque, however the requests of national specialities or especially needed brands are generally not excluded.

7.6.3 All items listed are divided into 8 sections:

- Medicine (human)
- Consumables (human)
- Medicine (dental)
- Consumables (dental)
- Laboratory
- Hygienics
- Medicine (veterinarian)
- Consumables (veterinarian)

7.6.4 Human medicines are divided into the following categories depending on their indications of use:

- ANAESTHETICS
  * Local
  * Pre-operative
- ANALGETICS, ANTI-PYRETICS, ANTI-INFLAMMATORY
- ANTI-ALLERGICS AND DRUGS USED IN ANAPHYLAXIS
- ANTIDOTES
- ANTI-INFECTIVE
  * Anti-bacterials, Penicillins
  * Anti-bacterials, Other
  * Intestinal Antihelminthics
  * Anti-Amoebic
  * Anti-Fungal
  * Anti-Malarial
  * Anti-Schistosomals
  * Topical
- BLOOD, DRUGS AFFECTING THE
- BLOOD PRODUCTS AND SUBSTITUTES
- CARDIOVASCULAR
  * Anti-anginal
  * Anti-dysrhytmic
  * Cardiac-glycosides

- DERMATOLOGICAL
  * Anti-fungal
  * Anti-infective
  * Anti-inflammatory
  * Astringent
  * Scabicides and pediculicides
- DISINFECTANTS AND ANTISEPTICS
- DIURETICS
- GASTRO-INTESTINAL
  * Antacids
  * Anti-emetic
  * Anti-spasmodic
  * Laxatives/Catharctics
  * Diarrhoea
- IMMUNOLOGICALS
  * Sera and Immunoglobulins
  * Vaccines
- MISCELLANEOUS
- MYORELAXANT
- OPHTHALMOLOGICAL
  * Anti-infective
  * Local anesthetics
- PSYCHOTHERAPEUTIC
- RESPIRATORY TRACT, DRUGS ACTING ON
  * Anti-asthmatic
  * Anti-tussives
- VITAMINS AND MINERALS

7.6.5 Whenever possible INN Code or Generics should be used. Trade Names/Brands should only be added, when this particular medicine is actually requested. Additional information should be added if necessary to describe specific items. No. per Pckg. will determine whether packages of this particular size, or bulk-ware are requested.

INN CODE/ GENERIC/ DESCRIPTION	TRADE NAME/ BRAND	PRESENTATION/ STRENGTH/SIZE	ADDITIONAL INFORMATION	NO. PER PCKG.

INN CODE/ GENERIC/ DESCRIPTION	TRADE NAME/ BRAND	PRESENTATION/ STRENGTH/SIZE	ADDITIONAL INFORMATION	NO. PER PCKG.

INN CODE/ GENERIC/ DESCRIPTION	TRADE NAME/ BRAND	PRESENTATION/ STRENGTH/SIZE	ADDITIONAL INFORMATION	NO. PER PCKG.