

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES
EVALUATION AND POLICY ANALYSIS UNIT



Evaluation of the UNHCR Medical Service

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EPAU/2004/08
August 2004

Evaluation and Policy Analysis Unit

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Introduction and methodology

The Evaluation and Policy Analysis Unit (EPAU) conducted a standard evaluation of the UNHCR Medical Service of the United Nations Joint Medical Service between November 2003 and May 2004. This evaluation has been conducted on behalf of the EPAU by Anton Verwey and Roger Vivarié (MD), assisted in part by Philippe Hug (on “pro-bono” basis) and Melvyn Pinto.

Terms of Reference

The Terms of Reference (TOR) of the Evaluation and Policy Analysis Unit for this evaluation were to:

- Assess whether and how effectively the JMS is carrying out its functions as these are set forth in its current Terms of Reference, including highlighting any discrepancies between these formal Terms of Reference and actual practice;
- Assess whether and how effectively relevant policies, guidelines, parameters and best practices are being applied in the management and administration of the Service.

Methodology

The evaluation started out with documentation reviews, including UN documents, records of meetings, mission reports, biennial confidential activity reports to the Joint Medical Service which track sick leave, morbidity, disability and mortality patterns amongst the staff of each member organization over a period of ten years or so. The evaluation conducted focus group discussions, structured and unstructured interviews of the Head and staff of the UNHCR Medical Service and other relevant internal as well as external interlocutors, in particular those who directly relate to, depend upon or are otherwise impacted by the Service’s activities.

The evaluation team also administered a specially developed questionnaire to all C, D, E, U and M duty stations / locations with a view to assessing how adequate are the current availability of services and the back-up plans. Finally the team assessed the need for and appropriateness of any medical interventions carried out by the Service.

Upon completion of its on-site work the team briefed the Head of the UNHCR Medical Service on its findings. Prior to finalizing the evaluation report, EPAU provided it in draft to the Inspector General, the Head of the UNHCR Medical Service and the Director of Human Resources Management for any comments or clarifications they wished to make. Such comments have been taken into account.

Executive summary

The evaluation has produced four key conclusions, which are substantiated in the body of this report:

- UNHCR has de facto established its own Medical Service since the mid-1990s and should now draw the administrative conclusions therefrom, fully incorporating the UNHCR Medical Service;
- As the vast majority of UNHCR staff serve in C, D, E, U and M duty stations, that is where the major focus of the UNHCR Medical Service should be, more than it has been until now;
- The preceding paragraph is not so much a criticism of the UNHCR Medical Service, as it is a call for some extra personnel (one medical doctor, one nurse, one medical secretary) who can be dedicated to prevention and health training in the field; this is cost effective, as failing to care for staff in the remotest duty stations is costly;
- Staff at HQs is disproportionately more on sick leave and the underlying reasons thereof need to be addressed.

UNHCR repeats over and over that its staff is its biggest asset. Maintaining the health of UNHCR staff in remote locations where medical services are limited or even completely absent therefore should be a top priority of the Office as a whole.

Within the context of very considerable organizational growth and persistent general human resource and budgetary restrictions, this concept has evolved from a service of a nurse only, to a service with a doctor, nurse and secretary, to the current staff of twelve (ten and a half if considering half time employment), comprising two doctors, two and a half nurses, three laboratory technicians, three (medical) secretaries and one administrative assistant.

Yet the top priority of maintaining the health of UNHCR staff in remote locations where medical services are limited or absent, is not as comprehensively addressed as it should be. With the regularization of all of the above staff as UNHCR staff members and the addition of one extra doctor, nurse, medical secretary and corresponding budget revision, the UNHCR Medical Service should be able to focus continuously the minimum required attention on building up and maintaining “minimum operational medical standards” (MOMS).

These MOMS would consist of a composite system of agreements and logistical arrangements to provide an essential level of care for staff in the remotest, most deprived duty stations, as well as other identified high risk duty stations. This will require to the extent possible the use of medical resources existing in the field, to be identified through answers by offices in the field to specific questions, be it in the context of the annual programme review, or in the follow-up to the questionnaires used for this evaluation. In addition ongoing systematic missions to the field must be

undertaken to periodically review available services and existing arrangements, and to explore the possibilities for cooperation and cost-sharing with in particular UNICEF and WFP who also have a major presence in the field. In some situations UNSRSG/DPKO medical services may be an option.

The results from the analysis of the questionnaire administered to all C, D, E, U and M duty stations clearly demonstrate that this is a long overdue issue that needs to be given immediate attention by the UNHCR Medical Service, as well as the additional resources required to accomplish this goal. The UNHCR Medical Service should, with PCOS and Budget Section support, develop its proposals for inclusion in the ORB sessions of May 2004, and if not feasible, soonest thereafter.

In this context health should not just be defined as the absence of illness, but rather as maintaining the best possible physical and psychological condition that allows for a high level of judicious productivity.

Standards would both be purely medical and go somewhat beyond to assist staff in maintaining their level of fitness, intellectual alertness, a proper work – personal life balance . Tools to be developed and deployed would be a “standard health kit”, generalized First Aid training, local exercise or sport options, and also various rest and recuperation schemes beyond annual leave as already in existence.

Recommendations

The specific recommendations resulting from this evaluation are found throughout the text of this report and presented here for the ease of the reader.

- 1) A future platform for inter-agency cooperation and exchange of information needs to be created to ensure appropriate harmonization of medical standards between the services of the different organizations. This platform should ensure harmonized interpretation and action on “binding” instructions received from New York, as well as being a Geneva partner for New York on staff medical issues. The change of function should be reflected in a name change from Joint Medical Service to Inter-Agency Consultative Group on Staff Health, or some title to that effect.
- 2) Harmonization of staff insurance policies resulting in a single staff insurance programme at the Geneva duty station (larger risk pool, centralized IT applications and economies of scale) and the establishment of a UNOG Advisory Board on Compensation Claims, containing increasing health-care costs as well as the safeguarding independent medical authority of the medical services through peer reviews of medical decisions by sister services should also be among the tasks of the Inter-Agency Consultative Group on Staff Health.
- 3) UNHCR should assume full control of its medical Service by fully integrating the Service and renaming it the UNHCR Medical Service. This entails the creation of the required posts and operational budget and placing the UNHCR Medical Service on the organigram with a direct reporting line to the Director of Human Resources Management personally, as a formal guarantee of its medical professional independence.

