MEDICAL SUPPORT MANUAL FOR UNITED NATIONS FIELD MISSIONS

4th EDITION *(2024)*

UNITED NATIONS

DEPARTMENT OF OPERATIONAL SUPPORT

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Medical Support Manual for United Nations Field Missions (4th Edition)

This manual is published and distributed by the Department of Operational Support/Office of Support Operations/Division of Healthcare Management and Occupational Safety and Health, United Nations Headquarters, New York.

The first edition was issued in 1995, the second revised edition was issued in 1999, and the third revised edition was issued in 2015.

Executive Summary

A. General

The first Medical Support Manual for United Nations Field Missions was published and distributed in 1995, with the second revised edition issued in 1999, and the third and last revised edition in 2015. Over the last decade, peacekeeping has evolved, highlighting the need to adapt medical support provided to field missions. Both the High-level Independent Panel on Peace Operations report (HIPPO report) of 2015 and the Cruz report on Improving Security of United Nations Peacekeepers of 2017 emphasized the need to review the chain of care, policies and guidelines to provide timely, consistent, efficient and reliable medical support.

The revised Medical Support Manual will serve as a standard reference document on medical support aspects of United Nations peacekeeping operations and political missions in the field. This current revision aims to reflect the restructuring of the United Nations and provide Troop/Police Contributing Countries (T/PCCs) with guidance on the oversight structure, as well as operational and procedural guidelines for medical support in the field. The goal is to create uniformity in the delivery of medical support across all United Nations missions globally by maintaining consistent standards.

The manual has been restructured to contain substantive information and adapted to serve as an online resource. It is designed as a living document, allowing for ongoing user feedback, changes and updates to keep it current. This project was made possible through the generous contribution of the Government of Germany.

B. Structure of the manual

The introductory section of the manual comprises a table of contents, abbreviations to facilitate understanding of the text, a list of the tables and figures included in the manual anda table of annexes. The main body of the manual is composed of four modules with respective chapters covering administration, medical planning and

emergency preparedness, healthcare management and occupational safety and health. The annexes listed at the beginning are included for reference.

C. Relationship to other official documents

The contents of this manual are compatible with the financial rules and regulations of the United Nations, administrative issuances, official United Nations guidelines and other documents relevant to the administration of United Nations field operations. Chapter 12, the public health chapter of the Healthcare Management module, is written with reference to World Health Organization policies and guidelines on health care and is considered a living document. Therefore, when used, all references should be checked to ensure that it is still current and reflects the latest advice from the World Health Organization.

D. Distribution and revision

The Medical Director, Division of Healthcare Management and Occupational Safety and Health, controls the digital resource and distribution of this manual. In consultation with the Department of Operational Support/Office of Support Operations, the Medical Director is responsible for the regular review of its contents and for the revision/updating of its text and annexes where required. This manual is a living document and all suggestions and comments from its users are welcomed to ensure continuous valuable improvements to its contents.

E. Acknowledgements

The Department of Operational Support/Office of Support Operations/Division of Healthcare Management and Occupational Safety and Health would like to thank the Government of Germany for the generous funding of this project, and the Advisory Committee of Member States (Bangladesh, Chile, China, Czech Republic, Ethiopia, India, Mongolia, Morocco, Nepal, Nigeria, Republic of Serbia, Senegal, Togo) and supporting Member States (Australia, Germany, Hungary, the Netherlands) for all of their invaluable input and support in ensuring the success of this revised manual.

Contents

Abbreviations

ABCC	Advisory Board on Compensation Claims
ACLS	Advanced Cardiac Life Support
AIDS	Acquired Immune Deficiency Syndrome
AMET	Aero-Medical Evacuation Team
ATLS	Advance Trauma Life Support
BFAC	Buddy First Aid Course
CAP	Commons Appeals Process
CASEVAC	casualty evacuation
CBRNE	chemical, biological, radiological, nuclear, environmental
CMO	Chief Medical Officer
CMS	Chief of Mission Support
CMT	Crisis Management Team
CMWG	Crisis Management Working Group
COE	contingent-owned equipment
COE-WG	Contingent Owned Equipment Working Group
CONOPS	Concept of Operations
CPAS	Comprehensive Planning and Performance Assessment System
CPR	cardiopulmonary resuscitation
DHMOSH	Division of Healthcare Management and Occupational Safety and Health
DMS	Director of Mission Support
DOC	Designated Operations Centre
DOS	Department of Operational Support
DPO	Department of Peace Operations
DPPA	Department of Political and Peacebuilding Affairs
EarthMed	The United Nation’s electronic health information management system
ECG/EKG	electrocardiogram
EHO	Environmental Health Officer
EMR	electronic medical record
EOSG	Executive Office of the Secretary-General
ERP	Enterprise Resource Planning

EVD	Ebola virus disease
FC	Force Commander
FGS	Force Generation Service
FHO	Force Hygiene Officer
FMAC	Field Medical Assistant Course
FMC	Force Medical Cell
FMO	Force Medical Officer
FPU	Formed Police Unit
GSC	Global Service Centre
HC	Humanitarian Coordinator
HF	high frequency
HIV	Human Immunodeficiency Virus
HoM	Head of Mission
HQ	Headquarters
ICT	information and communication technologies
IPO	individual police officer
IRS	Incident Reporting System
ISF	Integrated Strategic Framework
JOC	Joint Operations Centre
LOA	Letter of Assist
LD	Logistics Division
MCI	mass casualty incident
MEDEVAC	medical evacuation
MHE	mental health expert
MMC	Mission Medical Cell
MOC	Military Operations Centre
MOU	memorandum of understanding
MSA	Medical Staff Aid
MSS	Medical Support Section
MRT	Medical Reporting Tool
MTF	medical treatment facility
NFC	near-field communication

NGO	non-governmental organization
NOTICAS	Notification of Casualty
OCB	Operations Coordination Body
ODA	Office for Disarmament Affairs
OHR	Office of Human Resources
OIOS	Officer of Internal Oversight Services
OLA	Office of Legal Affairs
OMA	Office of Military Affairs
ORT	e-Outbreak Reporting Tool
OSH	Occupational Safety and Health
OSCM	Office of Supply Chain Management
PCC	police-contributing country
PDV	pre-deployment visit
PEP	post-exposure prophylaxis
PHTLS	Prehospital Trauma Life Support
PKO	peacekeeping operation
PLF	permanent loss of function
PM	Permanent Mission
POC	Protection of Civilians
POI	point of injury or illness
RC	Resident Coordinator
SG	Secretary-General
SLA	service level agreement
SMO	Senior Medical Officer
SO	Staff Officer
SOP	standard operating procedure
SORT	A process for sorting injured people into groups based on their need or likely need of immediate medical treatment. Triage is used in medical emergencies.
SPM	Special Political Mission
SRSG	Special Representative of the Secretary-General
SSS	Sourcing Support Service

TAM	Technical Assessment Mission
TCC	troop-contributing country
T/PCC	troop- or police-contributing country
UCSD	Uniformed Capabilities Support Division
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Fund
UNDP	United Nations Development Programme
UNDSS	United Nations Department of Safety and Security
UNFPA	United Nations Population Fund
UNGSC	United Nations Global Service Centre
UNHQPS	United Nations Healthcare Quality and Patient Safety Standards
UNICEF	United Nations Children's Fund
UNJMS	United Nations Joint Medical Services
UNLB	United Nations Logistics Base
UNMEM	United Nations Military Experts on Mission
UNMERT	United Nations Medical Emergency Response Team
UNOCC	United Nations Operations and Crisis Centre
UNOE	United Nations owned equipment
UNOPS	United Nations Office for Project Services
UNSDCF	United Nations Sustainable Development Cooperation Framework
VDRL	Venereal Disease Research Laboratory
VHF	very high frequency
WHO	World Health Organization
WRA	Workplace Risk Assessment

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MODULE 1: ADMINISTRATIVE MODULE

Chapter 1: Medical Structure of the Health Services at UNHQ

1.1. Medical support and oversight structure at UNHQ

Medical support to the field is provided by the Department of Operational Support (DOS) through the Division of Healthcare Management and Occupational Safety and Health (DHMOSH) and the Medical Support Section (MSS). See the organizational structure of the United Nations in Annex 1.1 for further information. DHMOSH provides expert health-care management, occupational safety and health and public health services to all United Nations Secretariat entities, including field missions, Offices Away from Headquarters and Economic Commissions and the New York-based United Nations agencies, funds and programmes. It also provides strategic leadership on whole-of-system medical issues through the United Nations Medical Directors and strengthens governance over the safety and quality of the health care delivered in the field, particularly in T/PCC health-care facilities, aiming to reduce preventable harm and improve health-care outcomes.

Its goal is to increase the effectiveness of the United Nations by promoting and maintaining the health of all United Nations personnel. This is achieved through effective planning, coordination, monitoring and professional supervision of medical services and support in the field. MSS provides technical expert advice and guidance to improve the health-care supply chain by identifying sourcing solutions for health-care equipment, consumables and supplies, pharmaceuticals including drugs and blood products, allied health and medical services.

The organizational chart below illustrates the oversight structure:

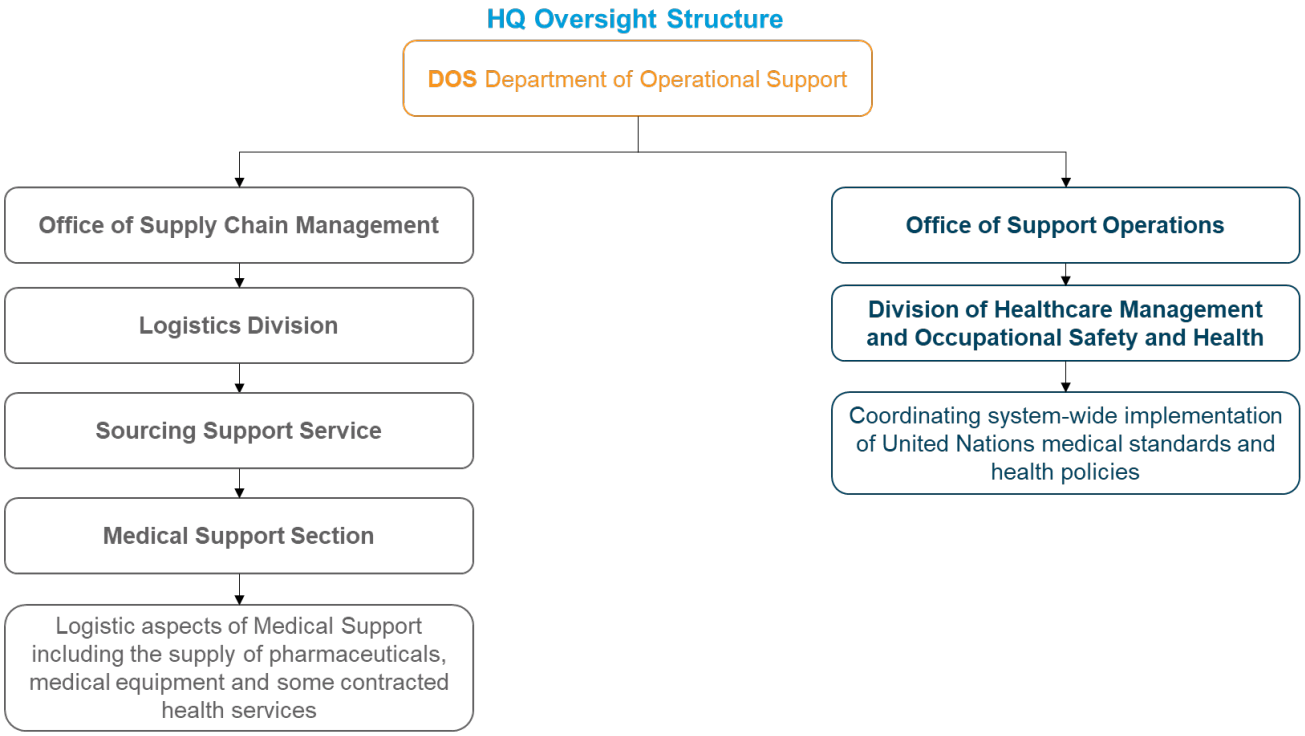

Figure I: UNHQ oversight structure

1.2. Division of Healthcare Management and Occupational Safety and Health: structure, roles, and responsibilities

The Division of Healthcare Management and Occupational Safety and Health (DHMOSH) provides on-site occupational health services in New York and delivers services to over 100 locations worldwide. Through the two components of health-care management and occupational safety and health, DHMOSH focuses on improving access to and provision of related services to staff in all locations under its responsibility.

Quality health-care management is achieved through the maintenance of a health-care management framework that includes standards for the quality of care provided and for United Nations practitioners, medical facilities and medical evacuation (MEDEVAC) capabilities, alongside the implementation of workforce planning.

DHMOSH delivers its mandate through its organizational structure, which includes the following sections:

a) Office of the Director

b) Clinical Governance (CG)

c) Medical Workforce Management (MWFM)

d) Occupational Safety and Health (OSH)

e) Public Health (PH)

f) Staff Counsellors' Office (SCO)

g) United Nations Medical Emergency Response Team (UNMERT)

Figure II: Division of Healthcare Management & Occupational Safety and Health

1.3. Overall policy and advisory role of DHMOSH

The roles and responsibilities of DHMOSH include, but are not limited to, the following:

- Formulating and reviewing United Nations medical standards, policies and guidelines and ensuring coordination and monitoring of system-wide implementation.
- Providing occupational health and safety guidance and oversight.
- Providing professional and technical oversight to medical personnel in the missions.
- Providing technical guidance on recruitment of medical personnel.
- Performing other medico-administrative functions such as sick leave administration, medevac administration and medical entitlement management.
- Determining if an injury/illness is job-related and calculating permanent loss of function when applicable.
- Conducting technical assessments of referral hospitals and regional evacuation centres.
- Conducting advisory and assessment visits.
- Conducting workforce capacity-building and management.

1.4. Office of the Director

The main functions of the Office of the Director are:

i. Acting as principal adviser to the Secretary-General and heads of New York-based Agencies on all health-related matters of their personnel (including United Nations Secretariat uniformed and civilian personnel and personnel of UNDP, UNICEF, UNFPA, UN Women and UNOPS).
ii. Overseeing health-care standards in all United Nations health-care facilities, including civilian- and troop-operated facilities worldwide.
iii. Overseeing the work of the Division of Healthcare Management and Occupational Safety and Health.
iv. Overseeing and being responsible for all managerial tasks necessary for the efficient and effective functioning of DHMOSH, including the preparation of

budgets, reporting on budget performance, individual and team performance management, staff development and career support.

v. Providing leadership in the continuous assessment of needs and development, implementation, monitoring, evaluation and/or updating of policies, procedures, standards, protocols, guidelines and emergency plans, and coordinating health promotion programmes and initiatives in conjunction with managers, human resources staff and other key partners.

vi. Providing health-care management oversight through professional and technical advice and supervision relating to the workforce and clinical quality standards of all United Nations health-care facilities and United Nations examining physicians worldwide to ensure staff access to health-care in all field duty stations.

vii. Providing reviews of workplace accommodation requests and medical travel upgrade requests for the United Nations Secretariat, UNDP, UNICEF, UN Women, UNFPA, and UNOPS (UNHQ).

viii. Acting as medical adviser to the Advisory Board on Compensation Claims (ABCC), the United Nations Joint Staff Pension Fund (UNJSPF) and investigative and legislative bodies of the Secretariat.

ix. Planning and implementing programmes of strategic change for the management of health-care in the United Nations system, taking into consideration the field presence of United Nations staff and the increased danger of peacekeeping missions, and including the representation of health-care issues as needed on inter-agency governance bodies, including the High-Level Committee on Management, the United Nations Medical Directors , the Human Resources Network, and the Inter-Agency Security Management Network.

x. Identifying strategic partners outside the United Nations system and exploring areas of potential cooperation for the benefit of improved health-care delivery within the United Nation system.

1.5. Clinical Governance

The Clinical Governance Section focuses on improving and standardizing the health-care quality and patient safety standards of all health-care facilities in the United Nation system through a United Nations-wide accountability framework for health-care services. It includes a system application for ensuring adherence to United Nations Healthcare Quality and Patient Safety Standards (UNHQPS) and the continuous improvement of services.

The main functions of the Clinical Governance Section are:

i. Ensuring compliance of field health-care facilities and referral hospitals with United Nations Healthcare Quality and Patient Safety Standards. This is achieved through training Hospital Commanders, Chief Medical Officers (CMOs), and other health-care providers in the field, the evaluation of hospitals and other health-care facilities, making recommendations and monitoring implementation plans. This also involves developing and implementing performance monitoring tools and developing e-learning platforms for health-care quality and patient safety.

ii. Developing evidence-based clinical pathways on field-relevant medical conditions and assisting the pertinent United Nations and Troop-/Police-Contributing Country (T/PCC) health-care providers to implement these pathways in their facilities.

iii. Undertaking clinical audits of United Nations and T/PCC health facilities.

iv. Promulgating the Standard Operating Procedures for Root Cause Analysis (RCA) of sentinel events,[1] undertaking RCAs and training medical personnel in the field on how to undertake RCAs as needed in field missions.

v. Maintaining the Patient Experience Dashboard for use by medical facilities to provide a feedback loop on the quality of care being provided in that facility.

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[1] According to the Joint Commission, a sentinel event "is a patient safety event that results in death, permanent harm, or severe temporary harm".

vi. Responding to patient complaints and providing recommendations to health facilities.
vii. Developing and implementing a clinical adverse event reporting system, as part of the introduction of a “just culture” (Just Culture is a movement to shift from blame for errors and instead focus on system issues in order to enhance event reporting and learning from failures).
viii. Undertaking assessment visits to medical facilities in field duty stations and regional evacuation centers to assess their services and ensure their compliance with policies.
ix. Reviewing T/PCC submissions on death and permanent loss of function connected to mission-related illness/injury in uniformed personnel and providing advice on compensation.
x. Participating in advisory, assessment and pre-deployment visits to T/PCCs to familiarize them with United Nations health-care policies and medical standards, how to comply with them before and during deployment and how to monitor implementation.
xi. Ensuring medical projects from extra-budgetary (XB) funds are initiated and completed.

1.6. Medical Workforce Management

The Medical Workforce Management Section undertakes the strategic planning and management of the United Nations medical workforce. The team provides guidance on health-care professional recruitment, training and professional development programmes, and technical clearance reviews to ensure the suitability of health-care professionals for their designated roles.

The main functions of the Medical Workforce Management Section are:

i. Streamlining and standardizing technical clearance procedures through ensuring compliance with the Guidelines on Technical Clearance Review of Medical Personnel for Deployment to United Nations Field Duty Stations.
ii. Advising on or conducting recruitments for medical personnel as appropriate.
iii. Providing technical support to all medical personnel deployed in field missions and duty stations.
iv. Maintaining a medical workforce database.
v. Delivering medical workforce training guidance and coordinating and organizing continuous training for the medical workforce through regular webinars, seminars and workshops.
vi. Participating in integrated mission support planning and contingency medical planning.
vii. Providing guidance and support for field mission and duty stations in developing and updating Medical Support Plans and standard operating procedures (SOPs).
viii. Developing tailored medical planning solutions with contracted providers.
ix. Overseeing policy implementation and delivery relating to a range of medical entitlements including sick leave, MEDEVAC, repatriation and special dependency allowance for civilian staff.

1.7. Occupational Safety and Health (OSH)[2]

The Occupational Safety and Health Section aims to reduce workplace incidents, illnesses and injuries by conducting risk assessments and implementing mitigation measures for workplace hazards. These cover exposure to chemicals, infectious diseases, equipment and machinery and general work practices. By establishing systems for injury and illness prevention and efficient management, the section also helps reduce health and safety-related costs. In addition, it strives to improve the client

[2] For further reading refer to Module 4: Occupational Safety and Health.

experience and increase the effectiveness of the incident management process through the integration of automation alongside better recording and reporting of health and safety data. Ultimately, the goal of Occupational Safety and Health is to create a secure and healthy work environment in line with United Nations requirements.

The main functions of the OSH Section are:

i. Establishing an integrated United Nations Occupational Safety and Health (OSH) management system to meet the capability requirements of the High-Level Committee on Management's Occupational Safety and Health Framework. This covers five key areas:
    a. Leading the development of United Nations OSH policy and standards
    b. Implementing an incident reporting system
    c. Establishing an OSH risk register (integrated with Enterprise Risk Management approaches)
    d. Develop OSH capacity in the United Nations workforce including the development and delivery of OSH training, and the selection of occupational health or workplace safety qualified staff.
    e. Provide annual reports to senior management on United Nations OSH performance.
ii. Providing advice and support on high-risk or high-priority OSH matters to Offices, Economic Commissions, missions and United Nations Country Teams worldwide when these entities do not have an internal OSH capability.
iii. Providing an OSH capability in UNHQ, including support to the New York-based OSH Committee and the development of UNHQ specific policies and communiques (such as those relating to infectious disease management at HQ).
iv. Clinical services, including:
    a. Providing an on-site occupational health clinic for travel consultations, preventive health services (such as vaccination campaigns) and other related occupational health activities

b. Providing ergonomic and environmental health services to staff in UNHQ

c. Where required, providing immediate assistance for on-site injuries and illnesses, including medical emergencies, and support for a mass casualty event in the UNHQ.