- 4) The UNHCR Medical Service should actively explore ways to reinforce its cooperation with the respective medical services of WFP and UNICEF, in particular in the field, as these agencies frequently operate in the same theatres as UNHCR and coordinated, if not consolidated, medical arrangements in such theatres reinforce harmonized practices, efficiency and cost-sharing.
- 5) To carry out the functions required from the UNHCR Medical Service and to manage the Service itself, the current number of medical staff is insufficient. This leads to a more reactive approach to the work than considered desirable in the interest of staff health and containing health costs. The Head of the Medical Service is supposed to play a central and deciding role in advising the highest levels within UNHCR with regard to specific medical cases and to supervise implementation of health policies and practices in order to maintain an optimally efficient workforce in often trying circumstances. At a minimum, one more full-time medical doctor, another full-time nurse and another medical secretary are required. Proper job descriptions must be established and the posts graded accordingly, giving due recognition to the volume and impact of decisions required from in particular the senior personnel in the Medical Service.
- 6) A general communication to all staff should be sent out informing Geneva based staff that they should - in principle - consult local medical services for any medical attention they might possibly need, as no doubt many are already doing. Exceptions are obvious for Geneva based staff departing for or returning from missions to the field and staff based in the field on mission in Geneva. The UNHCR Medical Service should maintain a limited list of interventions / standard clinical functions that it shall perform for staff based in Geneva. This list needs to be communicated to the staff.

A "walk-in" clinic should be maintained for non-Geneva based staff visiting Headquarters.

In the reception procedure of the UNHCR Medical Service, an experienced nurse may screen patients for referral of only the more demanding cases to either of the medical doctors and to answer routine questions and execute routine minor medical interventions, whether or not followed by an examination by a medical doctor of the UNHCR Medical Service or a referral to local medical services.

- 7) UNHCR must establish office and housing standards and give a copy of them to all staff members on post outside their home country. Office and housing standards include the physical environment: adequate light, safe structures, acceptable noise levels, adequate furniture, functioning communications equipment, a decent bed, a regular clean water supply, predictable electricity, a sufficiently diversified diet, refrigerator, adequate and clean sanitary and washing facilities.
- 8) The UNHCR Medical Service needs to serve still better and more systematically UNHCR staff in the field, in particular C, D, E U and M duty stations. Coordination with the Regional Bureaux needs to be more formally established, in particular with regard to periodic regular missions and crisis and special missions, in response to emergency situations.

- 9) Cooperation between the UNHCR Medical Service, respective Bureaux and EPRS should be intensified, associating medical staff with emergency contingency planning meetings and initial needs assessment missions to new areas, to assess medical risks and options, to prepare medical briefings and educational materials. The anticipated impact of such measures is expected to outweigh by far the related costs.
- 10) The UNHCR Medical Service's management of medical records should be made part of the Management System Renewal Project / People Soft system that is being set up in DHRM, while providing data security for the portions of information relating to medical information and precluding Medical Service staff from having access to personnel data that doesn't concern them. The UNHCR Medical Service should soonest define its data and functional requirements and submit a formal request to the Deputy High Commissioner for inclusion of its data processing needs in the People Soft / MSRP process.
- 11) Within the context of the establishment of the UNHCR Medical Service, by 01 July 2004, new Terms of Reference (TOR) for the UNHCR Medical Service are required. They must properly reflect the new structure and vastly evolved roles. A draft text has been prepared by the UNHCR Medical Service and should be reviewed, amended as appropriate and adopted for implementation by 01 July 2004.
- 12) Individual staff members at HQs have between 2000 and 2003 been between 3.47 and 4.09 times more on sick leave than UNHCR staff in the field. The investigation of the reasons for this phenomenon and the relationship with comparator data of other Geneva based organizations needs to be independently studied by a team of medical experts and their report shared with the staff at large.
- 13) Individual staff female members have between 2000 and 2003 been between 1.63 and 2.8 times more on sick leave than male UNHCR staff members. The study of the reasons for this phenomenon and the relationship with comparator data of other Geneva based organizations needs to be independently examined by a team of medical experts and their report shared with the staff at large.
- 14) The field activities of the medical service should be much more structured and carried out very systematically. The field visits should be planned in advance on a two years cycle, with an average of 4 to 6 per year according to criteria of priority approved by the Senior Management.
- 15) UNHCR Medical Service should develop UNHCR Medical Service Field Conditions Database and receive the required IT assistance to do so. The database should be updated on an annual basis as part of the Country Operations Plan and Operational Review process. With the regular inputs from Field Offices, the Regional Bureaux and the UNHCR Medical Service should target their attention and resources to the most critical situations and improve the balance between a curative and a preventive modus operandi.
- 16) A more detailed review of the performance of local medical facilities and their categorization needs to be undertaken, in particular in the aforementioned more isolated duty stations. Such more detailed information would permit the

definition of a health programme for staff adapted to each duty station. Given the volume of work involved, and the need for consistency of standards applied, this may initially be undertaken in the form of a “special project” with qualified consultants.

- 17) Identification of a suitable UN physician in duty stations where there is no UN physician should be undertaken as competent and committed UN physicians will be critical in assisting UN staff with health issues and UNHCR Field Offices with the assessment of the locally available medical services. They may also play a crucial support role in cases of medical evacuations.
- 18) The quality of services, as well as types of services offered by the various UN-Dispensaries needs be reviewed systematically, in cooperation with UNDP and the Director of Medical Services in New York. This activity could possibly be combined with implementation of Recommendations 16 and 17.
- 19) As 42% of offices in C, D and E duty stations seem to operate without a plan for local management of health emergencies the systematic establishment of such plans, and their annual updating, should be initiated as part of the submission of the annual Country Operations Plan, as a matter of highest priority. It is furthermore recommended that hand-over notes prepared by a Head of Office and an Administrative Officer for their respective successors should include a paragraph or more on the current status of the plan for local management of health emergencies. Incoming Heads of Office and Administrative Officers should within the first month after their arrival in a duty station have made familiarization visits to the principal local medical health care facilities. Instructions to that effect must be issued.
- 20) Guidelines on Health Hazards, including malaria, HIV/AIDS, hepatitis, intestinal infections, STD's, eye infections and skin disorders should be made more widely available, not least to local staff and where appropriate in the local language. Other UN or international programmes may be sources for such materials. Such guidelines need to be complemented with periodic awareness training for all working regularly at UNHCR premises, as further steps in the prevention and treatment of highly communicable diseases.
- 21) The UNHCR Medical Service in Geneva maintains up-to-date records of vaccinations, in respect of all staff. However the degree to which this can be accomplished depends on individual staff members sending photocopies of the relevant pages of their vaccination certificates to the UNHCR Medical Service. All Heads of Office and Administrative Officers are urged to remind staff members of their responsibility in this regard. Offices in C, D and E duty stations should keep locally safe vaccination stocks and syringes.
- 22) The UNHCR Medical Service should undertake systematic briefings of security advisers on their new responsibilities as custodians of PET supplies.
- 23) All security incidents must be reported to the UNHCR Medical Service, as service incurred health implications must be recorded in the staff member's dossier and for follow up with the compensation claims committee where necessary.

- 24) General HIV/AIDS prevention and awareness activities and the provision of PET kits as well as information about their use and location should be stepped up to cover all duty stations.
- 25) The development and maintenance of Medical Evacuation Plans should be extended to all Offices in C, D, E, M and U categories. This includes a back up system to cover for situations of absence of the Head of Office and standing arrangements for stabilization of patients and stretcher transport to the airport. The Medical Service should file annual compliance reports in respect of these and Heads of Office be held accountable therefore.
- 26) The UNHCR Medical Service and the Staff Development Section should develop a plan to have all international and national professional staff working in the C, D and E duty stations, whether assigned there or just on mission, complete a basic first aid training course by end 2006, and to have them attend refresher courses thereafter regularly. Certified completion of first aid training and regular refresher courses need to become obligatory for all international and national professional staff working in the C, D and E duty stations, whether assigned there or just on mission.
- 27) Availability of complete and up-to-date First Aid Kits in all UNHCR offices and all UNHCR vehicles is a basic requirement that should be paired with regular First Aid Training. This basic requirement should be extended to all Offices. The Medical Service should file annual compliance reports in respect of kits and training and Heads of Office held accountable therefore.
- 28) The UNHCR Medical Service should complete its work started on MOMS (minimal operational medical standards) and be reinforced to enable it to roll the MOMS out to the field, giving priority attention to the remotest, most deprived duty stations, as well as other identified high risk duty stations.
- 29) Full incorporation of the UNHCR Medical Service staff into UNHCR, as recommended in Recommendation 3 will require the medical Service posts to be classified and included into the CMS - PAR system.
- 30) A regular ABOD needs to be established for the UNHCR Medical Service. Heads of the offices in the field should be instructed to submit as part of their own responsibilities their office's need for medical services for staff, including training. Such needs should henceforth be presented annually in a dedicated segment of the Country Operations Plan.

Part 1. General management

History: institutional structures and evolution

Mandate

1. The Joint Medical Service was established in 1968. Its basic mandate was then, and still is, to advise UN member organizations¹ on medico-administrative issues, provide preventive medical care, as well as health promotion and education services to the staff of the organizations. The JMS is managed by WHO.
2. The JMS mandate is performed through the following principal functions:
 - Medico-administrative functions²
 - Clinical functions³
 - Health promotion and education⁴

Coverage

3. The geographical scope of JMS is essentially Geneva, except for UNV and UNFCC in Bonn and supervises the provision of drugs to some 50 UN dispensaries in the field. Additionally, the administrative workload of JMS includes clearance of medical reports from field-based examining UN physicians.
4. A major flaw in the 1968 Agreement establishing JMS is that it does not specifically provide for JMS medical support for the field staff of its member organizations. By 31 October 2003, in UNHCR the aggregate field staff outnumber Geneva-based staff by a factor of 62.53% for C,D, E, U and M duty stations against 17.45 % for H and a combined 19.96% for A and B duty stations. In addition the service has some responsibilities for 8,860 dependents in C, D, E, U and M duty stations and 3,287 dependents in H, A and B duty stations.

¹ UNOG, WHO, UNHCR, ILO, ITU, WIPO, WMO, UNV (Bonn), ITC, UNICEF (Geneva Office), UNAIDS, as well as WTO which is not part of the UN system.

² - Medical examinations and clearance of staff at various stages of their period of service with the organizations; administration of sick leave and staff benefits programme under the Pension Fund, compensation and health insurance schemes of the organizations; provision of advice on work environments, staff medical fitness, and health-related field issues such as evacuations, or state of local medical facilities.

³ Consultations on a wide spectrum of occupational health problems, such as emergency care, confidential medical counselling or inoculations and laboratory tests; medical briefings and debriefings of staff before and after field missions; support to field UN dispensaries by way of provision of drugs and assessment of field medical facilities.

⁴ Promotion of the application of guidelines on a healthy work environment; dissemination of information through brochures and other means on necessary preventive measures regarding various diseases and health hazards (HIV-AIDS, smoking, substance abuse .); special health promotion and inoculation campaigns.

Internal factors pushing for quality service

Creation of JMS / UNHCR Medical Service

5. From the early 1990s UNHCR - multiplying presences in difficult and very remote field locations - has had to respond more often to situations placing its staff frequently in acute danger and. In particular in these locations sub-standard living and working conditions are often the rule. Staff members still are rarely afforded or take time to make adequate preparations prior to taking up duty. Briefings, training and guidance, logistical support and safety equipment remain scanty as staff at HQs and in the field are under considerable pressure and still have little practical knowledge of the consequences of acute stress and protracted stress and social isolation on performance and personal health.

6. The JMS/UNHCR Medical Service drew the attention of the then High Commissioner to the fact that a failure to properly manage cumulative and critical incident stress did lead to debilitating, potentially disabling, and sometimes life-threatening conditions. Apart from the human dimensions of ignoring these effects, UNHCR's liabilities could become potentially a disproportionate burden on UNHCR. Growing awareness among staff of the personal situations of an increasing number of staff members provided the impetus for the creation of the JMS UNHCR Service and the Staff Welfare Section by 1994. Previously the Staff Counsellor had primarily focussed on HQs. Since 1994 the latter section - with its field based colleagues and through field missions - increasingly provides a range of services designed to help staff members in the field through social, psychological and personal problems that may interfere with their capacity to function. Such support may include staff members' families, as well as retired staff. A close cooperation between UNHCR Medical Service and the Staff Welfare Section, each with its specific responsibilities, has become and should remain the norm.