1.8. Public Health[3]

The Public Health Section works to improve the health and well-being of the United Nations community both inside and outside the workplace.

The main functions of Public Health Section are:

i. Strategic leadership and policy guidance required for the management of public health emergencies and crises, United Nations duty stations and missions across the globe.

ii. Undertaking epidemiology and analytics – with disease outbreak response when required.

iii. Undertaking health promotion activities for the United Nations system.

iv. Overseeing projects that promote an active and healthy lifestyle among United Nations personnel.

v. Coordinating and providing technical support for the HIV programme in peacekeeping/political missions and the global management of the HIV post-exposure prophylaxis (PEP) kit programme.

1.9. United Nations Medical Emergency Response Team

UNMERT assumes primary responsibility for the medical emergency and trauma-related aspects of DHMOSH operations.[4] It focuses on coordinating the shared

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[3] See *Medical Support Manual for United Nations Field Missions* (2024), chap. 12 .

[4] United Nations, Human Resources Portal, "Medical Services: a critical part of organizational resilience", 15 March 2017.

responsibility of security and medical personnel in crisis management scenarios involving mass casualties.

The main functions of UNMERT are:

i. Designing and overseeing emergency/trauma response systems, as well as emergency/trauma response training and preparedness.
ii. Advising field duty stations on the medical aspects of casualty evacuation (CASEVAC) as well as mass casualty incident (MCI) preparedness and participating in CASEVAC stress tests as required.

1.10. Staff Counsellors' Office [5]

The Staff Counsellors' Office (SCO) operates as an independent office within DHMOSH, with the Chief of SCO reporting to the Deputy Medical Director. SCO provides a variety of services which aim to support United Nations staff in managing their mental well-being and psychosocial challenges.

The main functions of the Staff Counsellors' Office are:

i. Individual mental health counselling
ii. Consultations for managers
iii. Psychosocial risk assessments
iv. Policy guidance and development
v. Animal-assisted activities
vi. Psychoeducational and prevention initiatives.

1.11. Office of Supply Chain Management (OSCM)/Logistics Division (LD) / Sourcing Support Service (SSS) / Medical Support Section (MSS)

Under DOS, the Office of Supply Chain Management (OSCM) brings together logistics and procurement functions to ensure a seamless end-to-end process. MSS is a

[5] *Medical Support Manual for United Nations Field Missions* (2024), chap. 14. Mental Health

medical support solution provider and enabler for all DOS clients, including United Nations and non-United Nations peacekeeping, special political and other field missions. MSS is structured according to medical categories reflecting specific functions, as follows:

a. Medical equipment and consumables
b. Health services
c. Pharmaceuticals and blood products.

The main functions of United Nations medical supply chain management include

i. **Client demand:** Fulfils United Nations mission requests for goods and services.
ii. **Track & Trace**: Monitors the status of requisitions, purchase orders, or shipments to follow progress and ensure completion.
iii. **Demand planning:** Develops optimized plans for sourcing, logistics, storage, transport and distribution.
iv. **Sourcing:** Evaluates and secures the best suppliers for the Organization.
v. **Inbound logistics:** Organizes storage, transportation and delivery of incoming goods from supplier to a distribution location.
vi. **Storage and transport:** Stores or prepares goods for transport according to relevant schedules.
vii. **Outbound logistics:** Distributes goods and services to clients.
viii. **Delivery and receipt:** Ensures clients receive the right goods, at the right time, and of the best quality.
ix. Providing **Technical Expert Advice and Guidance** for an improved health-care supply chain.
x. Identifying sourcing solutions for the following:
    a. **Healthcare equipment** (Medical and Dental), consumables and supplies
    b. **Pharmaceuticals** (Drugs and Blood products)

c. **Allied health and medical services** (personnel and/or medical capability requirements, for emergency measures).

xi. Putting in place and managing **Global Systems Contracts covering the above-mentioned solutions.**

xii. Developing and updating the medical categories' strategies, introducing innovation and leading the relevant category management initiatives.

1.12. Inter-agency relationships with UNHQ and field missions in the delivery of health-care services

MSS works with United Nations and non-United Nations partners to **plan**, **establish,** and **sustain** operations in complex environments. Relationships between stakeholders in health-care delivery in peacekeeping operations span across a range of entities, requiring effective cooperation. These relationships are shown in the diagram below. The mission Chief Medical Officer (CMO) also has a functional relationship with the Medical Director, DHMOSH for clinical, administrative and operational matters, and with the Chief of MSS, for medical logistics matters. Beyond these relationships, cooperation also extends across different agencies, funds and programmes.

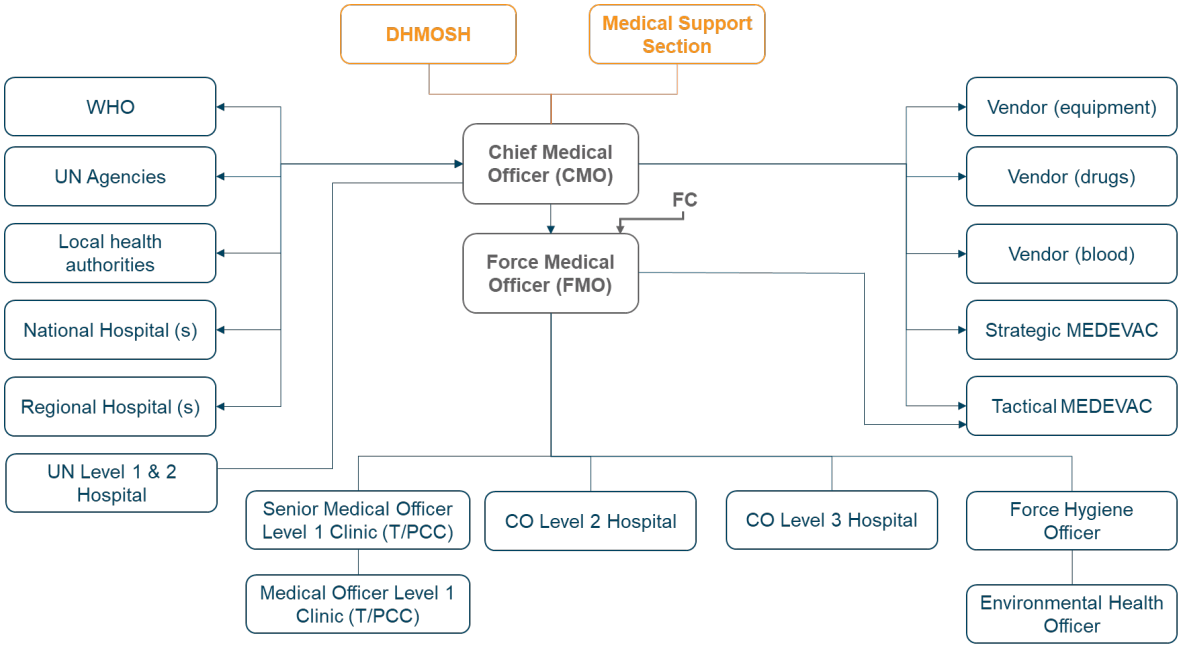

Figure III: Integrated civilian and military medical support in peacekeeping operations (PKO)

1.13. Key messages

- DHMOSH provides expert health-care services to all United Nations Secretariat entities, including field missions, Offices Away from Headquarters and Economic Commissions, and the New York-based agencies, funds and programmes, as well as strategic leadership on whole-of-system medical issues through the United Nations Medical Directors.
- The CMO has a functional relationship with the Medical Director, DHMOSH for clinical, administrative, and operational matters, and with the Chief of MSS, for medical logistics matters.

Chapter 2: Medical Structure of the Health Services in the Field

In Security Council-mandated missions, medical support often consists of both civilian and military/police components. A clear understanding of the roles and responsibilities of the various medical components of such missions and well-defined professional reporting lines for civilian and military/police medical personnel are critical to sustaining efficient medical support operations in the field.

This chapter aims to clarify the roles and responsibilities of senior civilian and military medical appointment holders in the field. The reporting relationship for medical professional and technical matters is defined within the structure of an integrated civilian-military/police mission. Given that peacekeeping missions vary in structure, the following guidance should be understood as exemplary but may not necessarily be applicable in its entirety in all possible or actual mission structures. Smaller missions, for example, may not have a CMO or a Force Medical Officer (FMO), in which case these functions would be combined into one.

2.1. Medical oversight structure in the mission

The Medical Services Section, under the leadership of the CMO, normally reports to the Chief of Service Delivery.

2.2. Medical support management

Ultimate responsibility for the medical system of the mission lies with the Head of Mission (HoM), and accountability is exercised through the Director or Chief of Mission Support (D/CMS) and the CMO.

The medical support requirements are outlined in the mission Concept, military and police component concepts of operations and support concept. These requirements are integrated into the Medical Support Plan, which is a part of the overall Mission

Support Plan. The Medical Support Plan identifies the necessary medical goods and services and the options for sourcing and delivery (Annex 1.2).

In addition to the annually updated Mission Support Plan, all missions have a Crisis Management Team (CMT), integrated contingency plans, and established delegated approval procedures for assigning mission and non-mission CASEVAC assets. The CMO is a member of the Crisis Management Working Group and is responsible for providing medical advice and recommendations to the CMT and contributing medical inputs to contingency plans.

2.3. Field mission medical structure

For effective resource utilization, field missions integrate United Nations-owned, T/PCC-owned (or contingent-owned) and contracted medical resources into a single medical system to ensure the provision of high-quality and timely medical support to United Nations personnel.

2.4. Mission Medical Cell

The Mission Medical Cell (MMC) is an informal structure that brings together the Medical Services Section and the Force Medical Cell (FMC) to form a single office to better facilitate cooperation. Where possible, the offices of the CMO and FMO should be co-located to maximize the potential for collaboration. The CMO leads the MMC and is responsible for the collective implementation of all the medical functions of the mission. Those functions can only be implemented through effective cooperation between the CMO and FMO offices. The roles, responsibilities and skill sets of each individual in the MMC are described in annex 1.3.

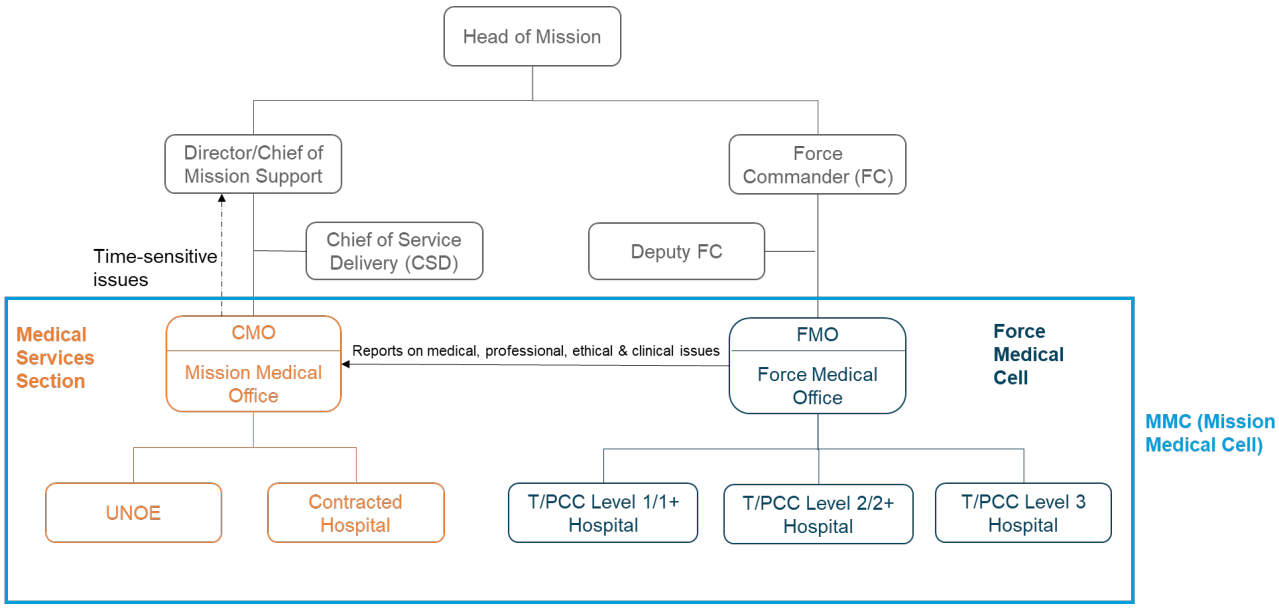

Figure IV: Medical command and control structure in the field

2.5. Medical Services Section

Mission medical services are led by the CMO. The CMO is responsible and accountable for the delivery of comprehensive, integrated, and quality medical services to all mission personnel. The CMO has a functional relationship with the Medical Director, DHMOSH, for all clinical and administrative matters, and with the Chief of Medical Support Section for medical logistic matters.

At the mission level, the CMO plans and administers the medical component of the mission's budget and is accountable to the CMS or DMS for all medical-related issues with financial implications. The CMO supervises all enabling medical capabilities (United Nations-owned equipment and TCC Level 1, 2 and 3 medical facilities), and ensures contracted medical capabilities are in compliance with the terms of the contract.

2.6. Force Medical Cell

The FMC is led by the FMO and includes all other force medical staff officers. The FMO is the most senior ranking military medical officer within the peacekeeping force.

The FMO is accountable to the Force Commander (FC) for the health of the military peacekeeping force and the operational readiness of T/PCC medical units. The FMO is accountable to the CMO for the medical effectiveness of military medical units. The FMO reports to the CMO on the professional and clinical performance of the FMC. The FMO also ensures that military medical resources meet the United Nations standard through regular participation in contingent-owned equipment (COE) inspections. The FMO is required to be of the rank of colonel.

2.7. United Nations Joint Medical Services

Support services, including medical services such as those within United Nations Joint Medical Services (UNJMS), are offered upon subscription to such services by agencies, funds and programmes through a memorandum of understanding and a structure outlined in the service level agreement (SLA). The SLA sets out the framework for cooperation and coordination relating to support services or common services. Participation in the SLA shall be voluntary. Unless otherwise regulated, the common services shall not be available to United Nations entities who are not participating in the SLA.

The UNJMS is primarily an occupational health service concerned with the health and well-being of United Nations personnel and eligible dependents. It provides a menu of specific services to subscribing United Nations agencies funds and programmes that operate in the mission area. In some missions, however, the UNJMS provides primary and emergency care and organizes MEDEVACs, when indicated, for all nationally and internationally recruited United Nations personnel and their eligible dependents.

To achieve the required United Nations medical standards, the UNJMS is guided by the policies and guidelines of an Oversight and Policy Committee on Common Services, which includes the head of each participating organization. The committee is chaired by the Special/Executive Representative of the Secretary-General (S/ERSG). The Oversight and Policy Committee is responsible for the overall coordination and supervision of the implementation of the SLA.

2.8. Key messages

- The CMO leads the Mission Medical Cell and is responsible for the collective execution of all the medical functions of the mission. These functions are implemented through effective cooperation between CMO and FMO offices.
- The FMO leads the Force Medical Cell and ensures that military medical resources meet the United Nations standard through regular participation in the COE inspections.
- The UNJMS is concerned with the health and well-being of United Nations personnel and eligible dependents. It provides services to subscribing United Nations agencies, funds, and programmes that operate in the mission area.

Chapter 3: Medical Capabilities in Field Missions–Levels of Care

3.1. Introduction

This chapter provides an overview of the multi-level support concept for providing medical care in United Nations field missions. It should always be read in conjunction with the most current edition of the *Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions* (the COE Manual). In the event of any conflict with the content of the COE Manual, COE Manual provisions should take precedence over the Medical Support Manual.

3.2. Concept of medical support

The medical system within United Nations field missions follows a multi-level framework that encompasses various levels of care, ranging from first responder care at incident sites to comprehensive specialist medical care at hospitals. The objective is to provide routine clinical care and limb and life-saving treatments within the mission area, with complex and definitive care taking place outside of the mission area. Rehabilitation usually occurs outside United Nations field missions under the responsibility of the respective T/PCC.

Medical support is modular, meaning it can be adapted to address the specific needs of each mission. CASEVAC and MEDEVAC capabilities also play a vital role in ensuring timely transportation of critically ill or injured patients.

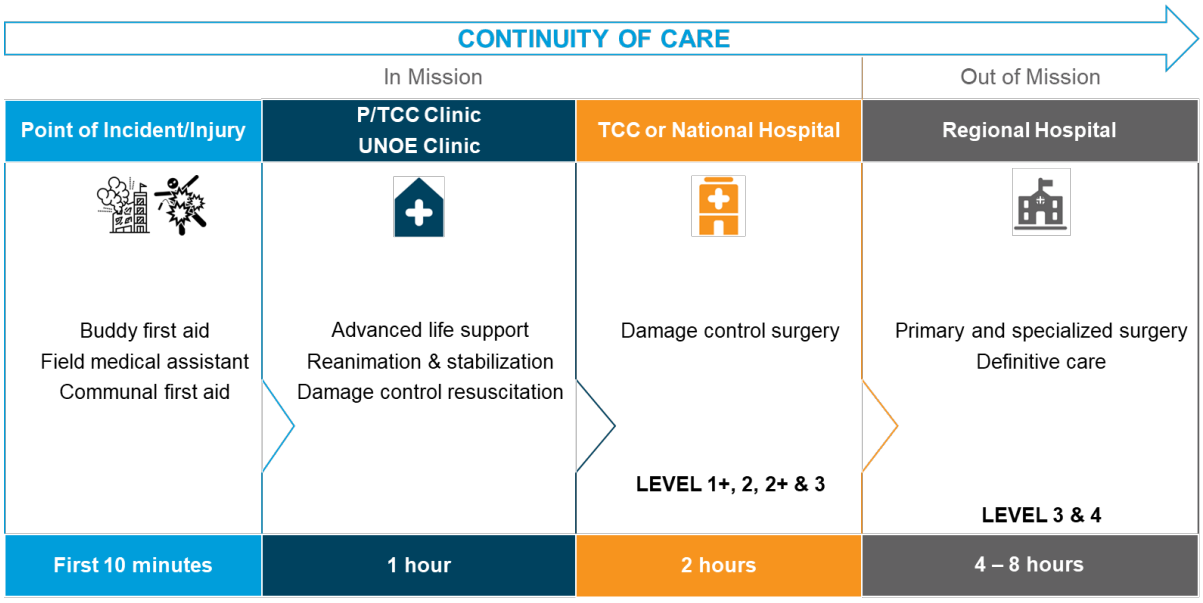

Figure V: United Nations medical support concep

The medical care model is intended to meet the requirements of military, police and civilian personnel in remote locations where easy access to other medical care providers is not available. The model aims to provide skilled first aid by trained non-medical staff, paramedics, medics or nursing assistants within ten minutes of a trauma or the onset of symptoms, and advanced life support as soon as possible, but ideally within a time frame not exceeding one hour. Damage control surgery, if needed, should be performed within two hours.

3.3. Levels of care

The 10-1-2 timeline is an approach based on scientific evidence that aims to enhance the survivability of ill or injured United Nations personnel. It is used as the basis for the medical emergency planning processes in all circumstances.

3.4. First 10 minutes

Immediate life-saving measures are applied in the first 10 minutes by personnel trained in either the United Nations Buddy First Aid Course (UNBFAC) and/or the Field Medical Assistant Course (FMAC). The UNBFAC is the most basic course, providing

training in essential interventions to control heavy bleeding and other immediate live-saving measures, as well as in how to recognize more serious injuries. The FMAC trains personnel in the provision of advanced care to treat the most common causes of death from injury, including recognizing and preventing the life-threatening complications of such injuries.

The following capabilities are available for use in these first 10 minutes:

- Buddy first Aid kit
- Field medical assistance kit
- Communal first aid kit

Further details are available in the COE Manual Chapter 3, Annex C.[6]

3.5. Level 1 medical facility

A level 1 medical facility, under national government responsibility, is the first level of medical care where a medical doctor or physician is available. It is the first stationary level of medical care, i.e. where primary health care and immediate life-saving and resuscitation services can be secured. Basic level 1 capabilities usually include: routine sick calls and the management of minor illnesses and injuries for immediate return to duty; casualty collection from the point of injury and limited triage; stabilization of casualties; preparation of casualties for evacuation to the next level of care; limited inpatient services; and advice on disease prevention, medical risk assessment and force protection within the area of responsibility.

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[6] A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023), chap. 3, annex C p. 85 and appendices 1–3.