External factors pushing for coordination and cost-sharing

7. The Joint Medical Service was established in 1968. Its underlying rationale of cost-effectiveness remains a core concern, as evidenced by the managerial principles of Secretary General's reform plans introduced some 7 years ago, which remain relevant.

Plan of Action for Geneva common services: 2000-2010

8. The JIU Report "Plan of action for Geneva common services: 2000-2010" was designed to become a tool in this regard. Part I of this report subtitled "Overview of administrative cooperation and coordination" was a cross-sectional analysis of broad policy and organizational issues of administrative cooperation. Part II is a case-by-case review of five common services (ICC, JMS, TES, DPS, JPS) at the Geneva duty station.

9. The JIU's Part II, RECOMMENDATION 2⁵ concerned the Joint Medical Service. It suggests reorganizing the present JMS structure into four Services, and reinforcing full and effective oversight by a more structured management committee, WHO providing only administrative support. The JIU suggested additional measures to enhance the independence of the JMS in relation to the management of its member organizations.

10. The JIU furthermore suggested that the staff insurance policies and rules of JMS member organizations should in the short term be harmonized to ensure equality of treatment and entitlements for all staff members in keeping with the spirit and letter of the common system. This should in second instance result in a single staff insurance programme at the Geneva duty station in order to maximize the benefits of a larger risk pool, centralized IT applications and economies of scale. The latter should bring about the establishment of a UNOG Advisory Board on Compensation Claims independent of UN Headquarters and the recognition of the independent medical authority of JMS.

11. Finally the JIU suggested that the Geneva UN system community should develop a bold and long-term vision for JMS in the light of increasing health-care costs to the organizations and staff, and in order to strengthen considerably JMS medical support for the field-based staff of its members.

Transformation of the Joint Medical Service

JMS crisis and creation of agency Medical Services

12. The slumbering crisis in the JMS deteriorated over the years as participating agencies became increasingly critical of the lack of added value provided by the system and the lack accountability of the service, leaving agencies guessing whether they obtained what they paid for. Medical issues had become of secondary importance. By December 2000 a working group was set up to examine how the JMS should be restructured. By March 2001 its proposals were tabled, but were

⁵ The JIU's Part II, Recommendation 2 concerned the Joint Medical Service. (a) The possibility should be considered of reorganizing the present JMS structure into four Services together with a more appropriate grading of the posts of physicians in the four Services, as proposed in paragraph 43; (b) JMS needs a more structured management committee similar to that of ICC and including the chiefs of staff insurance schemes and staff representative bodies at Geneva, and necessary measures should be taken to enhance the independence of JMS in relation to the management of its member organizations, and ensure its full and effective oversight by the proposed management committee, with WHO providing only administrative support as may be agreed by the committee; (c) The staff insurance policies and rules of JMS member organizations should be harmonized to ensure equality of treatment and entitlements for all staff members in keeping with the spirit and letter of the common system; subsequently, the organizations should aim to create, like the New York based organizations, a single staff insurance programme at the Geneva duty station in order to maximize the benefits of a larger risk pool, centralized IT applications and economies of scale; (d) In the context of the decentralization process under way in the Serviceed Nations, UNOG should be enabled to have its own Advisory Board on Compensation Claims independent of UN Headquarters; the independent medical authority of JMS should be fully recognized; (e) The Geneva UN system commServicey should develop a bold and long-term vision for JMS as outlined in paragraphs 68-70 in the light of increasing health-care costs to the organizations and staff, and in order to strengthen considerably JMS medical support for the field-based staff of its members. In so doing, lessons should be drawn from the WIPO Medical Service which in turn should reintegrate a reformed and strengthened JMS, particularly in the light of the aforementioned UN General Assembly resolution 54/255 of 4 May 2000.

considered insufficient. By November 2001 a "Joint Medical Service Management Committee" was established with the mandate of defining the role and functions of the "new" JMS, and the relationship between the JMS and the participating agencies.

13. Discussions of the "Joint Medical Service Management Committee" have towards the fall of 2003 come close to reaching a consensus that each organization shall have its own medical service, as needs are vastly different between the organizations. There are organizations with the vast majority of its staff in the field, like UNHCR on one end of the scale and organizations that are entirely Geneva based like WIPO on the other end. Each medical service would be headed by a Chief Medical Officer who would report within the hierarchy of his/her own organization. Priorities would be established at agency level, fully integrated with overall organizational objectives, strategies and priorities and with other related functional areas (human resource management, staff welfare and staff safety / security).

14. Whereas the above is positive from UNHCR's point of view, the "Joint Medical Service Management Committee" has failed to apply the same logic to the administrative aspects. No doubt there is pressure to maintain a semblance of a Joint Medical Service, rather than reducing the institution to a medical information clearing house only.

15. In EPAU's opinion, continuing to channel funds and award employment contracts through the JMS / WHO lends a new life to the institutional fictions and managerial weaknesses that led to the crisis mentioned above. This is not in UNHCR's interest. The JMS should have been redefined to become merely a platform for inter-agency cooperation and exchange of information and a name change should reflect this.

- Recommendation 1: A future platform for inter-agency cooperation and exchange of information needs to be created to ensure appropriate harmonization of medical standards between the services of the different organizations. This platform should ensure harmonized interpretation and action on "binding" instructions received from New York, as well as being a Geneva partner for New York on staff medical issues. The change of function should be reflected in a name change from Joint Medical Service to Inter-Agency Consultative Group on Staff Health, or some title to that effect.
- Recommendation 2: Harmonization of staff insurance policies resulting in a single staff insurance programme at the Geneva duty station (larger risk pool, centralized IT applications and economies of scale) and the establishment of a UNOG Advisory Board on Compensation Claims, containing increasing health-care costs as well as the safeguarding independent medical authority of the medical services through peer reviews of medical decisions by sister services should also be among the tasks of the Inter-Agency Consultative Group on Staff Health.

16. This would, as regards the UNHCR Medical Service, be an opportunity for UNHCR to revise the completely obsolete JMS-TOR of 1968 and clarify aspects current practices that are at present not covered in a single document. See further below.

Inter-Agency Consultative Group on Staff Health and links with UNHCR's Medical Service

17. As UNHCR created its Medical Service in 1994, the Joint Medical Service has progressively lost its value to UNHCR and in fact functioned as an obstacle. UNHCR's needs and concerns remained simply under-valued by the JMS, concerned about its own existence and control, shifting personnel into and out of the UNHCR Medical Service, questioning frequently the Service's objectives and managing the Service's financial resources in a not fully transparent manner. Gradually not just UNHCR but other organizations have taken their distance, to the point of breaking completely away in the case of UIT, WTO and WIPO. In particular since the dismissal of the JMS Director over 2 years ago the JMS has only continued to function as a forum for peer consultations for the respective heads of medical Services within the different organizations. Such consultations comprise both medical technical issues and harmonization of interpretation of policies and directives, and elaboration of shared proposals. Any future JMS would only be useful in this particular role and the name Joint Medical Service should be amended to reflect this reality of a medical coordination secretariat.

18. The UNHCR Medical Service follows scrupulously the administrative and medical directives issued by the Medical Director of the UN in New York. Regular contacts with New York, as well as Geneva based services of sister organizations include a dialogue concerning the adaptation of certain directives, rules or regulations, to the situation of UNHCR and other agencies' staff in the field.

19. UNHCR should confirm to the JMS Management Committee and Director Human Resources of WHO that the separation of the UNHCR Medical Service from the Joint Medical Service takes effect 01 July 2004 and will henceforth be staffed and administered by UNHCR independently. The secretariat of the Inter-Agency Consultative Group on Staff Health could still be housed in and serviced by the WHO. UNHCR should also consider introducing to that effect a proposal for replacing of the TOR of the JMS by new TOR for the Inter-Agency Consultative Group on Staff Health for further discussion in the "Joint Medical Service Management Committee".

20. This separation of the UNHCR Medical Service from the Joint Medical Service taking effect 1 July 2004 means that the staff of the JMS Medical Service in UNHCR needs to be absorbed by UNHCR. They should all get regular UNHCR contracts (as replacements of in some cases very unsatisfactory protracted TA arrangements). According to DHRM the cost for UNHCR is not expected to differ significantly from what is being spent hitherto, combining the UNHCR contribution to WHO and direct expenses. At the time of writing DHRM is already preparing the required submission to the ORB for creating the UNHCR Medical Service by 01 July 2004 for decision during its May 04 annual session.

21. In the spirit of learning from each other, following identical or similar standards evidence-based cost-effective treatments and building shared capacities in the field UNHCR should approach WFP and UNICEF. Both these agencies, more than other UN agencies, operate in the same theatres as UNHCR and are likely to respond favorably to an initiative from UNHCR in this regard.

Between staff member and administration

22. The distinguishing essentials of a medical service are that the service operates with neutrality between the staff member / patient on the one hand and the administration on the other hand and that the service maintains total confidentiality of medical information. If these two elements are not evident to the staff members/patients they will not use the UNHCR Medical Service. As such it would not be of use to the administration, which would be likely to be perceived as using the medical service only for protecting the organization from litigation in case of service incurred illnesses or accidents. Staff productivity is built on the pursuit of medical best practice and implementation of health promotion policies. It is therefore vital that the position of the UNHCR Medical Service in UNHCR's organigram, demonstrate its ability to operate in the professionally independent manner mentioned above. Its position should be at a distance from any human resource management process that could be perceived to have conflicting purposes.

- Recommendation 3: UNHCR should assume full control of its medical Service by fully integrating the Service and renaming it the UNHCR Medical Service. This entails the creation of the required posts and operational budget and placing the UNHCR Medical Service on the organigram with a direct reporting line to the Director of Human Resources Management personally, as a formal guarantee of its medical professional independence.
- Recommendation 4: The UNHCR Medical Service should actively explore ways to reinforce its cooperation with the respective medical services of WFP and UNICEF, in particular in the field, as these agencies frequently operate in the same theatres as UNHCR and coordinated, if not consolidated, medical arrangements in such theatres reinforce harmonized practices, efficiency and cost-sharing.

Medical services in-house

23. The clinical activity of the Medical Service at HQs is considered a plus by many, notwithstanding the availability of numerous competent medical services in Geneva and environs. The principal advantage for staff, in particular those on missions at HQs from remote duty stations, is being able to receive medical advice / support without a prior appointment and with a minimal loss of time, as no transport time is required. More importantly, appointments with medical services in Geneva and environs always require being taken well in advance as waiting time can reach up to six weeks and more. Consultations without appointment at the Hôpital Cantonal invariably mean substantial time passed in waiting rooms.

24. The Medical Service has, while attempting to monitor health risks globally, furthermore analyzed the health risks to which UNHCR staff, in particular during emergencies and in D and E duty stations are exposed to, as well as the concomitant financial liabilities for the organization. These analyses have led to the introduction of measures and policies to improve performance and reduce the incidence of accidents and illness, in particular during the first few months of an emergency operation. The actual implementation of these of measures and policies, in particular mandatory rest time, remains unsatisfactory. The Medical Service continues to see the resulting health problems among staff members concerned. UNHCR's ethos

needs to be adjusted to make managers understand that all, including they themselves, are replaceable and that it is intelligent professional behaviour to take regular breaks and maintain perspective instead of working to the point of exhaustion, becoming accident and illness prone, struggling with diminished judgement and poorer communication.

25. Staff members can consult a medical doctor or a qualified nurse, each with extensive experience of tropical and travel medicine and backed up by a competent complete laboratory service and equipped with an emergency stock of medicaments. The Medical Service can, in case of justified need, assist in getting quicker appointments with specialists and hospital services, which is very important for staff based in the field.

26. The staff of the UNHCR Medical Service, based on its experience with field conditions and field staff, will typically reach some diagnosis faster than the Cantonal Hospital. The UNHCR Medical Service, for example, sees annually more malaria patients (return from mission) than the parasitological service of the Cantonal Hospital. Another recent example, intoxications by lead and by depleted uranium in Kosovo, led, besides guidance to staff members, to a joint publication on the subject which had a wide international distribution.