Level 1 facilities are expected to be able to treat up to 20 ambulatory patients per day, have temporary holding capacity of five patients for up to two days, and hold medical supplies and consumables for 60 days.[7]

Most level 1 medical facilities are able to split in two units to serve two separate locations (e.g., service in the camp and during patrol/recce). If there is a need for a formed unit to provide medical services to more than two locations, then adjustments should be made to the memorandum of understanding (MOU) to enhance the capabilities of the level 1 facility, so that it is able to medically support all locations effectively.

Depending on the health risk assessment, a level 1 facility can be augmented with modules to enhance its capabilities, including primary dental care, basic laboratory capabilities, preventive medicine, a forward surgical team and an Aero-Medical Evacuation Team (AMET), at which point they are referred to as level 1+.[8]

3.6. Level 2 medical facility

A level 2 medical facility is the next highest level of medical care, offering surgical and life-saving capabilities, as well as common hospital services. It can be United Nations-owned (UNOE) or contingent-owned (COE).

A level 2 medical facility provides all level 1 capabilities and, in addition, includes capabilities for emergency surgery, damage control surgery, post-operative services and high-dependency care, intensive care resuscitation, inpatient services, and basic

[7] A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023), chap. 3, annex C, appendix 4.

[8] A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023), chap. 3, annex C.

imaging, laboratory, pharmaceutical, preventive medicine and dental services.[9]The number of level 2 facilities in a mission is dependent on the size of the mission population, its dispersion across the area of operation, the military and police concept of operations, the threat environment, the availability of host nation or regional United Nations or commercial medical services, etc. Level 2 facilities are not mobile, i.e., patients have to be transported to the facility. Depending on the health risk assessment, level 2 facilities can be augmented with modules to a **level 2+ facility** through the addition of one or more modules providing orthopaedic, surgical or gynaecological capabilities, as well as internal medicine and/or diagnostic imaging.

Level 2 facilities are expected to be able to perform three to four surgical interventions per day and provide hospitalization for 10 to 20 casualties for up to seven days. They should be able to treat up to 40 outpatients per day, conduct 5 to 10 dental consultations per day, and hold all necessary medical supplies, fluids and consumables for 60 days (including resupply to level 1).

3.7. Level 3 medical facility

After level 2 facilities, Level 3 medical facilities represent the next highest level of medical care within a United Nations mission area. They usually fall under COE but can also be commercially contracted. A level 3 facility includes all the capabilities of the lower-level facilities. It offers multidisciplinary surgical services, specialist services and specialist diagnostic services, increased high-dependency care capacity, extended intensive care services and specialist outpatient services. Level 3 facilities are expected to be able to perform 10 surgical interventions per day, provide inpatient services for 50 patients for up to 30 days, hold 60 outpatient consultations and 20 dental consultations per day, conduct 20 X-rays and 40 laboratory tests per day, and

[9] The requirements for level 2 medical facilities are set out in appendix 5 to annex C of chapter 3 of the *Manual on Policies and Procedures concerning Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions* (2023).

hold all necessary medical supplies and consumables for 60 days. The Medical Support Section (MSS) and Procurement Division in DOS have significant experience contracting medical services through Letters of Assist (LOA) with Member States or commercial contracts with civilian hospitals.[10]

3.8. Level 4 medical facility

A level 4 facility provides the highest level of and definitive, comprehensive care, usually outside of the mission area. The specialist services it offers include the management of burns, not otherwise available in mission, and rehabilitation and convalescence. Level 4 facilities are commercially contracted or contracted under a LOA with a national government.

Additional medical capabilities which could be deployed depending on the health risk assessment are listed in the COE Manual referenced above and in footnotes. Possible modules include: light mobile surgical module, a laboratory-only facility, a dental-only-facility, an aero-medical evacuation module, a forward surgical module, a gynaecology Module, an orthopedic module, a physiotherapy module and an internal medicine module.[11]

3.9. Key messages

- The 10-1-2 timeline is always used as the basis for the medical emergency planning processes.

[10] For more details on level 3 facility requirements see appendix 6 of chap. 3, annex C of A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023).

[11] For more details on these see appendices 7–15 of chap. 3, annex C of A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023).

- Level 1 facilities are expected to be able to treat up to 20 ambulatory patients per day, have temporary holding capacity of five patients for up to two days, and hold medical supplies and consumables for 60 days.
- Level 2 facilities are expected to be able to perform three to four surgical interventions per day and provide hospitalization for 10 to 20 casualties for up to seven days. They should be able to treat up to 40 outpatients per day, conduct 5 to 10 dental consultations per day, and hold all necessary medical supplies, fluids and consumables for 60 days.
- Level 3 facilities are expected to be able to perform 10 surgical interventions per day, provide inpatient services for 50 patients for up to 30 days, hold 60 outpatient consultations and 20 dental consultations per day, provide 20 X-rays and 40 laboratory tests per day, and hold all necessary medical supplies and consumables for 60 days.
- Level 4 facilities are contracted facilities that provide the highest level of and definitive, comprehensive care outside the mission area.

Chapter 4: Medical Logistics

4.1. Introduction

Medical logistics for United Nations field missions encompasses the planning and management of the activities involved in ordering, sourcing, delivery, storage, maintenance and distribution of pharmaceuticals, medical equipment and devices, medical consumables, and other products required to provide medical support to field entities.

There are a range of unique considerations that apply to medical items and which have implications for the design and operation of their supply chain. These include national and/or international regulations, shelf life, sterility, special storage requirements, packaging requirements and possible dangerous/hazardous contents. Continuity and consistency in the provision of medical supplies is particularly important given the poor availability of effective local resources. The management of the medical logistics system therefore requires specialist technical knowledge and close monitoring to ensure the appropriate flow of goods through an effective and efficient supply chain.

4.2. Definitions of key categories in United Nations medical logistics support

Categories	Description
Health services	The provision of a diverse range of services, including personnel, geared towards providing the medical care necessary to sustain operations. Includes the provision of health care at all levels, preventive medicine, emergency medical treatment and casualty/medical evacuation services.

Pharmaceuticals and blood products	The selection, procurement, storage, distribution, and rational use of pharmaceuticals (including vaccines), blood, and blood products to ensure the continuous operation of medical facilities deployed in the field.
Medical equipment and consumables	The sourcing, storage, distribution, installation, operation, and maintenance of **medical equipment** and **devices** as well as consumables required for the routine operation of medical facilities.
	Medical devices: articles, instruments, apparatus, or machines used in the prevention, diagnosis or treatment of illness or injuries, or for detecting, measuring, restoring, correcting, or modifying the structure or function of the body for health purposes.
	Medical equipment: medical devices requiring calibration, maintenance, repair, user training and decommissioning.
	Medical consumables: Specific items associated with delivering clinical care or the functioning of medical equipment. Includes items used in the administration of pharmaceuticals which are designed for single or short life use. **Medical equipment and consumables** encompass the following sub-categories: i. Laboratory equipment, reagents and supplies ii. Imaging equipment, consumables and supplies iii. Dental equipment, consumables and supplies iv. Physiotherapy equipment, consumables and supplies

	v. General medical equipment, accessories, installations and supplies vi. General medical and surgical consumables, instruments and supplies vii. Medical equipment spare parts, maintenance and repairs
Installation, maintenance, and user training of equipment	The installation and periodic preventive maintenance of deployed medical equipment and all repairs, including labour costs, spare parts, and transportation. Installation and maintenance services may be provided by the United Nations, T/PCC or international or local contractors, depending on the type of contract established. The training of medical personnel on how to use the equipment can also be contracted to suppliers or individual technicians.
Medical gases	Gases used in medical procedures such as oxygen and nitrous oxide. These gases are essential commodities, and their procurement, including their supply to T/PCC medical facilities, is a mission responsibility. T/PCC's with their own arrangements for resupply must make the CMO aware of this.

4.3. Effective medical logistics management – key responsibilities

Logistics for all United Nations missions are a multinational effort and must share common principles as well as being agile. Responsibilities for effective and efficient medical logistics will change throughout the phases of the mission[12] and the stages of the supply chain.[13] United Nations reference documents[14] and the national and/or

[12] Mission Start-Up, Mandate Implementation, Transition to Mission Hand-Over and Withdrawal
[13] Planning, Sourcing, Making, Delivering And Returning
[14] See "Annex 1.4, "Medical logistics planning considerations for field missions", and Annex 1.6, "United Nations Department of Operational Support – Supply Chain Policies and Guidelines" of this manual.

international standards relevant to the products serve as points of reference for both the United Nations and T/PCCs. In new or start-up missions, it often takes time to establish a functioning medical supply chain. For this reason, all levels of medical facility (whether UNOE or COE) must be able to manage without resupply for an initial period of 60 days for all supplies.

Medical supply chain key responsibilities for relevant mission appointment holders include the following:

Appointment	**Responsibilities**
Chief Medical Officer of mission	Oversees all health-care delivery related matters, including supplies and medical logistic standards in the mission area.
	Ensures that relevant processes and controls are employed and sustained to guarantee the seamless and continuous availability of medical supplies and services.
	Ensures that all mission medical staff are conversant with the United Nations medical logistics, supply chain and procurement systems as well as rules and standards governing them.
	Ensures mission-specific standard operating procedures (SOPs) on the management of cold chain products such as vaccines and laboratory reagents, developed and revised annually.
	Ensures performance of United Nations vendors and contractors is monitored and reflected accurately and punctually in Vendor Performance Reports.

	Is responsible and accountable for the hemovigilance[15] of the mission.
	Advises medical units on the proper disposal and destruction of medical/biological waste as well as expired medical products (drugs and consumables).
Force Medical Officer	Supports the CMO to ensure mission directives and processes are complied with by T/PCCs.
	Ensures all T/PCC medical units within the mission area comply with medical logistics and medical waste disposal standards.
Contingent Commander	Informs the mission immediately if any T/PCC, while deployed, finds that it cannot adequately supply medical equipment, drugs or consumables under self-sustainment arrangements. In such cases, the United Nations will take over the resupply of drugs, consumables, and medical supplies permanently.[16]
Commander of the T/PCC medical facility	Notifies CMO regarding whether the medical facility will be depending on the mission for the supply of medical gases.
	Complies with mission directives and processes regarding the medical supply chain.

[15] *Guideline: UN Haemovigilance System Framework for Data Collection, Recording and Reporting* (2021).
[16] A/78/87 "Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions" (2023), chap. 3, annex C, p. 83.

4.4. Medical standards and quality assurance

Standard categorization and nomenclature of medical products to cater to multinational medical units in United Nations field missions is particularly important since:

- common terminology and standards enable multinational users to identify products, and ensure greater safety when prescribing, dispensing, and administering drugs.
- it facilitates the proper use of medical equipment and consumables.
- it facilitates requisitioning – the international bidding process adopted by the United Nations.
- it regulates medical supply through national channels.
- it permits quality control and performance measurement against transparent and common minimum United Nations standards.

Processes for assuring medical products meet the required quality standard within the United Nations health-care system are outlined in Annex 1.5 to this chapter.

4.5. Supply of blood and blood products

The supply of blood and blood products – a critical component of medical support in the field – to multinational operations is complex and sensitive. There are significant challenges involved in securing a sustainable source of blood products, with supply affected by respective national government regulations on imports, cold chain requirements and the need for certain rare blood types. The United Nations provides strict guidelines for and oversight of this process through a centralized approach to procurement and supply.

The United Nations provides blood and blood products according to United Nations standards for transport, testing, handling, and administration, unless the medical facility of T/PCC finds it necessary to negotiate the sourcing on reimbursement basis.

Such arrangements are negotiated on a case-by-case basis and reflected in the corresponding MOU. The United Nations provides the appropriate climate-controlled storage and transport capability to prevent the deterioration or contamination of blood and blood products.

Where large-scale emergencies make it imperative to obtain blood from the field, great care must be taken to ensure quality control. For such emergencies, "walking blood bank" donation can be explored in conformity with the relevant blood policy issued by DHMOSH.[17] Additional blood supplies which meet United Nations standards can also be sourced at cost to the Organization from host nation or regional organizations such as the Red Cross Society. Transfusion of non-United Nations personnel with United Nations-sourced blood is discouraged in normal situations and must be duly documented in emergency situations. Mission-specific SOPs on the management of cold chain products such as blood, vaccines and laboratory reagents should be developed and revised annually.

Key considerations for managing and ensuring good quality of blood in the field are listed in Annex 1.5.

4.6. Medical waste disposal

Expired items should be accounted for, written-off and disposed of by burial, incineration or according to other internationally accepted procedures and the local regulations, and in compliance with the DOS environmental policy covering field missions.[18] Particular attention must be paid to the disposal of biohazardous materials.

[17] DOS/2021.06 "Policy on the Clinical Use of Blood in Field Situations".

[18] DOS/2022.01 "Environmental Policy for Peacekeeping Operations and Field-based Special Political Missions".

4.7. Key messages

A lack of understanding of United Nations systems is a major contributor to supply chain shortfalls, delays and/or inefficiencies. The CMO plays a significant role in ensuring that all mission medical staff are familiar with the United Nations medical logistics, supply chain and procurement systems as well as the rules and standards governing them. In collaboration with United Nations Headquarters, Chief of Mission Support, mission logistics staff, the FMO and medical contingent commanders, the CMO should promote awareness and implement oversight measures regarding medical supply chain and procurement matters in the mission. To ensure that the United Nations gets better value for money for contracted medical goods and services, the performance of United Nations vendors and contractors should be monitored and reflected accurately and punctually in required Vendor Performance Reports.

Since United Nations missions can vary in many parameters including size, mandate, personnel and geographical location, etc., medical logistics support needs to be tailored to each mission. Consequently, mission-specific medical logistics and supply chain SOPs should be developed and revised periodically.

MODULE 2: MEDICAL PLANNING AND EMERGENCY PREPAREDNESS

Chapter 5: Planning and Deployment of Medical Support in the Field

5.1. Introduction

The effective planning and deployment of medical support in the field requires a comprehensive assessment of needs, robust communication systems, logistical preparedness, skilled personnel, appropriate infrastructure and collaboration with local stakeholders. Implementing these elements and best practices can significantly enhance the capacity to provide life-saving medical care and support in challenging environments.

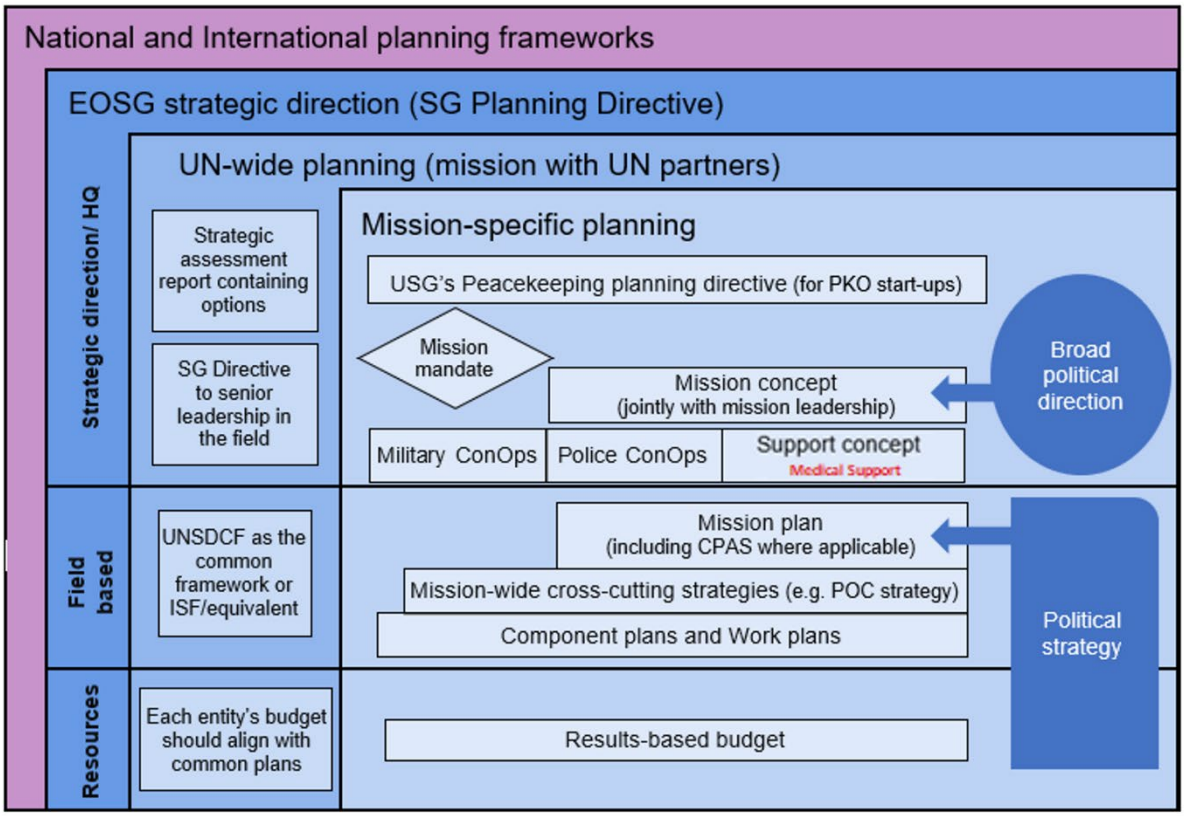

Figure VI: Planning instrument landscape

The diagram maps out the universe of main planning documents as they relate to the planning of peacekeeping operations. Medical support is part of the support concept and is a critical capability in the military concept of operations (CONOPS).

5.2. Principles of medical support

The Medical Support Plan aims to ensure the health and well-being of United Nations personnel in the field. As part of the Mission Component in the CONOPS, the Medical Support Plan is guided by the following principles.

Figure VII: Guiding principles for Medical Support Plan

5.2.1. Emergency preparedness

The provision of timely and effective emergency medical care must include a combination of ground and air evacuation capabilities involving fully equipped road ambulances, fixed- or rotary-wing military or civilian air facilities, well-qualified, trained experienced and equipped Aero-Medical Evacuation Teams (AMETs) and a well-functioning communication network linkage for rapid and expert medical response. Mass casualty incident (MCI) plans and adequate ongoing training are the cornerstone of a successful response.

5.2.2. Continuity of care

Continuity of care refers to the provision of continuous medical care from the point of injury or acute illness to the final point of treatment. It requires a seamless transition of patients from the point of injury to higher, specialized levels of care.

5.2.3. Health-care standards[19] [20]

Recognizing the central importance of standards, and to reduce ambiguity regarding which standards are applicable in United Nations settings, DHMOSH developed Healthcare Quality and Patient Safety Standards which are applicable to all United Nations-owned equipment (UNOE) and contingent-owned equipment (COE) health-care facilities. Expected outcomes of implementing these standards include the following: the reduction of preventable harm and morbidity and mortality; consistency and reliability in processes and systems in all United Nations hospitals and clinics; meeting the expectations of all mission and United Nations personnel for trustworthy, consistent and dependable care; the ability to collect and measure clinical outcomes for quality improvement; and the ability to measure patient experience.

5.2.4. Access to health facilities

There should be timely access to health facilities and services for all United Nations personnel in a peacekeeping mission.

5.2.5. 10-1-2 timeline

For detailed information on this concept refer to Chapter 7: “Casualty Management in the Field: Casualty Evacuation (CASEVAC), Medical Evacuation (MEDEVAC) and Repatriation”.

The overall medical support structure should be determined in accordance with the operational requirements of the mission. The COE Manual referred to in Chapter 3 provides a flexible framework for these purposes. The generation of new medical facilities and solutions should not be constrained by the modular approach but be determined by operational needs.

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[19] *United Nations Manual on Healthcare and Quality and Patient Safety Level 1 Clinics* (2020).

[20] *United Nations Manual on Healthcare and Quality and Patient Safety Level 1+, 2 and 3 Medical Facilities* (2019).

5.3. Medical support planning process

Medical planning is carried out in conjunction with the integrated assessment planning process: medical planners must be aware of the overarching planning process and their place in it.

The integrated assessment planning process outlines the procedures and responsibilities governing the preparation, approval, implementation and review of operations plans to enable a common approach to operations planning.

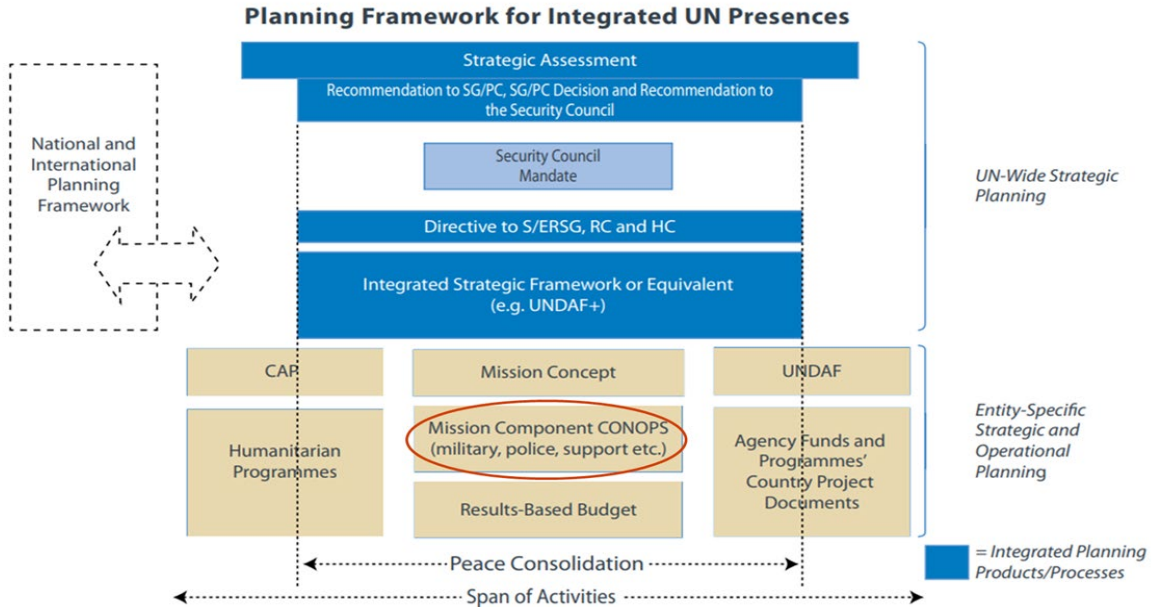

Figure VIII: Overview of planning framework for integrated United Nations presences

The medical contribution to operational planning involves two main activities. Firstly, providing medical expertise and interacting closely and cooperating with other sections and units within DOS and at mission level. Secondly, the development of a Medical Support Concept and a Medical Support Plan.

The intended end product of medical planning is a plan outlining the requirements, policies and support to be provided to mission personnel throughout all phases of

operations. The plan must define medical capabilities throughout the mission structure in line with the size of the deployed personnel footprint and the assessed risk. Medical planning must ensure that the standard of medical care to be provided conforms as closely as possible to best medical practice, taking into consideration the operational environment.

5.4. Medical planning considerations

The medical requirements for every mission differ and are influenced by several factors, including the mission mandate, its CONOPS, the assessment of its area of operation, prevailing health threats, the United Nations medical standard of care, the available medical facilities and operational efficiency. Other factors to be considered include how to bridge the gap between the issuance of a mandate and deployment of facilities at full operational capacity, as well as the accommodation infrastructure into which the facilities will be installed. The Medical Support Plan should be determined in reference to the mission requirements and should be adjusted at least annually to reflect changes in the mission operating environment. Medical support plans are often drafted based on the CONOPS before a Technical Assessment Mission (TAM) is undertaken but finalized after the exercise.[21]

[21] See Annex 2.7 “Medical Support Plan Format” of this manual.

The main considerations in medical support planning include:

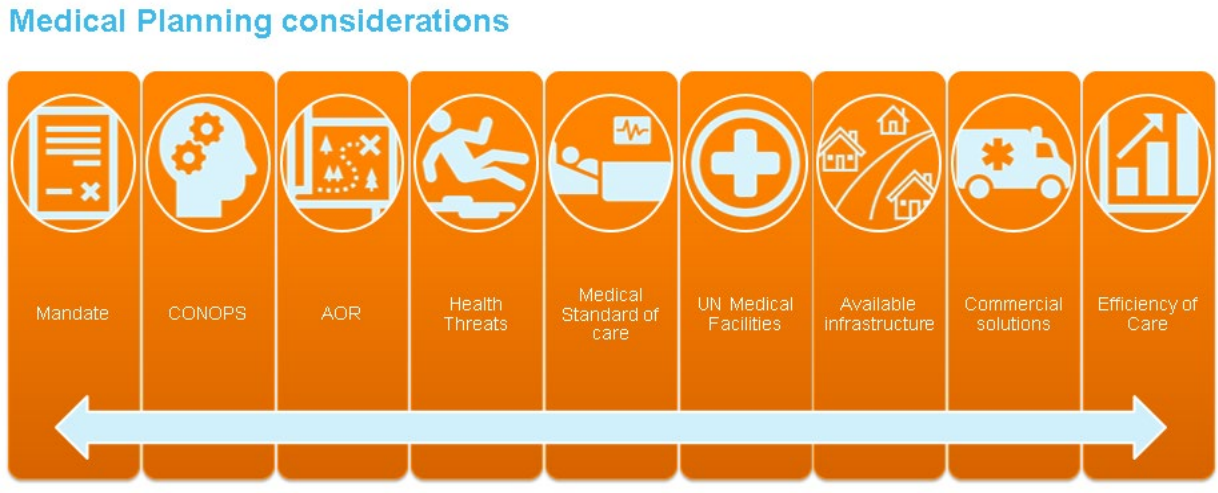

Figure IX: Main considerations in a Medical Support Plan

5.4.1. Mandate

The mandate determines the nature of peacekeeping activity and security risks. United Nations medical assets primarily serve peacekeeping personnel and are not intended for the local population. In specific missions where the mandate includes the provision of humanitarian assistance, medical services may be expanded to serve the local population.

5.4.2. Concept of operations

The medical plan is determined by the military and police CONOPS, which includes troop strength, force composition, deployment concept, nature and intensity of peacekeeping tasks, and the command and control structure. The CONOPS will assist planners in assessing the risks faced by mission personnel and contingents, which will affect the degree of medical support required. Mission risk levels may change over the life of the mission, warranting increases or reductions in mission medical support. The medical system requires a built-in surge capacity to deal with unanticipated contingencies. In this regard, the provision of medical services by the mission to United Nations agencies, funds and programmes may be considered, in the event that this

would lead to increased system-wide efficiency, and as outlined in the United Nations Policy on Integrated Assessment and Planning.[22]

5.4.3. Area of operations

The medical plan may be influenced by factors in the mission's area of operations, including:

i. **Geography:** land masses, water bodies, mountains, jungle, desert and risk of natural disasters.
ii. **Infrastructure:** state of electrical, water, gas, and sewage services.
iii. **Road and rail network:** state and suitability of land transport system for evacuation by land.
iv. **Airports:** location and suitability of airports and helicopter landing zones for evacuation by air and maintenance of medical supply chain.
v. **Seaports and rivers:** location and suitability of seaports and/or rivers for evacuation, deployment of hospital ships and maintenance of medical supply chain.
vi. **Medical facilities:** state and quality of host nation and regional health facilities and their capability and capacity to support the United Nations mission.
vii. **Climate:** impact of yearly weather pattern and extremes of temperature on health of deployed personnel.
viii. **Security:** the security situation will impact on the level of medical capability to be deployed.

5.4.4. Health threats

A recce visit should be undertaken to the mission area of operation to conduct an evidence-based health threat analysis to inform the development of the mission's force

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[22] *United Nations Policy on Integrated Assessment and Planning* (2023).

protection plan. A comprehensive health threat analysis must take into account endemic, epidemic and outbreaks of disease, in particular contagious and infectious diseases such as Ebola, Lassa fever and other viral haemorrhagic fevers. It should also address hostile action and other potential hazards such as landmines, chemical, biological, radiological, nuclear and environmental (CBRNE) hazards and occupational and workplace hazards. Environmental safety and occupational health considerations must be integrated into the overall force protection plan. The health risk assessment system catalogues identified threats and generates a risk map. A standardized medical recce visit can be undertaken to conduct a health risk assessment and complement the mission-specific health threat analysis. The latter is more focused on force protection while the standardized medical recce visit is focused on the occupational health component.

5.4.5. Medical standard of care

The United Nations medical support concept includes compliance with the medical standards of care laid out in various policies and standard operating procedures (SOPs) developed by DHMOSH and endorsed by Member States. The metrics to measure the standard of care include adhering to the 10-1-2 timeline as laid out in the CASEVAC policy,[23] meeting the credentialling requirements set out in this manual and the COE Manual, and adhering to the Healthcare Quality and Patient Safety Policy and the Occupational Safety and Health Policy.

5.4.6. United Nations medical facilities

Each field mission will design its medical support structure based on the approved Medical Support Plan which evolves from the mission concept, military and police CONOPS and the mission support concept.

[23] DOS/2020.7 "Casualty Evacuation in the Field".

For effective resource utilization, field missions integrate United Nations-owned, TCC, PCC and contracted medical resources into a unified medical system, ensuring all authorized United Nations personnel receive quality and timely medical support.

United Nations medical facilities are described in Chapter 3 of the Administrative Module. Each level of facility can be enhanced with additional capabilities to ensure that operational capability requirements are met. The modular concept of these capabilities makes it possible to provide effective medical support through its staffing.

5.4.7. Availability of accommodation infrastructure

A standard construction layout plan for various levels of field medical facilities should be developed jointly by the engineering section and the medical section within the missions. The size and requirement of the mission will determine the infrastructure.

5.4.8. Bridging gaps in medical support requirements in the field through commercial solutions

Gaps in medical support may be bridged by commercial solutions or by identifying Member States who meet the United Nations standards and can deploy at short notice for short-term periods. Such deployment can also be achieved through contracts (LOAs, MOUs, or other long-term agreements) with Member States or commercial sources.

5.4.9. Efficiency of care

Medical planning shall identify the most cost-effective means to achieve the degree of medical coverage required. The Medical Support Section (MSS) in collaboration with partners in DOS will assist in preparing cost estimates.

5.5. Medical Support Plan

The Medical Support Plan identifies the principal considerations and recommendations for establishing an integrated health-care system, which is aimed at maintaining the physical and mental well-being of the United Nations personnel in

a mission. It also covers the staffing and material resources required to execute the plan. Key components of the Medical Support Plan can be found in Annex 2.7.

5.6. Pre-deployment visit

A pre-deployment visit (PDV) is a critical component of mission planning. PDVs are undertaken to ascertain the state of the contingent's preparedness before deploying in the area of operation, and to facilitate the negotiation of the terms and conditions of the deployment of contingents (MOU/LOA negotiations). There is a high incidence of medical repatriations and deaths arising from the deployment of peacekeepers with chronic pre-existing diseases that should preclude deployment into peacekeeping operations (PKOs), with a related impact on the morale, resources, reputation and mandate of the mission. It has therefore become essential that the medical aspects of PDVs go beyond just medical equipment counting/inspection to cover briefing on the need for adequate pre-deployment medical screening, assessment of training and proficiency in the Buddy First Aid Course (BFAC), knowledge of personal and environmental hygiene, disease threats and environmental protection.

5.7. Key messages

- The guiding principles of a medical support plan are: emergency preparedness, continuity of care, health-care standards, health-care availability and the timeline concept (10-1-2).
- The Medical Support Plan must outline the requirements, policies and support to be provided to mission personnel throughout all phases of operations. The plan must define medical capabilities and ensure that the standard of medical care is maintained.

Chapter 6: Medical Training

6.1. Introduction

The United Nations medical support concept aims to deploy appropriate categories of medical staff and levels of medical care in the challenging environment of field operations. Standardizing medical training and applying medical standards is of paramount importance in enhancing the performance and competency of field medical services and support. The Report of the High-level Independent Panel on Peace Operations (HIPPO Report),[24] and the United Nations Action for Peacekeeping initiative (A4P)[25] and Action for Peacekeeping Priorities for 2021-2023 (A4P+) all emphasize this.

6.2. Definitions of key terms

6.2.1. Pre-deployment training – First aid training for all peacekeepers

Faced with situations in which medical personnel are not readily available, non-medical peacekeepers must rely heavily on their own skills and knowledge of life-sustaining methods to survive in semi-combat situations or other hostile circumstances in field missions, as well as to minimize further suffering and disability. All United Nations peacekeepers, including uniformed contingent members, United Nations Military Experts on Mission (UNMEM)s, military observers and individual police officers (IPOs), as well as civilian staff, must have basic knowledge of and be trained in first aid. The United Nations BFAC and Field Medical Assistant Course (FMAC) are good resources to support pre-deployment basic first aid training and enhancement of immediate life-saving response skills among peacekeepers. At a minimum, the

[24] A/70/95-S/2015/446 "“Report of the High-level Independent Panel on Peace Operations on uniting our strengths for peace: politics, partnership and people”.

[25] *Action for Peacekeeping – Declaration of Shared Commitments on UN Peacekeeping Operations* (2018).

training must cover the following areas: cardiopulmonary resuscitation (CPR),[26] bleeding control, fracture immobilization, wound dressing and bandaging, casualty transport and evacuation and communication and reporting (see Annex 2.8 for further information).

6.2.2. Pre-deployment training – Professional training for medical personnel

Medical personnel deployed are required to enhance their capabilities in emergency medical responses through updated trainings in Advanced Cardiac Life Support (ACLS), Advance Trauma Life Support (ATLS) and Prehospital Trauma Life Support (PHTLS) or any equivalent training. In addition, the following related knowledge and skills specific to United Nations field missions are required to maintain operational readiness and proficiency (see also Annex 2.9):

- Knowledge of the mission-specific political and military situation in the country, the mission mandate, and epidemiological and medical intelligence for the mission area, as well as the United Nations medical support structure, medical planning and operational parameters, and United Nations medical support guidelines (e.g. United Nations Healthcare Quality and Patient Safety standards, casualty evacuation policy, medical administrative and logistics procedures, etc.) (see Annex 2.10).
- Updated training in preventive medicine, environmental health and tropical medicine and diagnosis and treatment of infectious diseases and common conditions that are likely to be encountered in field missions, including malaria, heatstroke, burn, snake bites, influence of alcohol and drugs and medical NBC management, etc.

[26] Note that cardiopulmonary resuscitation (CPR) is not a component of the BFAC.

- Updated knowledge on women's health with a view to providing gender-sensitive services in the field.[27]
- Proficient skills in conducting first aid training and health education programmes for designated contingents, including prevention of vector-borne diseases, HIV/AIDS prevention and control, accident prevention and stress management, etc.
- Experience in conducting mass casualty and trauma drills during pre-deployment training to ensure all members in the medical unit work as a team with clear roles and developed skills.

6.2.3. Pre-deployment training – Health education for contingents

All contingent members and individual officers and experts shall receive basic preventive medicine and health training, with an emphasis on preventive measures for key vector-borne diseases and environmental health risks, HIV/AIDS prevention and control, accident prevention, stress management and good personal hygiene and sanitation, etc.

6.2.4. In-mission continuing training – Continuing professional development and training

Medical training should continue following deployment as medical skills may deteriorate during long duration deployment due to relative professional inactivity. Continuous in-mission medical training programmes should therefore be well planned and coordinated to ensure core medical skills and procedures are regularly practiced by all categories of personnel. In conjunction with the Chief Medical Officer (CMO), the Force Medical Officer (FMO) and other Senior Medical Officers (SMOs) are responsible for the coordination of such programmes, including enhanced ACLS/ATLS/PHTLS training, training to familiarize personnel with medical equipment

[27] UN Women's Health online training course is a good training resource for pre-deployment preparedness.

and supplies from other countries that they may be required to use, refresher training regarding the mission area, rules of engagement and mission medical SOPs. In-mission joint medical exercises and drills are a good means of assessing core competencies and enhancing response capabilities and the operational compatibility of various levels of medical facilities deployed by different countries.

6.2.5. In-mission continuing training – First aid training and health education for contingents and individual officers

Continuing training to be organized and conducted within the mission area should include refresher first aid training to enhance peacekeepers' preparedness to deal with real-life situations and emergencies and regular health education programmes on malaria prevention, HIV/AIDS prevention, road accident prevention and stress management, etc. The FMO and SMOs are responsible for overseeing these programmes, and the medical units managing the health care of respective contingents are usually tasked with conducting the trainings.

6.3. Roles and responsibilities

Professional and technical training of medical personnel remains the responsibility of the T/PCCs. Such training will take place in accordance with national requirements for the registration or certification of medical personnel. In addition, the T/PCCs should fulfil related aspects of medical training specific to United Nations field missions for maintaining the operational readiness and medical proficiency of personnel deployed in the field, as well as others recommended by DHMOSH.

The field mission medical authority should include continuous medical education as an integral component of the mission medical training program.

DHMOSH/DOS provides professional guidance and support for field missions on the issue of continuing professional development and training.

6.3.1. Assessment and oversight

During PDVs to T/PCCs, the DHMOSH medical representative will assess the training and proficiency of contingent members in the administration of first aid, knowledge of personal and environmental hygiene and health protection, as well as the competencies and skills of medical personnel in immediate life-saving responses. In cases of non-compliance or signs of incompetency, unit deployment should be delayed or suspended on the basis of a lack of operational readiness and proficiency. Furthermore, T/PCCs are required to comply with technical clearance for the medical personnel deployed, for which valid training certificates on ACLS/ATLS/PHTLS or any equivalent training should be submitted for review and clearance.

6.4. Key messages

- Medical training is essential to the provision of quality health services and addressing challenges related to medical support in United Nations field missions.
- Professional and technical training remains the responsibility of T/PCCs, and training should continue following deployment. Pre-deployment training and continuing training in mission aimed at both peacekeepers and medical professionals rely on the joint efforts of Member States, field missions and UNHQ.
- Training assessment and oversight are enhanced to promote training standardization and compliance.

Chapter 7: Casualty Management in the Field: Casualty Evacuation (CASEVAC), Medical Evacuation (MEDEVAC) and Repatriation

7.1. Introduction

Casualty evacuation (CASEVAC) and medical evacuation (MEDEVAC) capabilities are a vital component of emergency and medical support, which ensures timely care for the critically ill or injured. They involve transportation of the ill or injured to the nearest medical facility, as well as the entire continuum of medical treatment, rehabilitation, and repatriation, when appropriate. The CASEVAC/MEDEVAC process should be driven by the 10-1-2 timeline concept and rely on location-specific CASEVAC and MEDEVAC planning. A well-coordinated evacuation process can significantly enhance the chances of survival for the ill or injured.

7.2. Definitions of key terms

Terms	Definitions
Casualty	Individual affected by an acute illness or injury that requires medical intervention.
Casualty evacuation (CASEVAC)	Evacuation of any casualty from the point of injury or illness (POI) to the closest appropriate medical treatment facility (MTF), utilizing the most effective means of transportation.[28]
Medical evacuation (MEDEVAC)	Evacuation of ill or injured individual from the first MTF to any subsequent MTF.[29]
Repatriation	Return of United Nations military or uniformed personnel to their country because of medical unfitness for duty for 30 days or longer.

[28] DOS/2020.7 "Casualty Evacuation in the Field".

[29] DOS/2020.7 "Casualty Evacuation in the Field".

Mission/Field-specific CASEVAC and MEDEVAC SOPs	SOPs that must be established by all field operations and must clarify the delegated authority in place to expedite critical decisions.
Life-threatening condition	Condition that might lead to loss of life, or significant and permanent loss of bodily functions.
10-1-2	Operational planning tool providing the optimal time frame for CASEVAC. It reflects a trade-off between clinical need and operational risk. It specifies that first aid should be provided within 10 minutes, the provision of medical care within one hour, and damage control surgery, if needed, within two hours.
MEDEVAC approving authority	The authority to approve MEDEVAC lies with the Head of Mission (HoM), Director of Mission Support (DMS) or Chief of Mission Support (CMS), based on the medical advice of the CMO and/or FMO, and in consultation with Movement Control (MovCon)/Aviation, and Security.
Notification Of Casualty (NOTICAS)	Each case of critical illness, injury, or death is to be reported immediately through a Notification of Casualty (NOTICAS). This information is to be used for consideration of any subsequent claims, and for timely and accurate reporting of casualties.

7.3. CASEVAC, MEDEVAC and repatriation: roles, responsibilities and procedures

7.3.1. CASEVAC

CASEVAC involves the evacuation of a casualty from the POI to the closest appropriate MTF. The HoM is accountable for CASEVAC, typically with delegated authority to a Designated Operations Centre (DOC) such as the Military Operations Centre (MOC), or a CASEVAC coordination cell. The DOC should ideally have three duty officers: operations, aviation and medical. CASEVAC relies on the minimum number of personnel at all levels for maximum efficiency, significantly enhancing the

probability of successful outcomes in critical life-saving situations. Ownership is at the highest level and execution at the lowest level.

7.3.2. MEDEVAC and repatriation

MEDEVAC involves the evacuation of a casualty between two medical facilities, either within the mission area or out of the mission area. A MEDEVAC should be conducted according to the medical urgency and potential to save lives.

Authority to approve MEDEVAC/repatriation is delegated to the HoM. The decision to evacuate shall be taken upon the recommendation of the CMO.

The DHMOSH Medical Director is available for consultation and assistance in all cases. Roles and responsibilities in MEDEVAC are outlined below.