27. A financially non-quantifiable aspect is the continuity in the upkeep of the medical history of staff members who frequently rotate and who by necessity change their general practitioners equally frequently, or simply lose a file during the move from one duty station to another. These staff member's long term health interests are served by the continuity that the Medical Service's records provide, as they are by the medical preparation before and, if required, check-up after a mission.

28. Moreover one medical doctor and one nurse have followed a special training in diagnosing and accompanying post-traumatic stress disorders. They have concrete experience with dealing with the aftermath of serious accidents involving the death of staff members and survival of others, hostage takings and shootings.

29. Swiss law presents no obstacle for a medical practice as performed by the UNHCR Medical Service. The physicians maintain regular and fruitful contacts with the "Amicale des médecins de Genève". They also have a regular professional contact with hospitals and private doctors in Geneva and surrounding area.

Still under-resourced and mostly reactive

30. The UNHCR Medical Service consists of 12 staff members, of whom three are on protracted temporary assistance (TA) and two are half time employees.

31. There are two professionals: the Head P5 on a FT WHO contract, the other P4 on a TA for the past few years. Both are medical doctors. The Service further counts "two and a half" nurses, one and a half with FT WHO contracts, the other a fulltime TA. The latter has been frequently changed at the behest of the JMS-WHO. In addition, there are three laboratory technicians; two with FT WHO contracts, the third against protracted TA. And there is a complement of secretariat staff: two medical secretaries with FT WHO contracts and another with a protracted TA contract, as well as a FT Administrative Assistant.

32. As is well known TA staff are required to take "breaks". Apart from the administrative disadvantages for the staff concerned, the protracted TA employment affects their morale and should not be allowed to continue indefinitely as still is the case under the WHO administered JMS staff deployed in UNHCR's Medical Service. With the incorporation of the UNHCR Medical Service staff into UNHCR by 01 July 2004 special attention must be given to avoiding making the staff members concerned suffer further consequences from the aforementioned prolonged crisis in the Joint Medical Service and the institutional delays in implementing decisions in this regard.

33. Staff in the UNHCR Medical Service performs a specialist service for UNHCR. They meet advanced medical standards and provide quality care to the staff of UNHCR. To maintain continuity, to have both organizational and patient memory, so that the approach to each staff member remains optimal, it is critical that professional staff in the UNHCR Medical Service not be subject to rotation as regular professional staff are. Rotation would simply replicate and amplify those very conditions that, besides the lack of financial clarity in terms of the budget administered at the WHO, are the main reasons for the "crisis" within the JMS which led various agencies, including UNHCR, to consider leaving the JMS.

The required / mandatory functions of the Medical Service are:

- Periodic medical examinations (carrying these out for HQs staff and field staff passing at HQs and evaluating reports sent in from the field)
- To advise or take action with respect to the medical situation of staff members whose medical condition requires special attention (local treatment, medical evacuation and follow-up); this may also involve dependents of staff members in the field.
- To maintain up-to-date vaccinations of all staff (and dependents in the field) and keep records thereof
- To carry out field missions for evaluation of health infrastructures / services, establish protocols, provide medical-technical assistance
- To brief staff prior to taking up posts, departing on missions
- To clear medically staff prior to taking up posts, departing on missions
- To develop and administer preventive medicine and health educational programmes for staff
- To advise UNMIS, MIP for non-work related illnesses and accidents, the UN Indemnification Committee for work-related illnesses and accidents and the UN Invalidity Pensions Committee for UN staff and their family members (UNPF).
- Medical evaluation of requests for special education grants for handicapped children of staff members, the health of pregnant female staff members working in high risk zones and for children of staff members for whom there is no suitable medical facility at the duty station.

The client base

34. By 31 October 2003 the above functions concerned 6,379 staff members, and 12,147 dependents (see table) of whom 4,011 staff members (62 %) and 8,860 dependents (73 %), find themselves in C, D E, U and M locations, where medical services are sub-standard to non-existent.

35. The UNHCR Medical Service attempts to maintain some 20,000 dossiers for all regular active and retired staff members alive, international and local. This number does not cover the internal dossiers inside each staff member's dossier for their dependants. The Service needs to maintain these dossiers for the following reasons:

- The international staff rotate from post to post so often that it is practically impossible for them to establish a permanent relationship with one health care provider. Therefore the maintenance of a continually updated dossier in the UNHCR Medical Service is their only means of having their medical history monitored and documented.
- The local staff benefit from this process as well because the UNHCR Medical Service has access to a very wide group of medical experts globally and can - in case of need - recommend evacuation from their home country to another location where appropriate treatment of their condition can be ensured. Local facilities or local health care professionals would in C, D and E duty stations typically not have equal access to such a network.
- The medical standards that are applied by the UNHCR Medical Service are internationally accepted. These same international standards may not be evenly applied in the field should there be a decentralization of the dossiers.

Severely understaffed

36. EPAU observes that, by comparing the sum total of the number of staff members at HQ and in the field carrying the word "human resource" management related element in their job title, namely 594, with the number of staff members in the medical service in Geneva, namely 12 - both groupings covering the same population of staff members - it would seem obvious that the UNHCR Medical Service is severely understaffed. This statement rings true even if one takes into account the very different functions of each. This observation is furthermore strongly supported by findings further down in the report which make EPAU conclude that the UNHCR Medical Service faces the perpetual dilemma of settling for the least unattractive consequences of its priority setting, rather than having the capacity to respond to identified requirements.

37. The considerable responsibilities on the part of UNHCR Medical Service staff members, should be appropriately acknowledged, not least those of the Head of Service whose medical decisions have direct health and administrative consequences of considerable importance. With the incorporation of the staff into UNHCR proper specialist job descriptions and job classifications need to be established. The existing JMS staff members converted into UNHCR accordingly should be given the benefit of due recognition of the effective period that they have served in the JMS.

- Recommendation 5: To carry out the functions required from the UNHCR Medical Service and to manage the Service itself, the current number of medical staff is insufficient. This leads to a more reactive approach to the work than considered desirable in the interest of staff health and containing health costs. The Head of the Medical Service is supposed to play a central and deciding role in advising the highest levels within UNHCR with regard to specific medical cases and to supervise implementation of health policies and practices in order to maintain an optimally efficient workforce in often trying circumstances. At a minimum, one more full-time medical doctor, another full-time nurse and another medical secretary are required. Proper job descriptions must be established and the posts graded accordingly, giving due recognition to the volume and impact of decisions required from in particular the senior personnel in the Medical Service.