Role	Responsibility
Head of Mission	Delegated authority to approve MEDEVAC/repatriation upon recommendation of the CMO.
Director of Mission Support / Chief of Mission Support	Approves MEDEVAC/repatriation in consultation with CMO.
Chief Medical Officer	Recommends MEDEVAC/repatriation for DMS/CMS approval.
Force Medical Officer	Recommends MEDEVAC/repatriation of uniformed personnel for Force Commander (FC) approval in missions where there is no CMO.
Force Commander	Approves MEDEVAC/repatriation of uniformed personnel in consultation with the FMO in missions where there is no CMO.
DHMOSH	Provides advice for planning and establishing an effective MEDEVAC/repatriation system.
Medical Support Section	Provides guidance and oversight on the procurement of equipment, personnel and transportation services, including external contracts.

Effective CASEVAC/MEDEVAC operations require detailed planning, coordination, training and compliance with current policies. CASEVAC/MEDEVAC plans must be included in the mission/field-specific SOPs. If adherence to the 10-1-2 timeline is not achievable, the HoM must decide if the risks are acceptable and formal risk

acceptance should be notified to the Medical Director at UNHQ for information. The HoM must explore mitigation measures.

Upon receipt of the MEDEVAC request, the CMO should activate and coordinate the evacuation process and determine the severity and urgency of the medical condition, the patient's fitness to fly, the mode of transportation and escorting personnel and destination, in accordance with the required level of care. The CMO should provide the MEDEVAC recommendation to the approving authority.

A recommendation must include:

- the initial supported period (typically no more than five days, with possible extensions as per clinical updates)
- the mode of transportation (i.e. air ambulance, United Nations flight, commercial flight, ground, etc.) in accordance with fitness to fly
- if an escort is required/supported, and which type (medical, non-medical, etc.)
- the location (based on the designated regional area of care or home country, where applicable)

MEDEVAC can be supported for uniformed personnel for the purpose of securing essential medical care or treatment not available at the duty station.

MEDEVAC becomes a national responsibility covered by national budgets should a T/PCC decide to evacuate its own personnel due to a pre-existing medical condition undisclosed at the entry medical clearance, or against the CMO/FMO's advice.

For MEDEVAC expected to exceed 45 days or for any extension of MEDEVAC beyond 45 days, authorization must be obtained from the United Nations Medical Director via the EarthMed system.

When determined by the CMO or the Medical Director, a patient who is medically evacuated must receive medical clearance before returning to the duty station.

Medical repatriation involves the return of uniformed personnel to their country when they are unfit for duty for 30 days or longer due to a medical condition. Whenever feasible, uniformed personnel should be repatriated for medical care. MEDEVAC should be reserved for conditions that require urgent and specialized medical

treatment. In such cases, MEDEVAC to the closest recognized MEDEVAC centre with appropriate care should be supported. Subsequent repatriation of personnel to their country should be supported as early as clinically possible. If a uniformed personnel is deemed fit to resume duties within 30 days following an injury or illness, the CMO may authorize sick leave for this duration and, in case of an out of mission MEDEVAC, endorse their clearance to return to the duty station.

Uniformed personnel with pre-existing medical conditions undisclosed at the pre-deployment medical examination should be repatriated at their country's cost. In case of pregnancy, uniformed personnel should be repatriated by the end of the fifth month of gestation (by end of the 24th gestational week). If possible, regular rotation or scheduled service flights should be utilized for repatriation.

7.4. Reporting requirements

7.4.1. EarthMed

CASEVAC/MEDEVAC questionnaires are to be completed and followed up and all documents are to be uploaded. The CMO is responsible for compliance.

7.4.2. NOTICAS

A NOTICAS must be issued in the event of death (within 6 hours), or serious illness or injury (within 24 hours). It applies to all United Nations personnel (including civilians) serving in all Peacekeeping and Special Political Missions. Responsibility for this lies with the HoM, with delegation to Human Resources.

7.4.3. After-Action Review

Following completion of each CASEVAC, systematic After-Action Reviews are to be conducted within three days[30] in line with the mission CASEVAC SOP. After-Action Review reports of real CASEVACs and exercises must be shared with the United Nations Medical Emergency Response Team (UNMERT).

[30] DOS/2020.7 "Casualty Evacuation in the Field".

7.4.4. Mass casualty incident or unusual situations with concerns

The CMO must contact the Office of the Medical Director by any efficient means (for example, email, or phone call) in the case of any unusual situation with concerns about a potential or actual MCI.

7.4.5. Medical documentation

The time sensitivity of a CASEVAC/MEDEVAC does not justify any failure to meet information and documentation quality standards. Written records of medical actions should be issued at each step of the CASEVAC/MEDEVAC journey without delaying the evacuation.

7.5. Key messages

- In the United Nations context, the word casualty" refers to all life-threatening emergencies involving an individual affected by an acute illness or injury.
- CASEVAC refers to the evacuation of a casualty to the closest appropriate medical treatment facility, utilizing the most effective means of transportation.
- CASEVAC takes priority over all other mission activities except actions to counter immediate threats to United Nations personnel.
- CASEVAC is a multidisciplinary operation. At the mission level, the HoM is ultimately responsible for the CASEVAC system. The role of DHMOSH is to support the field on medical issues, but not make decisions on CASEVAC.
- The CMO participates in CASEVAC/MEDEVAC multidisciplinary After-Action Reviews within the time frame defined by the mission. When required, DHMOSH can support the process.
- CMO must contact the DHMOSH Office of Director early in case of an unusual situation with potential or actual risk of an MCI.
- Medical confidentiality and documentation that meets quality standards is part of the CASEVAC/MEDEVAC process and should be ensured without delaying the evacuation. The CMO is responsible for compliance.
- MEDEVAC involves evacuation from the first medical treatment facility to any subsequent medical treatment facility. It can be conducted by land or air

transportation and should be to the closest appropriate medical facility to the duty station. The nature of illness or injury and the required type of treatment must be considered. It is essential that the patient's fitness to fly is confirmed and documented.

Chapter 8: Mass Casualty and Disaster Management [31]

8.1. Introduction

Climate change, global political instability and human population growth increase the risk of an MCI. The United Nations is particularly exposed because of its scope of work and area of operations. This chapter provides additional information to the reference guidance on managing an MCI.[32]

Since an MCI overwhelms the capacity of available local health-care systems, incident coordination often requires integrated management from the mission and UNHQ. Operational, security and medical professionals (among others) across the United Nations system and the whole of the United Nations system's area of responsibility may be involved in the response, along with external partners and stakeholders. Therefore, these situations call for a special contingency plan known as a mass casualty plan, which stipulates matters of policy and planning and outlines a pre-organized response system developed to mitigate the effects of an MCI.

8.2. Definitions of key terms

8.2.1. Categorization

Categorization assesses an individual's condition for the purposes of allocating a category that can be used for a number of different purposes (for example, to enable simple messaging in four or nine lines in case of an emergency in). Categorization is conducted irrespective of the number of casualties involved and reflects an individual's condition at a given time.

8.2.2. Chief of the Joint Operations Centre (JOC) / Chief of the Designated Operations Centre (DOC)

The Chief of the JOC or DOC supports the functioning of the Crisis Management Team (CMT) and acts as the 24/7 link between UNHQ (via the United Nations Operations and Crisis Centre, UNOCC) and the mission. The JOC (or DOC) provides secretarial

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[31] This chapter should be read in conjunction with Chapter 7: "Casualty Management in the Field".

[32] See Annex 2.11 of this manual,"Guide on Completing the Mass Casualty Incident Plan Templates" , Annex 2.12 "United Nations Crisis Management Policy", and the policy onAuthority, Command and Control in United Nations Peacekeeping Operations (AC2 policy).

support for the CMT and/or Operations Coordination Body (OCB) meetings, monitors and reports on the crisis and acts as the sole information hub for all crisis-related information.

8.2.3. Crisis Management Team

The CMT is a leadership-level, cross-mission decision-making body chaired by the HoM (or designated person in mission).[33]

8.2.4. Crisis Management Working Group (CMWG) / Operations Coordination Body (OCB)

The CMWG/OCB supports the CMT. A senior mission lead (usually the Chief of Staff) is appointed Crisis Coordinator and chairs the CMWG/OCB. They act as the link with the CMT to ensure that crisis management objectives are established and achieved.

8.2.5. Crisis manager

This responsibility usually falls to the HoM.

8.2.6. Designated Officials

In missions, the Special Representative of the Secretary-General (SRSG) is usually the Designated Official. SRSGs hold primary responsibility for the security of United Nations personnel.[34] This includes mass casualty planning. When crisis response procedures are activated, the Head of Mission is designated crisis manager.

8.2.7. Mass casualty incident

An MCI or disaster is a situation in which the need to manage multiple casualties overwhelms the available resources at the level of care.

It can result from natural (e.g., earthquakes) or man-made (e.g., terrorist actions, road traffic accidents) catastrophes and may be accompanied by substantial material

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[33] Roles in mission are delineated in chapter D.8. onwards (paras. 87–93) of the AC2 Policy. For mission-specific arrangements, please refer to the specific mission SOPs.

[34] "For each designated area, the Secretary-General normally appoints the most senior United Nations official in writing as the Designated Official for Security and informs the host Government of this designation.[…] The DO is accountable to the Secretary-General, through the Under-Secretary-General for Safety and Security, and is responsible for United Nations Security Management System (UNSMS) matters in the designated area." (*United Nations Security Policy Manual,* chap. II, section A "Framework of Accountability" F.13)

damage to infrastructure and the environment. An MCI is not only about multiple trauma cases (e.g., infectious disease or collective food intoxication, or chemicals (which may be industrial or not, such as carbon monoxide).

There are no fixed criteria defining an MCI. It may vary considerably depending on the setting and resources available.

8.2.8. Operations Coordination Body (OCB)

See Crisis Management Working Group (CMWG).

8.2.9. Triage

Triage is a system of prioritization of patient care (or victims during a disaster) based on illness/injury, severity, prognosis and resource availability. Triage is an ongoing process lasting until the end of the acute care journey. Patients are triaged at every step. Most often, triage is based on categorization. It is more than just a system of repeated categorizations along a care journey or incident management process: triage is a dynamic system integrating multidisciplinary items to generate the best possible provision of collective care and, as such, entails ethical and managerial considerations.

8.3. Role of DHMOSH

The UNMERT section in DHMOSH is part of the United Nations medical response capability for crises involving mass casualties.

UNMERT can advise on any aspect of global MCI management. In collaboration with other DHMOSH sections, it can assist with planning (MCI plan writing, review), training and education (design, implementation, existing resources), risk mitigation, response and recovery and continuous improvement.

UNMERT may be activated by the DHMOSH Director to provide remote assistance and coordination at the level of HQ and across the UN system (situational awareness, information management and situation monitoring) or regional/local assistance with medical-administrative capabilities. Emergency care telephone assistance can also be provided.

When UNHQ assistance is requested or deemed necessary, DHMOSH will coordinate the management of the incident's medical aspects, and MSS in the Logistics Division (LD) will assist with the logistics.

8.4. Reporting requirements

8.4.1. MCI plans bundles

"Where there is a UN medical element in a duty station, the medical service holds the primary responsibility for completing the 4 duty station documents – the Threat and Risk Analysis, the Health Support Summary, the Concept of Operations, and the Quick Reference Guide. Where there is no UN medical service, this responsibility falls to Security, with assistance from DHMOSH New York".[35]

In conjunction with the FMO, the CMO develops all medical aspects of crisis management.

Primary emergency care relies on local resources (United Nations or otherwise). Secondary measures of response support may involve local partners, United Nations or non-United Nations regional resources, UNHQ and the wider United Nations system and third parties.

All plan bundles (MCI plans of each duty station, including all entities and locations (if multiple buildings or camps) in the duty station; MCI plans of each medical treatment facility) must be shared with UNMERT and UNMERT must be informed of any updates or changes, educational activities and training.

8.4.2. Risk mitigation, unusual situations or concerns

Anticipation is a crucial part of crisis management. The CMO (or the most senior medical officer available) must inform DHMOSH, with UNMERT copied, of any implementation of mitigation measures, unusual situations or concerns.

8.4.3. MCI or crisis situation

The DHMOSH Office of Director and UNMERT must be immediately informed in case of a crisis or MCI situation in the mission. Standard formats are recommended (e.g.,

[35] Annex 2.11 “Guide on Completing the Mass Casualty Incident Plan templates”, p. 5.

Situation, Background, Assessment, Request, or SBAR) for initial correspondence. Focal points must be nominated.

8.4.4. Recovery

All After-Action Reviews or lessons learned activities and documentation must be shared with DHMOSH/UNMERT. When deemed appropriate, UNMERT should be invited to participate in such activities.

8.5. Key messages

- MCIs can happen at any time and anywhere. The first thing to read in preparation for deployment to a United Nations mission are the MCI plans of the mission, duty station and team.
- Medical team leads must prioritize ensuring that the information in their entity's MCI plan is accurate and up-to-date, and update the plan as often as necessary. They should inform their team about the plan and train them on it. Plans must be tested and regularly updated.
- Regardless of its level, every medical treatment facility must have an up-to-date MCI plan. Hospital commanders and SMOs (for Level 1 facilities) are responsible for the continuous improvement of these documents and for regular training.
- Triage is a system. Personnel must ensure they are familiar with the recommended protocol in their duty station. The recommended United Nations triage protocol should be followed.
- Personnel should network locally, and both formally and informally, as well as along their reporting lines. It is important to get to know people one may have to work with at some point.
- All documentation should be shared with UNMERT. In the event of a potential or unusual incident which may overwhelm or does overwhelm the duty station's resources, DHMOSH should immediately be contacted, and information escalated through the CMT up to UNHQ.

- MCI management is not only about response, and MCI preparedness is not only about plans. Education, training, drills and practice are paramount.

Chapter 9: Arrangements For Bodily Remains

9.1. Introduction

In the event of the death of uniformed or civilian personnel, all arrangements for the preparation and transport of the remains of the deceased will be made in conformity with the practices of the government concerned.

9.2. Definition of key terms, reporting requirements and responsibilities

Terms	Definitions and reporting requirements
Ascertain the nature of death	**Upon the death of a member of a mission:** • Medical services Section will be consulted to establish the cause of death. • If the death occurs as a result of an illness, accident or under unclear circumstances, the United Nations Department of Safety and Security (UNDSS) (where present) will implement or advise on immediate actions to secure the scene of death and collect information and evidence. • In the event that death occurs as a result of an emergency, accident or unclear circumstances, UNDSS will secure the scene of death and collect information.
Complete the web-based NOTICAS	All NOTICAS must be electronically submitted using the NOTICAS website.
Movement of remains	The remains should be moved to an appropriate United Nations or local government facility in preparation for repatriation and/or autopsy (applicable to all cases of suspected wrongdoing).

9.3. Role of DHMOSH

DHMOSH does not have a specific role but can support the field medical service on medical issues when and if needed.

9.4. Key messages

The United Nations has a well-established multidisciplinary process for arrangements involving the preparation and transport of the remains of the deceased in the event of the death of uniformed or civilian personnel. Medical components have no major role in this process.

MODULE 3: HEALTHCARE MANAGEMENT MODULE

Chapter 10: Technical Clearance of Medical Personnel

10.1. Introduction

The effectiveness and efficiency of field medical support is closely related to the qualifications and capabilities of the medical professionals deployed in field missions. The United Nations *Manual on Policies and Procedures concerning the Reimbursement and Control of Contingent-owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions* (the COE Manual), along with the *United Nations Manual for the Generation and Deployment of Military and Formed Police Units to Peace Operations* (2021) and the *United Nations Policy on Operational Readiness Assurance and Performance Improvement* (2015), highlight the mandatory requirement for the technical clearance of medical personnel who staff all levels of medical facilities in United Nations field missions. This chapter defines the minimum professional qualification requirements and technical clearance procedures for the deployment of medical personnel in field missions, with the aim of harmonizing the differences in national education and medical practices among T/PCCs and guaranteeing that medical personnel deployed demonstrate the appropriate mix of knowledge, skills and post-related competencies.

10.2. Definitions of key terms

10.2.1. Professional medical standards

The establishment of professional medical standards for medical personnel deployed to field missions takes into account all of the following: the qualifications and experience of medical care providers, United Nations medical care standards, the ethical code for medical practitioners and continuing professional development and skills maintenance.

10.2.2. Professional qualification requirements

Professional qualification requirements include medical-related education and training, years of practice, national accreditation for unsupervised practice and the full spectrum of required capabilities for a particular specialty, etc. The minimum qualifications and experience for medical personnel in different categories accepted

by the United Nations are defined in the United Nations *Guidelines on Technical Clearance Review of Medical Personnel for Deployment to UN Field Duty Stations*.[36]

10.2.3. Technical clearance review

For all new deployments and rotations of all levels of medical capabilities and other modularized medical components, official technical clearance requests, with full copies of government-certified education and clinical practice credentials, should be submitted to DHMOSH/DOS (technicalclearance@un.org), UNHQ through the Permanent Missions (PM) of Member States three months prior to the planned deployment timeframe. The key documents to be submitted for technical clearance requests include:

- University certificate/diploma
- Specialty training certificate (if applicable)
- Valid license or registration to practice
- Advanced Trauma Life Support, Pre-hospital Trauma Life Support or equivalent training certification
- Aeromedical training certificate (if applicable)
- A curriculum vitae or personal history profile

10.2.4. United Nations medical care standards

In all field missions, medical support must meet standards acceptable to the United Nations and all participating Member States. Though this may pose challenges due to differences between member states' medical standards and legal constraints, medical care must be provided to all mission personnel at a uniformly high level and in accordance with prescribed standards regarding quality, capacity and capability. Any shortfall or discrepancy in the implementation of these standards that result in avoidable harm to United Nations personnel renders the medical support unsatisfactory.

[36] DOS/DHMOSH/MWFM/2023.4 "Guidelines on Technical Clearance Review of Medical Personnel for Deployment to UN Field Duty Stations" (2023)

10.2.5. Ethical code for medical practitioners

As health-care professionals, medical practitioners have the duty to acknowledge their fundamental responsibility to patients, society and fellow health-care providers, as well as to themselves. In view of the increased recognition of the complex and sometimes competing responsibilities of occupational health and safety professionals towards workers, employers, the public, public health and labour authorities and other related bodies, the United Nations Medical Directors advise that any United Nations organization-wide statements of ethics on occupational health matters or group-specific professional ethical codes (e.g., for physicians, nurses, hygienists, psychologists, etc.) should be guided by and consistent with the International Code of Ethics for Occupational Health Professionals.

10.2.6. Gender perspective in medicine

With the increasing participation of women peacekeepers and civilian staff in peacekeeping operations, there is a growing demand for medical services that cater to the specific needs of women in missions. Member States planning to deploy medical facilities should prioritize the inclusion of well-trained and qualified female medical staff alongside their male counterparts. T/PCCs are also encouraged to deploy general medical practitioners with women's health practice experiences to strengthen gender-sensitive medical services at the first line of care.

10.3. Roles and responsibilities

Technical clearance review is mandatory for all staff deployed or contracted as medical personnel under the United Nations flag. During the force generation process, Member States should be briefed about related professional qualification requirements by the relevant entity in the Department of Peace Operations (DPO). During the pre-deployment visit (PDV), T/PCCs should support the initial assessment of professional competencies by the medical representative in the PDV team. Prior to the planned deployment, the PMs of T/PCCs should submit official technical clearance requests to DHMOSH within the appropriate time frame, and ensure that submissions are complete. Any incomplete submission will not be processed for clearance.

DHMOSH is mandated to establish a professional qualification framework and technical clearance mechanism based on related United Nations policies. The

DHMOSH Medical Workforce Management Team implements the processing in conjunction with the Force Generation Service in DPO (FGS/DPO) and the Uniformed Capabilities Support Division in DOS (UCSD/DOS) for the deployment of medical personnel to various levels of medical facilities. Following a standardized technical review, a technical clearance report will be forwarded to the PM of the Member State that submitted the request and copied to related stakeholders in UNHQ and the Chief Medical Officer (CMO) Office in the relevant field mission. DHMOSH also guides field missions in the establishment of procedures to verify personnel competencies in order to strengthen accountability (see Annex 3.13).

The field mission medical authority should coordinate with related entities in the field and establish working procedures on field medical personnel verification. The CMO and Force Medical Officer (FMO) focal points should join regular COE inspections and check personnel status and competencies in T/PCC medical facilities, alongside the assessment of major equipment and self-sustainment capabilities. Updated personnel verification reports should be submitted to DHMOSH regularly to optimize clearance procedures.

10.4. Key messages

- The effectiveness and efficiency of field medical support is closely related to the qualifications and capabilities of the medical professionals deployed in field missions. Mandatory technical clearance is applicable for all medical personnel who staff various levels of medical facilities in field missions, including Level 1, Level 1+, Level 2, Level 2+, Level 3 and related enhanced capability modules.
- Minimum qualifications and experience for medical personnel in different categories that are accepted by the United Nations are defined in the *Guidelines on Technical Clearance Review of Medical Personnel for Deployment to UN Field Duty Stations.* T/PCCs should comply with the technical clearance requirement and submit a clearance request in good time prior to deployment.
- Joint efforts by UNHQ, Member States and field missions are needed to optimize technical clearance processes and strengthen accountability.