Workload containment

38. Note is taken of the fact that the UN in New York and at ONUG, as well as the other agencies present in Geneva maintain "walk-in clinics" for their staff.

39. However, in order to reduce pressure on the staff of the UNHCR Medical Service, it is furthermore suggested that the standard clinical functions for staff based in Geneva be clearly circumscribed to a limited list of interventions. Staff based in Geneva and H, A and B duty stations have ample possibilities of consulting locally any medical service they might possibly need. The unnecessary additional work pressure on the UNHCR Medical Service could be reduced, while a first aid function is maintained for emergencies only. The argument of saving "precious staff time" for non-emergency medical consultations seems insufficient to offset the cost of employing additional staff in the Service to meet a non-essential need.

- Recommendation 6: A general communication to all staff should be sent out informing Geneva-based staff that they should - in principle - consult local medical services for any medical attention they might possibly need, as no doubt many are already doing. Exceptions are obvious for Geneva-based staff departing for or returning from missions to the field and staff based in the field on mission in Geneva. The UNHCR Medical Service should maintain a limited list of interventions / standard clinical functions that it can perform for staff based in Geneva. This list needs to be communicated to the staff.

A "walk-in" clinic should be maintained for non-Geneva-based staff visiting Headquarters.

In the reception procedure of the UNHCR Medical Service, an experienced nurse may screen patients for referral of only the more demanding cases to either of the medical doctors and to answer routine questions and execute routine minor medical interventions, whether or not followed by an examination by a medical doctor of the UNHCR Medical Service or a referral to local medical services.

Health preservation

Working and living conditions

40. The evaluation of working and living conditions is an important tool in health preservation. Too many UNHCR offices operate in a seriously sub-standard physical environment: lack of light, unsafe structures, high noise levels, inadequate furniture, faltering communications equipment . The same applies to living quarters (a poor bed, an irregular water supply, unpredictable electricity, an insufficiently diversified diet, no refrigerator, poor washing facilities).

41. It is harmful to expect staff to work in very difficult conditions and not afford them a decent minimum of accommodation where they can rest. There still is a tendency, both within UNHCR and outside it, to try to justify dreadful working/living conditions for staff by saying: “look at the poor refugees, they have nothing”.

42. Water-borne diseases are still quite frequent, even if mostly without serious consequences. There are however, many staff members who contracted complex parasitical pathologies which have a lasting negative impact on their health. Increased information and educational initiatives covering the risks should be undertaken. In addition, all offices in the C, D and E categories should be equipped to test and produce water hygiene information. A water quality standard should be adopted and where the water does not meet this standard filters and water purification equipment should be installed.

43. The various elements mentioned above are having a direct impact on well-being and therefore productivity. UNHCR has an interest in establishing office and housing standards and giving a copy of them to all staff members on post outside their home country. This would not only increase the knowledge of this standard but would have an action top down, bottom up to enforce the application of office and housing standards.

- Recommendation 7: UNHCR must establish office and housing standards and give a copy of them to all staff members on post outside their home country. Office and housing standards include the physical environment: adequate light, safe structures, acceptable noise levels, adequate furniture, functioning communications equipment, a decent bed, a regular clean water supply, predictable electricity, a sufficiently diversified diet, refrigerator, adequate and clean sanitary and washing facilities.

Cumulative stress and post traumatic stress disorders

44. Personal insecurity is a major element contributing to cumulative stress. Critical incidents do under certain circumstances create post traumatic stress disorders. Both affect staff health in a profound manner. It is therefore imperative that the Emergency and Security Service and the UNHCR Medical Service maintain regular contact, in particular in cases of medical emergencies and including the provision of post exposure treatment in case of accidental contamination with HIV infected blood or post rape.

Health education and health promotion programmes

45. Health education and health improvement programmes tailored to respond to local health risks and work and living environmental factors should remain a priority of the UNHCR Medical Service. However, the lack of resources has drastically restricted its ability to do this. At present its only partially addressed priorities remain HIV / AIDS, accidents, malaria, infectious diseases transmitted through vectors as rodents, as well as alcoholism and drug abuse.

46. Sanitary education programmes need, in order to be effective, be developed taking into account the specific local conditions, including the working and living conditions, in order to reduce the incidence of illnesses and accidents. During various missions, the Medical Service has combined the evaluation of available medical facilities and services with sanitary education for the staff and their dependents (examples: hygiene, specific locally frequent pathologies, first aid). Specific interventions such as these need to be truly systematically transformed into learning modules and learning events, using local capacities, guided by the UNHCR Medical Service.

47. If staff members are to be informed of the risks they run and the methods to reduce them, they must have time to learn. The operations in the field must factor into their plan time for the staff to attend courses and refresh knowledge. Although self learning and distance learning make a very good use of time, it is most often the staff members' personal time that is involved. The staff members are already working many extra long hours during a difficult emergency operation and living under difficult conditions. It is important that the education process, which has obvious benefits, does not become a source of additional pressure.

Risk targeting

48. If the UNHCR Medical Service is to target risks and address them it is important that the monitoring process of the staff through medical surveillance and the reporting of sick leave be carried out efficiently. This information must be entered in to the medical service database so that the service can produce statistics and extrapolate evidence based training plans and programmes. The impact of these programmes must be monitored and the programmes themselves modified to continue to meet the needs of each location.

Coordination with the regional bureaux

Health programmes for UNHCR field staff

49. In Part III of this report the findings of the questionnaire (Annex III-1) sent to all C, D, E, U and M duty stations / locations will be discussed in more detail. This questionnaire was specially developed with a view to enhance the impact of efforts by the UNHCR Medical Service to attend better and more systematically to preventive health programmes for UNHCR staff in the field, in particular C, D, E U and M duty stations.