Chapter 11: Clinical Governance

11.1. Introduction

Clinical governance ensures that systems are in place to deliver safe and high-quality health care and continuously improve services through monitoring and oversight. Providing safe and high-quality health care involves the right person, doing the right thing, at the right time. In other words, it entails the treatment of a patient's problem based on the best available evidence, in the way the patient wishes, by an appropriately trained and resourced individual or team. Those individuals and teams, in turn, should carry out their work within the framework of an organization that is accountable for the actions of its staff, values them (i.e., appraises and develops them), minimizes risks and learns from both good practice and mistakes.

11.2. Definitions of key terms

Terms	Definitions
Clinical governance	Structures, systems, and standards applied to create a culture, and direct and control clinical activities. Clinical accountability and responsibility, a subset of clinical governance, involves the monitoring and oversight of clinical activities, including regulation, audit, assurance and compliance by senior managers, regulators, and internal and external auditors.
Clinical pathway	Clinical pathways translate clinical guidelines into a standardized and structured process. They detail each step involved in the care of the patient, with strict timeframes for each step and strict criteria for progression to the next step. They may also be referred to as care maps, care pathways, integrated care pathways and protocols.[37]

[37] Leigh Kinsman and others, "What is a clinical pathway? Development of a definition to inform the debate", *BMC Medicine*, vol. 8 (May 2010).

Clinical audit	In 2002, the National Institute for Health and Care Excellence (NICE) defined a clinical audit as: a clinical audit is “a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change”. It measures a clinical outcome or process against well-defined standards founded on the principles of evidence-based medicine.
Clinical adverse events (and reporting systems)	An adverse event is an incident that results in preventable harm to a patient. Clinical adverse event reporting systems are designed to obtain information about events (and near misses) and situations affecting patient safety. These incidents can be used to inform individual and organizational learning and improvement opportunities for quality and patient safety.
Root Cause Analysis (RCA)	A RCA is a tool to help organizations retrospectively study events where patient harm or undesired outcomes occurred or could have occurred (near miss), in order to identify and address root causes. It is a systematic process designed for understanding what happened, how it happened and why it happened to identify how to prevent the same event from happening again.
Culture of Safety Survey	Culture of Safety surveys are a reliable and valid tool to assess perception of the culture of patient safety within a health-care facility. Their purpose is to identify areas that may be adversely impacting patient safety or hindering quality improvement by allowing active or latent threats to patient safety.
Patient Experience Survey	The collection of patient experience data elicits factual information from patients on their interactions with the people, processes and physical settings of a health-care institution. Measurement of patient experience is obtained via a survey

	administered after a patient has been discharged from an inpatient stay or immediately after an outpatient clinic visit.
Hospital Evaluation Tool	The Hospital Evaluation Tool is a self-completed assessment to be performed by Level 1+ and above field medical facilities during the fifth and tenth month of medical personnel rotation.
Patient grievance / Patient complaint	A patient grievance is a formal or informal written or verbal complaint that is made to a medical facility by a patient or a patient's representative . It concerns a patient's care (when a complaint was not resolved at the time of the complaint by the staff present), mistreatment, abuse (mental, physical, or sexual by medical personnel while performing their duties in the clinic) or neglect, or may relate to facility compliance issues.

11.3. Reporting requirements – what/when/how

When due	What is due	How
Daily	**Patient Experience Survey**	Medical facility should administer daily after a patient has been discharged from an inpatient stay or immediately after an outpatient clinic visit
First month of rotation	**Clinical pathways**	Within the first month after hospital rotation, all clinicians should download the WHO Malaria Toolkit app and other WHO/Firstline applications. The Hospital Commander should also submit trauma, acute coronary syndrome and COVID-19 customized clinical pathways.
Fifth and tenth month of rotation	**Hospital Evaluation Tool/report**	The Hospital Commander completes the report and passes it to the CMO and FMO. They walk through hospital together and discuss the results. The CMO submits the report to DHMOSH CGS.

When requested	**Clinical audit**	Medical facility should submit full medical records of all cases for the period under audit when requested by CGS. Comply with recommendations within recommended timeframe.
As scheduled	**Healthcare Quality and Patient Safety (HQPS) Assessment**	Hospital should prepare for an assessment if one has not been conducted.

11.4. Key messages

- Safe, high-quality medical care is the responsibility of **all** personnel from the front line or bedside to leadership.
- Personnel working in Level 1 clinics and Level 1+ and above medical facilities should submit required documents according to the time frame shown above.

Chapter 12: Public Health

12.1. Introduction

The Public Health Section of DHMOSH works to improve the health and well-being of the entire United Nations community, including United Nations civilians and uniformed personnel in United Nations System entities across the world, both within and outside the workplace. The section develops guidelines, policies and risk mitigation plans for the secretariat and field missions and operations. It also prepares UNHQ and field missions to monitor and respond to public health crises and emergencies irrespective of the context and locations. As the public health authority within the United Nations System, the section acts as the liaison between Organization stakeholders and local and international public health and medical authorities and provides advice to senior management on public health issues and their implications for United Nations personnel, promoting policy and systems improvements that support health.

12.2. Definitions of key terms

Terms	Definitions
Post-exposure prophylaxis	HIV post-exposure prophylaxis (PEP) is an emergency medical response given to an individual who has been exposed to HIV to prevent possible HIV infection in the exposed person. HIV PEP services comprise first aid (depending on nature of exposure), counselling, assessment of risk of exposure to HIV, HIV testing and, depending on the outcome of the exposure assessment, a 28-day course of anti-HIV medication, with appropriate support and follow-up.
HIV PEP custodians	HIV PEP custodians are United Nations staff members designated at each duty station to be responsible for maintaining and dispersing HIV PEP kits to United Nations staff members.
Outbreak	A disease outbreak is defined as disease cases exceeding what would typically be expected in a defined community, geographical area, or season.

12.3. Role of DHMOSH

12.3.1. General health promotion and chronic diseases prevention

With a mission to enhance and promote healthy lifestyle and opportunities for the United Nations community, the Public Health Section develops and implements targeted global health promotion campaigns to encourage healthy lifestyles and physical fitness, as well as integrated initiatives for the prevention of chronic and infectious diseases among United Nations personnel. This includes developing disease-specific prevention guidelines and health promotion webinars, publishing health-related articles, training the United Nations health workforce on health promotion and organizing disease-specific health promotion campaigns and public health talks where specific health issues are discussed by public health experts. The section also provides technical advice to personnel in United Nations field missions on health promotion strategies and planning.

12.3.2. Disease outbreaks, public health emergencies, and pandemic management

The Public Health Section is responsible for providing strategic and technical leadership and policy guidance required for the management of disease outbreaks, public health emergencies and crises affecting United Nations duty stations and missions globally.

To ensure the United Nations System has the capabilities in place to respond to a disease outbreak, the section continuously develops, reviews, updates and improves its disease-specific risk mitigation and preparedness plans. It advises on the implementation of policies to help individual duty stations put outbreak contingency plans in place. The section also evaluates and makes recommendations for improvement relating to the existing United Nations System Pandemic Plan and ensures that all missions have practical contingency plans in place and basic essential supplies available to respond to any disease outbreak.

To prepare the United Nations medical workforce, managers, and United Nations senior management to respond to public health emergencies, the section conducts periodic outbreak investigation, management and response training programmes to ensure that all these stakeholders are well informed on their roles and responsibilities. In addition, the section is responsible for the development and availability of all public

health emergency response tools in field locations. This includes appropriate databases and electronic data collection and systems that support case reporting and management, disease tracking/surveillance and data analytics.

During an actual pandemic, disease outbreak or public health emergency, the section's primary role is to ensure that the risks for United Nations personnel globally are appropriately managed and responded to and that United Nations leadership is provided with updated information on United Nations duty stations or countries with significant risk or impacts from the outbreak.

Together with the United Nations Medical Directors Group, the section develops appropriate and up-to-date guidance and protocols and facilitates and supports any public health outbreak investigation and management of case clusters in duty stations with and without United Nations medical presence, providing recommendations as necessary and maintaining communication flow amongst key stakeholders in the management of cases.

The section also supports the development of Information Education and Communication (IEC) tools required for health education and to create awareness about the outbreak/pandemic and the preventive measures that should be implemented in United Nations duty stations to mitigate the disease.

12.3.3. United Nations Global HIV Post-Exposure Prophylaxis Programme and HIV programme in United Nations missions

The Public Health Section provides technical support, training, and guidance to United Nations missions and duty stations on all matters related to the management and implementation of the HIV programme. This includes the management and coordination of the United Nations Global HIV Post-Exposure Prophylaxis (HIV-PEP) Programme, which ensures access to HIV PEP services and the availability of HIV PEP kits in all United Nations duty stations and countries globally in the event of exposure to HIV.

The section is responsible for the development of all required HIV PEP kit reporting tools, the training of HIV PEP custodians and the provision of technical support to field-based public health and medical teams that coordinate HIV prevention programme in United Nations missions. It also conducts periodic reviews of the existing HIV

programme and its mandate together with stakeholders and ensures that all necessary tools and systems are up to date and the necessary policy and guidance documents are in place. In addition, the section coordinates the sourcing of funds and the procurement of HIV PEP kits as well as their distribution to all United Nations duty stations globally, keeping track of their usage through the HIV PEP kit reporting platform.

12.4. Reporting requirements

12.4.1. Medical Reporting Tool (MRT)

The Medical Staff Aid 3B (MSA-3B) reflects the overall health status of United Nations personnel within the mission area and provides important epidemiological information for monitoring and response support planning.

The MSA-3B is to be completed by every contingent and formed police medical unit and submitted to the respective FMO on a bimonthly basis.

Please see Chapter 13 for detailed information on this tool and reporting requirements.

12.4.2. e-Outbreak Reporting Tool (ORT)

The e-Outbreak Reporting Tool (ORT) was developed by DHMOSH following the COVID-19 pandemic to enhance collective capacity to track, manage and prevent outbreaks of infectious diseases in field locations (i.e., Zika, Ebola, etc.).

All outbreaks in your duty station should be reported through the ORT online. This information provides senior management with a snapshot of currently active outbreaks involving personnel in your duty station. Please complete the form as accurately as possible, based on current information.

Please see Chapter 13 for detailed information on this tool and reporting requirements.

12.5. Key messages

- The Public Health Section responsibilities include, but are not limited to, the development and implementation of global health promotion campaigns, monitoring for infectious disease outbreaks, responding to public health emergencies and crises and coordinating the HIV PEP kit programme to ensure access and availability globally.

- The Public Health Section works with duty stations to provide leadership, policy guidance and support on all public health related matters.
- Accurate and timely reporting through the MRT and ORT is essential to providing the Public Health Section with real-time data to promptly respond to infectious disease outbreaks and for non-infectious disease programme development.

Chapter 13: Medical Records Keeping/Medical Reporting Tools

13.1. Introduction

The efficient management of medical information, particularly regarding patients, is a vital part of medical support planning and medical service delivery. This information must be standardized and distributed rapidly to all who need it, while complying with medical confidentiality. All information must be recorded by the medical facility initiating the treatment in compliance with the United Nations Healthcare Quality and Patient Safety Standards (UNHQPS) chapter on Management of Information. A patient file is created and passed along with the patient whenever the patient is referred or transferred to another medical facility. The initial medical facility will be responsible for maintaining a master file on the patient and is not to release any patient information without written authorization from the Office of the CMO. Next-of-kin notification is the responsibility of the appropriate national contingent commander in due consultation with the mission leadership and is to be done before any official statement of the incident is made public.

13.2. Definitions of key terms

Terms	Definitions
Medical records	Medical records describe the systematic documentation of a single patient's medical history and care across time within one or more health-care provider's jurisdiction. The medical record serves as the central repository for planning patient care and documenting communication among patient health-care providers and professionals contributing to patient care, hence the need for detailed and unambiguous reporting. For this information to be useful and to support the continuity of the patient's care, the patient record needs to be available during inpatient care, for outpatient visits and at other times as needed, and must be kept up to date. Medical, nursing and other patient

	care notes must be available to all the patient's health-care practitioners who need them for the care of the patient. Information recorded includes, but is not limited to,: • Personal details for patient identification (including name and date of birth or other secondary identifier for patients) • Clinical history • Assessment and reassessment, care plans • Medical care at all levels (documents to accompany the patient/casualty to the next facility, including diagnosis, investigations, treatment and plan of care) • Discharge/follow-up instructions • Evacuation requirements if applicable • Logistics support provided
Medical documentation	Complete and standardized medical documentation in an operation is essential for the following reasons: • Medical treatment and procedures • Patient consent • Patient assessment and reassessment, clinical status and monitoring • Statistics and medical surveillance system functions • Facilitating easy processing of administrative matters like medical claims, compensation and determining the degree of disability.
Pre-deployment medical examination documentation	All personnel participating in a United Nations operation are required to submit their pre-deployment medical examination records to the medical authorities in the mission area to aid in patient treatment. This documentation should also include a

	summary of significant medical history and/or pre-existing conditions, current medical treatment and medication (if any), known drug allergies, blood grouping and an updated international certificate of vaccination. These records are to be securely filed by the respective medical unit or authority responsible for the daily health care of the individual. Personal medical records are to be treated as "medical-in-confidence" and should not be provided to anyone not directly involved in the patient's care.
Deployment and repatriation documentation	If illness or injury occurs, the diagnosis and treatment provided must be accurately documented in these records, including any medical leave issued. As patient or casualty care may be disrupted by treatment by different doctors at different levels of medical support, there is a need to outline a clear treatment plan at each medical facility. Patient progress must also be periodically recorded under the progress notes. The medical records are to accompany the patient or casualty during evacuation to the next level of medical support, including repatriation to his or her home country. The records must be properly sealed and marked with the instructions "medical-in-confidence - to be opened by addressee only." **Copies need to be retained by the medical facility according to the appropriate medical records retention schedule.**
Post-deployment/ redeployment	At the end of a peacekeeper's tour of duty or following the completion of a mission, the health records are to be issued to the respective individual or unit in a sealed envelope, to be handed over to the respective national health authority or to his/her regular physician.

	Should a medical unit be repatriated, all medical records are to be handed over to the unit replacing it. In the absence of the latter, the records should be handed over to the Office of the CMO. No medical or treatment records should be left unattended within the mission area. If these are no longer required, the records should be repatriated with the respective unit. Medical records should be retained by the medical facility in compliance with the United Nations medical record retention schedule.

13.3. Role of DHMOSH

The effective organization and analysis of medical information is a cross-disciplinary task. At the mission level, the CMO is responsible for implementing a UNHQPS-compliant medical records system. DHMOSH offers multifaceted support to the field and oversees processes.

The Clinical Governance Section can assist in establishing UNHQPS-compliant processes and conducting quality control audits.

The Medical Workforce Management Section can provide guidance for updating the Mission Medical Support Plan as necessary and support the PDV team in the assessment of procedures and documentation of pre-deployment medical examination, prophylaxis and vaccination applied in the case of contingents and units.

The Occupational Safety and Health Section can offer guidance and tools for managing occupational safety and health records.

The Public Health Section can aid in public health outbreak investigation, management of case clusters, electronic data collection and systems that support case reporting and management, disease tracking/surveillance and data analytics. Using electronic reporting systems, the Public Health Section can implement health promotion/disease prevention programmes for non-infectious diseases and strengthening capabilities to respond to infectious disease threats and other public health emergencies/crisis.

13.4. Reporting requirements

The CMO is accountable for timely, complete and accurate medical documentation and reporting in all missions. The Office of the CMO or FMO shall ensure that reports arising from T/PCC medical facilities in all United Nations operations are reported to DHMOSH accurately and in a timely manner. The Office of the CMO or FMO oversees the collection and compilation of the required data from medical units for submission to DHMOSH. All medical units, including those in national contingents, must comply with CMO or FMO instructions on reporting procedures. Information on serious injuries and diseases requiring medical evacuation (MEDEVAC) or hospitalization must be communicated as soon as possible to DHMOSH. Medical facilities should report the following data to the mission CMO/DHMOSH:

Due	What is due	How
Daily	Patient Experience Survey	See chapter 11
First month of rotation	Clinical pathways	See chapter 11
Fifth and tenth month of rotation	Hospital Evaluation Tool/Report	See chapter 11
Once per rotation	Culture of Safety Survey	See chapter 11
When requested	Clinical audit	See chapter 11
As scheduled	Healthcare Quality and Patient Safety (HQPS) Assessment	See chapter 11
When needed	Medical Staff Aid 1 (NOTICAS)[38]	See Annex 3.14
Every three months or following any rotation or change in composition of medical units.	Medical Staff Aid 2 (Medical Facility Report)[39]	See Annex 3.14

[38] Annex 3.15 “SOP – Notification of Casualties (NOTICAS) in Peacekeeping Operations and Special Political Missions”.

[39] Annex 3.16 “Medical Staff Aid 2 (Medical Facility Report)”.

Monthly (prior to the fifth day of the preceding month)	Medical Staff Aid 3A (Medical Treatment Report Per Capita)[40] (online submission through the United Nations Medical Reporting Tool (MRT))	See Annex 3.14
Bimonthly (data should be collected and submitted from the 1st-15th of the month and from the 16th to the end of the month)	Medical Staff Aid 3B for Medical Treatment Report by Diagnosis[41] (online submission through the MRT)	See Annex 3.14
When needed	Emerging infectious disease outbreak(s) (online submission through ORT)	See Annex 3.14
End of tour	End of tour of duty report	See Annex 3.14
Daily	Medical mapping	See Annex 3.14

13.5. Reporting Tools

13.5.1. Medical Reporting Tool

The MRT is a secure, easy-to-use online application that provides user-friendly navigation and content creation. It is designed to streamline the collection of statistics on numbers of patients and diseases. It allows CMOs to input data directly into the electronic templates of MSA-3A, MSA-3B, and BUR. This facilitates data collation and analysis for planning purposes and is connected to business intelligence dashboards. Data entered into the MRT is stored securely and archived. It manages data for contingent members, United Nations civilian and local staff, staff of agencies, funds and programmes and other agencies, as well as local populations that access DPO medical facilities.

[40] Annex 3.17 “Medical Staff Aid 3A (Medical Treatment Report Per Capita)”.
[41] Annex 3.18 “Medical Staff Aid 3B for New Cases and Medical Treatment Report by Diagnosis”.

13.5.2. e-Outbreak Reporting Tool (ORT)

The ORT is a reporting system that enables United Nations health-care personnel in field locations to report suspected outbreaks of infectious diseases in real time. Real-time reporting provides the collective ability to track, manage and ultimately prevent outbreaks of infectious diseases in field locations. Accurate and timely reporting through the ORT allows DHMOSH to quickly respond and modify interventions to meet the needs of field locations. All peacekeeping missions and duty stations with United Nations clinics should be familiar with utilizing the ORT in order to readily access the Tool and respond promptly in the event of an emerging outbreak. All outbreaks, whether small or large, affecting United Nations personnel should be reported to DHMOSH through this portal by the CMO, FMO or United Nations Clinic Doctors or as designated by them.

13.5.3. Electronic medical records and the occupational health management system (EarthMed)

The current data management concept for the United Nations medical services envisions the extension of the EarthMed occupational safety and health record system to cover both medical and safety records as well as all United Nations Secretariat-supervised entities, including all field entities, and potentially all T/PCC facilities. This will ensure that there is a link between safety-related data that leads to illness and injury and associated health data. Managers at all levels will thus be able to understand both the workplace-safety related causes of illness and their impacts in terms of sickness absence, MEDEVAC, repatriation and compensation. The use of EarthMed in such a way will also consolidate, standardize and streamline clinical data in peacekeeping operations (PKOs). All medical records generated within United Nations clinics should be in EarthMed, and all safety-related records including incident reports and mitigation measures are being migrated to the system.

13.5.4. Submission of occupational safety and health reports

This paragraph is currently only applicable to United Nations-owned equipment (UNOE) facilities and those T/PCC with access to EarthMed.

Clinical staff entering diagnoses for illnesses and injuries considered likely to be service-related are to complete an incident report, generated automatically by EarthMed in such cases.

Safety staff recording workplace safety incidents, injuries, illnesses, exposures, near misses or dangerous occurrences are to complete an incident report in EarthMed, and where appropriate, refer it to clinical staff from within the application itself to ensure corresponding clinical outcome data is associated to the incident report. All personnel in missions that have a record in EarthMed (established through an Enterprise Resource Planning (ERP) system) are able to submit incident reports via the EarthMed portal, medical.un.org.

13.6. Key messages

- All medical facilities should keep medical records in compliance with the UNHQPS chapter on Management of Information for all patients.
- All medical facilities should timely submit routine medical reports to the CMO and FMO.
- All medical units, including those in national contingents, must comply with CMO or FMO instructions on reporting procedures.
- The CMO is accountable for timely, complete and accurate medical documentation and reporting in all missions.

Chapter 14: Mental Health

14.1. Introduction

Mental health and well-being are essential to maintaining the operational readiness of uniformed personnel. It is important for leadership in the mission to emphasize this. The World Health Organization's principles of prevention, Promotion and protection and support of mental health are foundational to the Mental Health Strategy for Uniformed Personnel and this module.

14.2. Roles and responsibilities of individuals in supporting the mental health of the uniformed personnel

Mental health care is delivered through a multipronged approach, involving different appointment holders in the mission. A brief outline of their roles is included here. Their roles throughout the deployment cycle are described in detail in Annex 1 to Mental Health Strategy for Uniformed Personnel.

14.2.1. Uniformed Mental Health expert

There shall be Mental health experts (MHEs) (psychiatrist/psychiatry nurse/general/clinical psychologist) available in two Level 2 hospitals per mission. In addition, there shall be a psychiatrist at each level 3 Hospital. These experts are integral to mission mental health teams.

14.2.2. United Nations system staff counsellors

In most missions, staff/stress counsellors are available to promote the psychological and social well-being and welfare of United Nations staff and the Organization. These counsellors respond to daily counselling needs and support medical services with United Nations civilian staff mental health cases.

14.2.3. Contingent clinical psychologist/psychiatrist or psychiatry nurse

Some T/PCCs bring their own clinical psychologist/psychiatrist/psychiatry nurses and provide mental health and psychosocial support to their troops on the ground. T/PCC mental health staff can work together with the mission uniformed MHE.

14.2.4. Senior Medical Officer

The Senior Medical Officer (SMO) of a national contingent is the most senior ranking medical officer in the contingent and reports directly to the national contingent commander. The SMO is also the FMO's point of contact on health issues in his or her contingent. The SMO reports to the FMO on professional matters concerning the health of troops and on medical services provided by the respective contingent. Among other duties, the SMO of a national contingent is responsible for:

- The mental health and well-being of his or her national contingent members and all United Nations personnel supported by the contingent's medical units.
- Overseeing the implementation of mental health measures as detailed in Annex I of the Mental Health Strategy for Uniformed Personnel within the contingent's area of operations.
- Overseeing mental health training and health education of contingent peacekeepers and medical personnel.
- Compiling mental health statistics and preparing reports required by the FMO for submission to UNHQ.
- Implementing the prevention/promotion/support activities on mental Health within the contingent throughout the deployment cycle. The SMO shall identify those needing mental health care and help them access it.
- Introducing uniformed personnel to the Mental Health Strategy concept and familiarizing them with the Digital Mental Health Platform (website and mobile app); assisting uniformed personnel in installing the Mental Health App on their mobile phones and understanding how to use it.

14.2.5. Force Medical Officer

The roles and responsibilities of FMOs regarding the mental health of uniformed personnel are described in Annex I to Mental Health Strategy for Uniformed Personnel. The FMO is responsible for:

- Coordinating the implementation of the Mental Health Strategy for Uniformed Personnel.

- Assisting the CMO in MEDEVAC of psychiatric patients.
- Coordinating mental health literacy/training on mental health issues for uniformed personnel, leadership and medical officers.
- Collecting and collating mental health statistics and reporting to DHMOSH/DOS at UNHQ.
- Ensuring that all uniformed personnel have downloaded the mental health app onto their mobile phones and updated their location and status as uniformed personnel through the near-field communication (NFC) tags. NFC tags shall be provided to missions by UNHQ. These tags identify individuals as United Nations uniformed personnel.
- Reassuring uniformed personnel that using the mental health app will help them build their resilience and that their data and identity will remain confidential.
- Introducing the mental health strategy concept to uniformed personnel and familiarizing them with the digital mental health platform (website and mobile app); assisting uniformed personnel in installing the mental health app on their mobiles and understanding how to use it, if not already done by the SMO.

14.2.6. Chief Medical Officer

Annex I to the Mental Health Strategy for Uniformed Personnel describes the CMO's roles and responsibilities regarding the mental health of uniformed personnel. The CMO is responsible for:

- Coordinating the work of the Mission Mental Health Team.
- Retention/repatriation of uniformed personnel experiencing mental health issues.
- Coordinating MEDEVAC of uniformed personnel needing mental health expert care.
- Supporting all uniformed personnel to download the mental health app and update their location and status as uniformed personnel through NFC tags.

14.2.7. Religious/spiritual teacher in the contingent

When stressed, uniformed personnel are likely to reach out to religious or spiritual teachers. These individuals play a key role in dispelling the stigma around mental health. With training, they can learn to identify red flags and help uniformed personnel to access professional mental health care. Their role is described in detail in Annex I of the Mental Health Strategy for Uniformed Personnel, and their training is detailed in Annex III of the same strategy.

14.3. Mental health care delivery

Mental health care should be integrated into general medical services. Mission and T/PCC medical professionals at all levels play a key role in providing mental health support.

Table 1: Components of a Mission Mental Health team and T/PCC Mental Health team

Mission Mental Health Team	**T/PCC Mental Health Team**
Senior Medical Officer Chief Medical Officer Force Medical Officer Mental Health Expert (s) in the Mission* Sector Commander	Senior Medical Officer Religious Teacher General/Clinical Psychologist**/ Counsellors Company Commander Unit Commander

**Psychiatrist, Psychiatry Nurse, General/Clinical Psychologist at the Level 2/3 hospital, and the Staff/Stress Counsellors.*
***General/Clinical Psychologist when available*

The work of medical professionals is indispensable for maintaining the overall readiness and effectiveness of uniformed personnel (see Annex 3.19).

14.4. Digital mental health platform

The Mental Health Strategy is accessible through a digital platform consisting of a website and a mobile app. The mobile app is available offline once downloaded.

The mobile app provides uniformed personnel with mental health resources and screening tools to assist them in assessing their mental health status. It is envisaged

that regular use of the mobile app resources will assist uniformed personnel in maintaining a psychologically healthy lifestyle and improving their mental health resilience.

It is recommended that the mobile app be downloaded in the pre-deployment phase. An email ID or mobile number can be used for registration. The mobile app is available in both Apple and Android stores.

All qualitative and identifying information in the mobile mental health app is encrypted from end to end and unavailable to anyone other than the user.

14.5. Training by medical staff deployed in various contingents

Medical personnel in PKOs are responsible for providing skilled medical services to peacekeepers and continuously training other non-medical members of the contingent to administer Psychological First Aid, mental health awareness and suicide prevention training/education, psychological resilience training and coping skills training.

Training modules relating to the above-mentioned skills are listed in Annex III of the Mental Health Strategy for Uniformed Personnel.

14.6. Training by mental health expert

Mental health experts will conduct training in Stress First Aid, Psychological First Aid, Problem Management Plus and mental health awareness/psychological resilience.

14.7. Management of mental health issues in the mission

The contingent SMO is the focal point for managing any mental health conditions emerging within the contingent while deployed in the mission area. He or she shall evaluate the individual and manage the situation or seek advice from a mental health expert in the mission or available locally. If the situation demands, he or she will request MEDEVAC to a higher health-care level where relevant expertise is available, in consultation with the FMO and CMO. Should a traumatic event occur, assistance from the mental health expert within the mission will be sought in coordination with the FMO and CMO.

14.7.1. Psychiatric illnesses that preclude participation in peacekeeping operations.

When detected before deployment to a United Nations mission, psychiatric illnesses listed in Annex 3.20 to this strategy should preclude participation in peacekeeping operations. Conditions must, however, be carefully assessed on a case-by-case basis, considering the severity of the disease and the proposed deployment area.

14.8. Key messages

- “Mental health is a state of mental well-being that enables people to cope with life’s stresses, realise their abilities, learn and work well, and contribute to their communities.” [42]
- Specialists such as psychiatrists and psychologists contribute additional expertise that enhances the capabilities of mental health response teams.
- Efforts to raise mental health awareness must be made by uniformed personnel at all levels and throughout the deployment cycle. Links to resources are provided in Annex III to the Mental Health Strategy for Uniformed Personnel.

[42] World Health Organization, "Mental Health", factsheet, 17 June 2022.

Chapter 15: Telemedicine

15.1. Introduction

Telemedicine is an innovative component in the context of United Nations mission support for health care. The key objective of telemedicine is to provide timely and efficient health-care services at remote/isolated locations using secure information and communication technologies (ICT) while eliminating/reducing resource limitations (e.g., the availability of experts, cost and time) and overcoming geographical barriers (such as different reasons for delays in CASEVAC or MEDEVAC)

15.2. Definitions of key terms

Terms	Definitions
Telemedicine	The delivery of health-care services where distance is a critical factor by health-care professionals using ICT for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, in the interests of advancing the health of individuals and their communities.
Teleconsultation	Provision of remote clinical services to patients using dedicated telemedicine technologies. This may not always involve a patient, for example, in the case of an interaction between health-care providers regarding a case.
Tele-expertise	Opinion or guidance given by a remote specialist to a patient-side health-care provider via teleconsultation. This can be further broken down into clinical specialties such as tele-dermatology, tele-ophthalmology, etc.
Store and forward	Exchange of clinical information (history, medical images, reports, etc.) between health-care professionals using a secure portal / electronic medical record (EMR) platform for specialist advice. It does not involve an interactive conversation with an audio or video component and is also referred to as asynchronous telemedicine.

Real-time telemedicine	Simultaneous exchange of clinical information between two or more parties (usually health-care providers but possibly also the patient) using secure audio/video technology for diagnostic and therapeutic assistance in the treatment of patients who would otherwise not have timely access to specialist care. Also referred to as synchronous telemedicine.
Referrer	The health-care provider, usually at the patient's side, who seeks a remote specialist's advice using telemedicine.

15.3. Implementation model

All United Nations civilian and military medical facilities are equipped with United Nations-approved telemedicine solutions (EMR platforms, software and hardware devices) capable of conducting store and forward and offering real-time telemedicine services.

- Level 1 clinics are the **referral sites for telemedicine**. Personnel at these clinics discuss applicable cases with specialists at designated higher-tier hospitals within the sector or mission using United Nations-approved telemedicine solutions. Depending on the site and risk level, Level 1 clinics (or TOBs) are also equipped with rapidly deployable telemedicine kits with satellite connectivity solutions for **dynamic use cases, such as point of injury for pre-hospital care**.
- Level 1+ hospitals or above within the mission area are **specialist sites for telemedicine**. Specialists at these hospitals will provide tele-expertise to support with case management and evidence-based referral decision-making at Level 1 clinics.
- Level 4 hospitals (in Member States) are specialist sites providing **cross-border telemedicine services** to selected Level 1+ or higher medical facilities in missions. These telemedicine referral centres are identified and cleared by DHMOSH via the provisions of an MOU.

15.4. Roles and responsibilities

Centralized governance of United Nations telemedicine services is provided by the Clinical Governance Section, DHMOSH. with the Office of Information and Communications Technology (OICT) supporting service delivery. The roles and responsibilities of all civilian and military personnel in telemedicine services are regulated by the document outlining the strategic framework of telemedicine.

Profiles	Roles
Chief Medical Officer	Has overall responsibility for the implementation of telemedicine services at all levels of care in mission. The CMO coordinates user management and ensures all users have access to United ations-approved telemedicine solutions including required ICT infrastructure.
Force Medical Officer	Coordinates with CMO to ensure implementation of telemedicine services for specific use cases as per standard operating procedures (SOPs) at all military medical sites. The FMO designates a telemedicine focal point (usually the SMO) at all military medical sites to facilitate user management, onboarding/offboarding and user training during deployment.
Senior Medical Officer	Ensures all users (clinicians or designated medical staff) have access to user resources, training materials and SOPs on telemedicine use. Reports telemedicine usage data and supports in evaluation of services. Manages handover and timely updating/reporting of user profiles to FMO and CMO Offices during rotations
Medical personnel	Must complete telemedicine eLearning and training requirements and utilize telemedicine services in accordance with SOPs.

Frontline medics	Must complete telemedicine eLearning and training requirements and utilize telemedicine services for applicable use cases.

15.5. Key messages

- Telemedicine provides timely and efficient health-care services at remote/isolated locations while eliminating/reducing resource limitations and overcoming geographical barriers.
- Telemedicine eLearning and training are mandatory for all field medical personnel.

MODULE 4: OCCUPATIONAL SAFETY AND HEALTH MODULE

Chapter 16: Medical Standards for Employment

16.1. Introduction

United Nations medical standards for employment are in place to ensure that all personnel (both military and civilian) are fit to perform their designated functions without risk to their own safety and health or that of others. Like all medical clearance processes, determining fitness for duty takes into consideration the individual's physical and mental health, the functions to be performed and the health risks and health support available at the proposed service location.

Official provisions are outlined in the administrative instruction on medical clearance (ST/AI/2018/4).

16.2. Overview of clearances

16.2.1. Pre-employment clearance for staff

Pre-employment clearance applies primarily to new or prospective United Nations staff members. It should also be carried out when a staff member changes position or nature of tasks (i.e., in the case of changes to their job description) or moves to another duty station (in view of corresponding changes to the location health profile). The clearance decision is taken by the medical service in the prospective mission / duty station, on the principle that the receiving medical service is responsible for the health care of staff joining their duty station. As such, the medical service has the right to exclude prospective staff from joining their duty station if it presents too high a risk.

There are two processes for staff employment clearances, with two corresponding forms:

1. The MS.2 form, which requires a medical history, physical examination, basic haematology, biochemistry and urine testing, an ECG and a chest X-ray depending on risk. Only security staff undertaking physical security functions, drivers and manual workers are required to complete a MS.2 as part of their medical clearance process. The MS.2 can be overseen by United Nations or external physicians, but clearance itself can only be granted by a mission clinician with delegated authority for employment medical clearances.

2. The MS.3 form, screens for information on past, current and future health factors. The MS.3 form is a screening tool and identifies very low risk candidates. Positive indicators on the MS.3 require follow-up and targeted intervention to identify any health risks applicable to the proposed work. The MS.3 form is completed by the candidate and reviewed by United Nations clinical staff to identify any follow-up action required. Clearance itself can only be granted by a mission clinician with delegated authority for employment medical clearances.

16.2.2. Pre-employment (pre-deployment) clearances for T/PCCs

All T/PCC members of formed units must undergo a MS.2 process. The MS.2 is conducted by the medical staff of the deploying national authority. Individual uniformed personnel undergo a MS.3 process. Clearance for individual uniformed personnel can only be granted by a mission clinician with delegated authority for employment medical clearances.

16.2.3. Travel clearances for staff

Any travel outside of the duty station arranged through Umoja, the United Nation's Enterprise Resource Planning (ERP) system, (requires a travel clearance. Travel clearance is mandatory, and failure to receive travel clearance prior to travel may result in exclusion from workers' compensation coverage under Appendix D to the United Nations Staff Rules. The travel clearance process uses form MS.4 which, like the MS.3 form, is a screening tool. Positive indicators lead to further review by United Nations clinicians to ensure staff members are as well prepared as possible for travel. Travel clearance may require vaccinations, prophylaxis or a briefing to address destination-specific issues. The medical service in the mission / duty station from which the staff member is departing is responsible for preparing and completing the travel clearance process.

T/PCC personnel do not require travel clearances.

16.2.4. Periodical medical clearances

There is no evidence indicating that undertaking periodic medicals as a routine measure is of any value. They are encouraged for those at higher risk if medical resources are available, but in general they are not mandatory unless required by a

specific duty station or task risk. In such cases, medical clearances are carried out by the medical service in the mission or duty station.

TPCC personnel do not need to undergo periodical medical clearances.

16.2.5. Exit medical clearances

Although a feature of some military processes, exit medical clearances are not conducted by the United Nations for either staff or T/PCC personnel.

16.2.6. Return to work

An assessment of fitness to return to work is of value following major injuries, illnesses, a significant period of sick leave or medical evacuation (MEDEVAC). While this is not the same as medical clearance, it is an integral part of the overall health-care process and determines if a “return-to-work” plan is needed, what form it should take, and if either medical restrictions or workplace accommodation should be implemented. Return to work rarely involves being incapacitated to work for an extended period and immediately being fully fit for work.

The return-to-work programme and any restrictions or workplace accommodation required is the responsibility of the mission medical service.

Return-to-work plans for T/PCC personnel are the responsibility of their supporting medical service, either that of the contingent or the United Nations depending on the duty station.

16.2.7. Medical clearance on request

Any mission medical officer with delegated authority for conducting medical clearances or for supervising the occupational health care of a staff member may at any time require a medical assessment to assess fitness for work. The medical officer can impose restrictions up to and including being unfit for any work. Medical restrictions must be followed by both the staff member and the supervisor.

Staff members may also request an assessment of fitness for their full duties through a request for for workplace restrictions or accommodation. This usually occurs in the context of sick leave but can happen independently of sick leave.

Although less common, supervisors may also request a medical assessment at any point if they have a legitimate and reasonable belief that one of their staff has a medical issue that is affecting or could affect their or others' health and safety.

Regardless of how the medical assessment is initiated (by the medical service, the staff member or the supervisor), this assessment does not represent medical clearance unless an employment clearance request is also submitted and responded to in Umoja.

Medical clearance on request for T/PCC personnel is the responsibility of their supporting medical service, either that of the contingent or the United Nations depending on the duty station.

16.2.8. Requirements for medical clearances

The United Nations Medical Director is responsible for establishing the use of different processes (e.g., MS.2 or MS.3) and setting the questions in these or similar forms, as well as for determining the physical examinations, tests or other investigations needed. These requirements may be subject to change over the lifespan of the Medical Support Manual as new processes are developed to reflect changes in medical evidence around health risk and to make improvements to administrative processing.

16.2.9. Standards for medical clearance

The mission Chief Medical Officer (CMO) is responsible for determining whether a response to a question or the findings of a physical examination, test or investigation meet the United Nations standards for employment. This is based on authority for medical clearances being delegated to the CMO. The CMO's assessment should be founded on a holistic appraisal that includes exam or test findings, the work expected of the staff member, and risks and capabilities pertaining to the duty station.

16.3. Role of DHMOSH

The role of DHMOSH in relation to clearance processes includes:

- Providing a Headquarters review process for missions who seek additional advice on a clearance. This can be requested using the 'HQ Review' function in EarthMed. While DHMOSH will provide advice on wider policy and medical

considerations and share the insights and view of DHMOSH, final authority to grant clearance rests with the mission and CMO.

- Establishing the framework to be used by mission clinical staff for undertaking standardized assessments.

16.4. Reporting requirements

Employment and travel clearances can only be done in EarthMed and are based on employment and travel clearance requests transferred by interface from Umoja. Manual clearances cannot be created in EarthMed for United Nations Secretariat or T/PCC staff. They will not therefore be recorded as a medical clearance.

End users and Headquarters entities can review clearances via the EarthMed Clearances PowerBITM dashboard. No additional reporting is required.

Where an assessment is made and mission medical staff wish this to be reflected as a clearance, this must be done via HR colleagues creating a request in Umoja. This cannot be done for T/PCC personnel.

16.5. Key messages

- Medical assessments regarding fitness for work can take place through several mechanisms (MS.2, MS.3, MS.4, etc.), but clearances are only given for employment and travel based on requests from Umoja or Hermes/FSS ERP systems.
- DHMOSH can provide advice via the ‘HQ Review’ function in EarthMed, but missions retain responsibility for the clearance decision.

Chapter 17: Occupation Safety and Health Framework

17.1. Introduction

Missions exist to meet their mandates, but for individual staff and contingent members, consultants, contractors and volunteers, missions are also workplaces. There is a universal obligation for employers to create safe workplaces for United Nations personnel. Safety arrangements are aimed at identifying and preventing exposure to hazards. Every mission should have a clear understanding of its safety risks based on its own incident and accident data and have a suitable safety programme in place to address these risks.

The fifth fundamental principle and right at work (FPRW) of the International Labour Organization (ILO) is the right to a safe and healthy working environment.[43] Along with this principle, the 13th ILO/WHO Joint decision on Basic occupational health services (BOHS)[44] represents the framework within which the OHS services shall be delivered to field staff. The ultimate objective of the BOHS initiative is to provide occupational health services for all working staff members and uniformed personnel in the world, regardless of the type of deployment, size of the workplace, or geographic location (ie, according to the principle of universal services provision).[45]

Recognizing the need to meet these obligations, the Secretary-General, in ST/SGB/2018/5, called for the introduction of an occupational safety and health (OSH) management system. This chapter outlines the fundamental components of this OSH management system, which missions must take into account when implementing their mandates.

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[43] The International Labor Conference - 110th Session in June 2022

[44] https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_protect/@protrav/@safework/documents/publication/wcms_110478.pdf

[45] World Health Organization (WHO).The world health report 2000—health systems: improving performance. Geneva: WHO; 2000.

17.2. Policy and standards

Occupational safety and health policy is generally applicable to all duty stations and covered entities, including Headquarters, regional offices, United Nations Country Teams and missions. Policy is therefore developed in Headquarters and requires a wide-ranging consultation process.

OSH standards are technical requirements that specify how the workplace should deal with specific workplace hazards, for example working at heights, managing sharps, ergonomics or handling specific chemicals. These standards are often also developed as part of the duty station's national workplace safety programme; hence each country may have different standards. Where an applicable United Nations standard does not exist for a specific hazard or work activity, duty stations are expected to follow local requirements for managing the hazard or work activity in question. While the privileges and immunities of United Nations workplaces apply, this should not compromise safety. Where both a United Nations standard and a national standard exist, the requirements of the more stringent standard are to apply.

17.3. Role of affiliated safety bodies

The United Nations OSH management system is still in active development and many aspects of workplace safety are currently managed by other groups.

17.3.1. United Nations Department of Safety and Security

UNDSS focuses primarily on security matters, but until the OSH management system has sufficient capacity, DSS covers a number of significant safety matters, including fire safety and road safety. DSS staff may also conduct investigations and reviews of safety incidents where no other capacity exists.

17.3.2. Aviation safety

Aviation safety staff cover a specific technical sub-set of safety relating to aircraft and air travel.

Aviation safety incidents that lead to injuries or illnesses, or near misses, should still be reported via the OSH IRS to promote a holistic understanding of the overall OSH risk in missions.

17.3.3. Environmental safety staff

Environmental safety staff provide guidance and support within missions to implement an environmental strategy and within this, to assist missions to operate with minimal direct or ecosystem-related risk to people. Hazard identification and the risk management of environmental hazards sits with safety staff, while the wider operational aspects that lead to or mitigate the environmental hazards themselves is more likely to fall within the responsibility of environmental safety staff. Specific responsibilities for a particular situation must be determined at mission level in accordance with available capabilities and expertise.

Environmental safety incidents that lead to injuries or illnesses, or near misses, should still be reported via the OSH IRS to promote a holistic understanding of the overall OSH risk in missions.

17.3.4. Investigative staff (Board of Inquiry staff)

Staff in certain specific roles may be called upon to investigate particularly serious injuries, fatalities or major events. Teams formed to investigate safety incidents should routinely include Safety Officers with professional skills in safety matters and should include occupational health staff in the case of relevant medical factors (such as infectious disease, treatment given or access to care). Investigative staff should ensure that where safety or medical staff are not involved, the findings from Boards of Inquiry or Head of Mission (HoM) reports that have an OSH component are made available to OSH staff so that these findings can be reviewed for potential inclusion within the OSH risk register.

17.4. Employment and travel clearances

Fitness for work and fitness to travel are fundamental OSH concerns. Every mission is to ensure that personnel who are commencing work in a duty station, who change the nature of their tasks or who change duty stations are cleared via an appropriate employment clearance process.

Similarly, personnel who travel on official business should be cleared for travel when either the new location has significantly different local health risks, or if the travel itself has the potential to impact health. Further information on employment and travel clearances can be found in Chapter 16.

17.5. Sick leave and return-to-work management

Occupational health covers any matter where work affects health, or health affects work. Sick leave therefore has an occupational health component. This is the case particularly upon completion of sick leave, i.e. when personnel return to work. All clinicians certifying sick leave should consider whether a return-to-work plan would be beneficial to the staff member when their sick leave comes to an end. The return-to-work plan must be:

- recorded in the medical record.
- developed in conjunction with the staff member and made available to the supervisor in a way that ensures medical confidentiality.
- time-limited, and cover tasks, work duration and any other relevant factors.

In some cases, work restrictions are appropriate to maximize safety for the staff member or the workplace. From an OSH perspective restrictions must be:

- documented in the medical record and made available to the staff member and their supervisor, usually with a review date.
- limited to describing what the staff member may not do, for example: “may not lift more than 10 kg” or “may not stand for more than four hours in a workday”. They should not specify a particular way of working, for example, “must work remotely” or “must be given only low-stress tasks”. This type of advice is more appropriately presented as part of a workplace accommodation request.
- considered as medical requirements for employment. Neither the staff member nor the employer may waive them. If the restriction is incompatible with the essential nature of the staff member’s tasks, then the staff member is to continue on sick leave or be assessed for clearance to work.

17.6. Workplace risk assessments and ergonomics

A fundamental component of workplace safety is the regular inspection of workplaces and work activities to determine if hazards are present that should be assessed, rated and mitigated. Workplace risk assessments (WRAs) can be based on the presence of known hazards (such as chemicals, welding, grinding, machinery, forklifts, etc.), or

based on an indication from accident and incident reports where either near misses or accidents have occurred. A WRA can be conducted by supervisors, who know their workplaces best, by Safety Officers, or in some cases by clinical staff. Regardless of who conducts the WRA, the key requirements are the same and should identify:

- what the hazard is
- who could be harmed and how
- what the risk is (considering the probability of the risk occurring and the severity of the outcome)
- what measures can be put in place to address the risk.

The greater the risk, the more important it is that the mission have qualified Safety Officers to accurately assess it and develop an appropriate mitigation plan. It is common for mitigation plans to have their own individual risks, and Safety Officers are best placed to develop suitable mitigation plans that do not substitute one risk for another.

A specific type of WRA often assigned to occupational health staff relates to ergonomics. While ergonomics is usually used to describe desk, chair and display unit set-up, it can cover any interaction between workers and the tools and equipment they use. Ergonomic assessments should be routinely recorded in EarthMed.

17.7. Incident reporting

To comply with the requirements of ST/SGB/2018/5 **all incidents that have caused illness or injury, or that have the potential to cause illness or injury, are to be reported**. This enables the Organization to proactively identify and prevent exposure to workplace hazards.. Incidents must be reported as soon as practical and can be signalled in several ways, as outlined below.

- CMOs are to ensure all United Nations clinical staff who record any illness or injury with a diagnosis in EarthMed also assess on a preliminary basis if the injury or illness is likely to be related to work or not. The creation of a diagnosis may be linked to clinical consultation, sick leave, MEDEVAC, repatriation or

disability submissions. A positive finding of “work-related” will trigger an incident report.

- T/PCC medical facility staff who do not have access to the EarthMed OSH system are strongly encouraged to report incidents to their Force Safety Officer, the mission (United Nations) Safety Officer, a United Nations clinic or a contingent or mission safety focal point. These personnel will then ensure the incident is recorded in the OSH IRS.
- Staff members including supervisors and managers who witness or are made aware of incidents in their workspaces or amongst their team members can report incidents directly into the OSH IRS by submitting an incident report via the EarthMed Portal, medical.un.org, or via the QR code in Figure X.
- Safety Officers or safety focal points may submit incident reports based on workplace risk assessments, workplace safety inspections or information gained in any other way through the normal course of their work, such as by email or phone call. Safety Officers may also create incident reports based on other investigations such as Boards of Inquiry or HoM reports.
- Compensation staff may create incident reports following compensation claims.
- Notification of Casualty (NOTICAS) reports also automatically trigger incident reports, and further automated interfaces may be developed to trigger incident reports (such as with security, transport or other systems).

Note that multiple reports of the same incident will be grouped together as part of the Safety Officer’s review process. These incidents link securely and confidentially to health records to better improve an understanding of the cost of the outcomes (for example in days lost, medical evacuations, etc.).

Figure X: QR code to submit an incident report

17.8. Incident report processing

All incident reports are reviewed by a Safety Officer or OSH Officer who has access to the safety module of EarthMed. The report will be reviewed and investigated (if required), classified and rated according to risk. A suitable mitigation plan will be developed and then followed up to assess if the overall risk has been reduced. Where risk is significant and cannot be reduced it will be passed to the mission OSH Committee for further action.

Where a mission does not have a qualified Safety Officer the reports will be reviewed as an interim measure by United Nations Global Service Centre, classified and a basic risk mitigation plan developed.

17.9. Responsibilities of mission personnel in OSH management

17.9.1. Senior management

Senior managers are responsible for supporting a safe workplace culture and ensuring there are OSH personnel and systems to meet the requirements of Staff Rule 1.2(c).

17.9.2. OSH Committee

OSH committees are the primary means by which workplace health and safety matters can be raised and discussed with the participation of staff, managers and technical representatives. An effective OSH committee is one of the requirements outlined in the DOS/DPO/DPPA Standard Operating Procedure (SOP) on Safety Risk Management.

17.9.3. Safety Officer / OSH Officer

All missions require access to a qualified Safety Officer or OSH Officer to meet the minimum requirements for an occupational safety capability. Safety focal points with

limited technical backgrounds can act as liaison and assist with communications and incident reporting, but in most cases they are not qualified to develop risk mitigation plans. The Force Safety Officer (if present) or the mission Safety Officer are required to be technical representatives on safety for the mission OSH Committee. When recruiting safety staff, missions must confirm requirements and suitability of job openings with UNHQ so that there is consistency in qualifications, skills, experience and approach with regard to workplace safety across all missions.

17.9.4. Medical staff

Medical staff are responsible for assessing injuries and illnesses and providing guidance on causation concerning work-related exposures. In general, however, medical staff are not qualified to develop safe mitigation plans for non-medical hazards, which requires the skills of Safety Officers. The Force Medical Officer (FMO) and CMO are required to be technical representatives on health for the mission OSH Committee.

17.10. Responsibilities of OSH support entities

17.10.1. United Nations Global Service Center (UNGSC)

UNGSC OSH staff provide safety, engineering and training support to missions. Where a mission does not have a qualified Safety Officer, incident reports from that mission will be reviewed by safety staff at UNGSC. The incident will be classified and a basic risk mitigation plan developed. Further action consistent with a full review, including verification that the incident has been effectively addressed and the assignment of post mitigation risk ratings, will only occur for significant incidents or severe outcomes.

For specific significant hazards, UNGSC may conduct an OSH Assistance Mission to the duty station to provide detailed technical assessment, advice, and communications.

17.10.2. DHMOSH

DHMOSH OSH section is available to provide guidance and support on any aspect of occupational safety and health listed in this chapter (via osh@un.org). Occupational safety and health matters are delegated to the field and DHMOSH does not process

incident reports for missions, though missions may escalate selected incidents for opinion and guidance.

DHMOSH retains overall responsibility for establishing an overarching OSH management system, including:

- Policy and standards
- Incident reporting system infrastructure
- An organizational risk register based on incident data
- Oversight of system-wide risk mitigation plans for significant or global workplace risks
- Capacity-building including staffing profiles and OSH training
- Reporting to senior management, and assistance with development of mission specific reports
- Monitoring and evaluation, including an annual compliance exercise with the core competencies outlined in the DOS/DPO/DPPA SOP.

17.11. Reporting requirements

There are two elements to reporting from missions:

- Through the incident reporting system, based on individual incidents and drawn from data collected through the incident reporting system. This is centrally managed via dashboards (which will also be made available to missions).
- The annual core compliance exercise which assesses the mission's OSH management system.

17.12. Key messages

The key elements of an effective OSH management system in missions are:

- *Having at least one qualified Safety Officer.* Occupational health staff provide only a partial capability. Safety focal points, even with United Nations-sponsored training, are not safety professionals and their role may be limited to communication plans and liaison with support services.

- *Ensuring all capacity-building is done in partnership with UNHQ.* The United Nations OSH system is developing, and therefore both the recruitment of staff with a safety/OSH role and the conduct of safety/OSH training must always be coordinated with UNHQ.
- *Holding regular OSH Committee meetings attended by senior representatives of management, staff unions and technical groups.* The OSH Committee raises and reviews issues and passes these on to senior management for action.
- *Actively creating a culture where all OSH incidents are reported.* The widespread use of the incident reporting system for every near miss, dangerous occurrence, accident, injury and illness is critical to creating an evidence base relating to workplace safety and health, and is the best indicator of the mission's commitment to safe work.

Security relates to undesirable events or malicious acts deliberately caused by a motivated human antagonist. Safety relates to undesirable events that are non-deliberate, i.e., exposure to workplace hazards, accidents and acts of nature in the workplace.

The cause of deliberate events is a "threat", while the cause of non-deliberate events is a "hazard". As such, the concept of "security" covers threats, and the concept of "safety" covers hazards.

Chapter 18: Compensation Claims

Compensation for death and disability of uniformed personnel (Compensation Claims)

18.1. Introduction

In accordance with General Assembly resolutions,[46] the United Nations provides compensation for the death and disability of uniformed personnel deployed to United Nations peace operations. As a result, **all** claims can be submitted even after the related missions have closed.

18.2. Definitions of key terms

Terms	Definitions
Criteria to qualify for compensation.	The general criteria used to determine eligibility for compensation in case of death or disability of uniformed personnel are described below: a. The death, injury or illness must have a causal link to service in the mission. b. The death, injury or illness must not be the result of gross negligence or wilful misconduct on the part of the uniformed personnel. c. Upon receipt of a claim from a T/PCC, the Uniformed Capabilities Support Division (UCSD) requests a Notification of Casualty (NOTICAS) confirmation from the field mission, ascertaining the facts regarding (a) and (b). d. The death, injury or illness must not be due to a pre-existing medical condition or complication.

[46] General Assembly resolutions governing the existing death and disability framework include A/RES/51/218E, A/RES/52/177, A/RES/64/269, A/RES/72/285, A/RES/76/274 and recalled resolutions A/RES/51/218E and A/RES/52/177.

Disallowed items/claims	In all cases where there is no clear evidence of a causal link, sympathetic consideration will be given to the details of the claim.[47] In accordance with the foregoing principles, the United Nations will not normally pay compensation for death or disability of uniformed personnel when such death or disability results from pre-existing medical conditions, suicide or wilful intent to bring about death, injury or illness to the uniformed personnel in question or another. Where the circumstances of a death, injury or illness are not clearly determined or where further questions arise, claims may be referred to the Office of Legal Affairs for advice.[48]
Submission procedure for Notification of Casualty[49]	Each case of injury or death is to be reported immediately to the United Nations Operations and Crisis Centre (UNOCC) in the form of a NOTICAS. This information will be used for consideration of any subsequent claims.
Medical confidentiality[50]	Medical information is to be treated as confidential and privileged. Confidentiality must be always maintained. Neither medical records nor information shall be released without proper authorization. Under no circumstances should information be provided to anyone not directly involved in the patient's care. Exceptions may be made in the event of a formal investigation or Board of Inquiry, where there is an instruction from a relevant authority to release such

[47] A/RES/61/276 "Administrative and budgetary aspects of the financing of the United Nations peacekeeping operations: cross-cutting issues," sect. X, para. 9(f).

[48] ST/SGB/2018/1, Appendix D "Rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations".

[49] See Annex 3.15 "SOP on Notification of Casualties (NOTICAS) in Peacekeeping Operations and Special Political Missions" (2017).

[50] See Chapter 13 "Medical Records Keeping/Medical Reporting Tools" in the Healthcare Management Module of the 2024 version of this manual.

	information. In this regard, in the preparation of NOTICAS, it is important to ensure that an individual's right to medical confidentiality is balanced with the Organization's needs and purposes. To achieve this, the NOTICAS should not include specific details pertaining to an individual's medical diagnosis, underlying medical condition(s) or any medical records. Care must be taken to ensure confidentiality in the transfer of patient medical records, the submission of reports and other routine administrative processes (e.g., compiling and submitting disbursement vouchers for medical expenses). Reports sent via United Nations pouch or the postal services should be properly sealed and marked with the instruction "to be opened by addressee only". In case of disability claims a document signed by the patient exempting the relevant doctors from medical confidentiality should be obtained.
Timeframe for submission and settlement of claims	The General Assembly has not placed any time limits on Member States submitting death and disability claims to the United Nations. In A/RES/52/177, the General Assembly requested that the Secretary-General settle death and disability claims as soon as possible but not later than three months from the date of submission of a claim. The Secretariat endeavours to settle claims received from Member States as expeditiously as possible and within 90 days of the date of receipt of all relevant documentation.

18.3. Role of DHMOSH and UCSD

Permanent Missions (PMs) to the United Nations submit death and disability claims to UCSD[51] of DOS. UCSD liaises with DHMOSH, field missions, PMs and other relevant stakeholders, certifies the claims and processes the disbursement of compensation.

Disability is compensated according to the percentage of the maximum GA-authorized amount in US dollars corresponding to the degree of permanent loss of function (PLF) upon completion of all treatment and where maximum medical improvement is achieved. The percentage of PLF is determined by DHMOSH according to the latest edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment.*[52]

18.4. Reporting requirements for Member States when submitting documentation in support of death and disability claims [53]

The claim should be submitted in the format provided in the "Claim for death or disability of members of national military contingents sustained in the service of United Nations peacekeeping operations" (A/52/369 Annex IV), along with a copy of the NOTICAS form (see Annex 3.15 of this manual).

Type of claim	Required support documentation
Death claims	a. A copy of the death certificate b. A copy of the autopsy report, if available c. A copy of the pre-deployment medical examination (MS.2 form)

[51] UCSD serves as a single point of contact for T/PCCs on all administrative and logistical issues related to force generation, memorandums of understanding, contingent-owned equipment and reimbursement.

[52] See https://ama-guides.ama-assn.org/

[53] See A/63/550 "Comprehensive review of the compensation of death and disability benefits to military contingents, formed police units, military observers and civilian police: report of the Secretary-General".

	d. A copy of the medical records to determine if there were any pre-existing medical conditions e. Medical reports from treating facility/physician f. Supporting documents for medical expenses claimed, if any g. A copy of invoices for funeral expenses.
Disability claims	a. Recent medical reports from the treating doctors indicating the diagnosis, treatment provided and the determination that maximum medical improvement has been achieved and no further treatment is expected or possible. b. Any medical reports associated with the injury/illness, including but not limited to X-rays, CT scans, pathology reports, MRI, etc. c. A copy of the pre-deployment medical examination d. A copy of the medical records to determine if there were any pre-existing medical conditions e. Supporting documentation for medical expenses claimed, if any The list of medical records/report listed above is not exhaustive and depends on the nature of injury/illness sustained.

18.5. Key messages

- The United Nations provides compensation for the death and disability of uniformed personnel deployed to United Nations peace operations.
- The General Assembly has not placed any time limits for Member States to submit death and disability claims to the United Nations.

- PMs to the United Nations submit death and disability claims to the UCSD of DOS on behalf of the claimant.
- The Secretariat endeavours to settle claims received from Member States as expeditiously as possible and within 90 days from the date of receipt of all relevant documentation.

Chapter 19: Cooperation with Investigative Bodies

19.1. Introduction

The release of confidential information to duly authorized investigative or review bodies including Boards of Inquiry is intended to support optimal quality of operations, effective personnel management, and to identify and address workplace risks as part of the Organization's general duty of care. Medical personnel are to support these bodies as much as possible through guidance and assistance, and where appropriate provide information in a way that avoids unnecessary medical terminology or jargon and contributes to an effective investigation process.

19.2. Definitions of key terms

Terms	Definitions
Confidential Medical Information (also referred to as "Protected Health Information")	Individual medical histories, test or laboratory results, physical or mental health conditions and diagnoses or other information related to interaction with health service providers.
Medical record	The electronic or hard copy medical file where all aspects of clinical care and medical administrative advice or determinations are recorded. This includes notes by clinical staff, referrals, medical documents submitted by the patient, laboratory and radiology results, etc., as well as determinations or recommendations on medical administrative matters.

19.3. Release of confidential medical information to investigative bodies

To balance the needs of investigative bodies with the data privacy rights of patients, the following applies:

The mandate/terms of reference of the requesting body must be reviewed by the releasing medical provider prior to the release of records to ensure:

- The body is authorized to be provided with medical information.

- There is alignment between the information requested or questions asked and the body's mandate.
- The medical record contains documentation that reflects the circumstances for which medical information was requested.

Where medical records form a substantive part of the deliberations, the investigative body should include a medical professional with the competencies to review them. If the medical professional is not a staff member already subject to the United Nations Medical Director's requirements regarding medical confidentiality, they shall be required to sign an appropriate confidentiality agreement. This agreement should be seen by the releasing provider prior to release of any records.

Where the investigative body does not have a medical professional, or for a Tribunal, the information released should be in the form of answers to questions or relevant summaries, not the record itself. Clinical records may not be released without the express consent of the patient (or next of kin, as appropriate).

In accordance with confidentiality requirements and the principles of fairness and due process, the information or records released must be limited to those portions of the record directly relevant to the terms of reference or mandate.

The information or records requested should be provided in a format and within the time frame requested by the requesting body unless it is unreasonable to do so.

The release must be recorded as a clinical note in EarthMed.

The patient may ask to know what information was released and the body to which it was released. The terms of reference or mandate of the requesting body are not to be shared.

19.4. Key messages

Every individual's right to medical confidentiality is balanced with the Organization's needs and purposes, while ensuring effective cooperation with investigative bodies.

List of contacts in DHMOSH

Entity	E-mail
DOS-Medical Director	medicaldirector@un.org
Headquarters Medical Clinic	unhqclinic@un.org
Clinical Governance Section	clinicalgovernance@un.org
Public Health Section	dos-dhmosh-public-health@un.org
UNMERT	unmert@un.org
Workforce Management Section	medicalworkforcemanagement@un.org