50. To achieve this objective, coordination with the Regional Bureaux needs to be more formally established. Such coordination is particularly important as regards collecting current information on conditions in all C,D and E duty stations and rolling out standard medical administrative procedures and punctual medical interventions in cases where medical technical support is required by field offices. In particular two types of missions need to be carried out:

51. Regular missions, planned in advance, to evaluate working and living conditions and corresponding health hazards, to evaluate local medical facilities, to establish and update medical evacuation plans, to carry out preventive medicine and health training.

52. Crisis and special missions, in response to emergency situations, to put in place a medical emergency support chain, to establish and update medical evacuation plans, to carry out medical entry exams in case of substantial local recruitment of local and international personnel, to carry out staff vaccination programmes.

- Recommendation 8: The UNHCR Medical Service needs to serve still better and more systematically UNHCR staff in the field, in particular C, D, E U and M duty stations. Coordination with the Regional Bureaux needs to be more formally established, in particular with regard to periodic regular missions and crisis and special missions, in response to emergency situations.

Emergency preparedness at HQs for the field: mostly reactive

53. The UNHCR Medical Service provides annually some 600 – 800 pre-emergency mission briefings on health related issues, to the extent possible, pertinent to the destination. If the UNHCR Medical Service had more staff and financial resources, and the required operational latitude, it could develop for the benefit of the staff more specific field medical preparation and preventive programmes.

54. In light of increasing risks of road accidents and physical aggression against staff members this kind of educational programmes should be considered a top-priority. They are still often no more than an after-thought.

Emergency contingency planning exercises

55. The UNHCR Medical Service is rarely, and if so mostly at a very late stage, brought into emergency contingency planning exercises. Its potential contribution to the process is often seen as of tertiary value. The scope of this evaluation affords no opportunity to establish just how many staff members sick days could be avoided if indeed the medical preparation of staff (including briefings on local health risks, preventative measures, vaccinations and distribution of basic medical kits) sent on mission was taken more seriously. Indeed most staff members on emergency missions don't pass through Geneva on their way to the mission destination. Communication with these staff members through various channels would require increased effort and time from the UNHCR Medical Service staff, which at present don't have that capacity.

- Recommendation 9: Cooperation between the UNHCR Medical Service, respective Bureaux and EPRS should be intensified, associating medical staff

with emergency contingency planning meetings and initial needs assessment missions to new areas, to assess medical risks and options, to prepare medical briefings and educational materials. The anticipated impact of such measures is expected to outweigh by far the related costs.

Database for individual files

UNHCR Medical Service's medical record management and MSRP

56. The UNHCR Medical Service operates an obsolete data management system being used to manage some 20,000 files of staff and retired staff. Within the files there are also dependents records. In the context of this evaluation a discussion was initiated to include some sensible recommendations on how the Service's record management can be made part of the Management System Renewal Project (People Soft) system that is being set up in DHRM, while providing data security for the portions of information relating to medical information and precluding Service staff from having access to personnel data that don't concern them. Such partial integration would avoid double data entry, ensure timeliness and consistency and would facilitate the fast tracking of medical clearances before missions are undertaken, just as are security clearances and travel authorizations (PT8) .

57. The UNHCR Medical Service should soonest define its data and functional requirements and submit a formal request to the Deputy High Commissioner for inclusion of its data processing needs in the People Soft / MSRP process. If required the Service should be assisted in putting this request together in a manner that shares the common staff data, avoids double data entry work, and gives fully protected access to authorized UNHCR Medical Service personnel only to the medical records associated with the common staff data.

- Recommendation 10: The UNHCR Medical Service's management of medical records should be made part of the Management System Renewal Project / People Soft system that is being set up in DHRM, while providing data security for the portions of information relating to medical information and precluding Medical Service staff from having access to personnel data that doesn't concern them. The UNHCR Medical Service should soonest define its data and functional requirements and submit a formal request to the Deputy High Commissioner for inclusion of its data processing needs in the People Soft / MSRP process.

Medical confidentiality

58. The UNHCR Medical Service performs a unique dual role. The Service functions as an administrative instrument for management, establishing authoritative medical records for operational and administrative purposes. The Medical Service simultaneously performs a medical service for staff members in need of this service. The Medical Service necessarily maintains therefore complete confidentiality with regard to the underlying medical information and services rendered to individual staff members. The independent status of the medical Service is based on trust, of both management and staff. The latter should be enabled to confide freely to UNHCR Medical Service personnel about their health, their work

environment and even family-related problems without fear of breach of confidentiality, which would compromise the very function of medical personnel.

Draft ToR for UNHCR Medical Service

59. Given the new structure and vastly evolved roles of the UNHCR Medical Service, new Terms of Reference (TOR) for the Service are required. It goes beyond the scope of this evaluation report to provide such terms of reference. The Head of the Service has however been asked to draw up terms of reference that adequately reflect the Service's current and foreseeable responsibilities, and that safeguard the independent nature of its medical work performed for the benefit of UNHCR staff members and their dependents. A first draft of the TOR is attached as Annex I-1 and the adoption thereof should take place over the coming months within the context of the establishment of the UNHCR Medical Service by 1 July 2004.

- Recommendation 11: Within the context of the establishment of the UNHCR Medical Service, by 1 July 2004, new Terms of Reference (TOR) for the UNHCR Medical Service are required. They must properly reflect the new structure and vastly evolved roles. A draft text (Annex I-1) has been prepared by the UNHCR Medical Service and should be reviewed, amended as appropriate and adopted for implementation by 1 July 2004.

Part II. The state of health of UNHCR's staff

60. Besides sending detailed questionnaires to all C, D, E, M and U duty stations as to be discussed in PART III of this report, the evaluation team also reviewed the bi-annual reports produced by the UNHCR Medical Service for the Joint Medical Service, as well as the more informative reports to the successive Directors of DHRM. Such reports provide epidemiological data and their incidence in terms of days of sick leave, service incurred illnesses and accidents, deaths and medical evacuations. The recording, year after year, of all major medical problems faced by the staff represents a very valuable source of statistical information on staff health developments and trends. Its analysis across the years should inform an assessment of the Medical Service, its priorities and its capacity or lack thereof to achieve these.

61. UNHCR staff, mainly through the regularization of "project staff" grew between 2000 and 2003 from 5,215 to 6,379 representing a growth of 22.32% against the baseline year and a corresponding increase in routine medical administrative activities carried out by the UNHCR Medical Service. The total number of cases grew from 926 or 17.76% of the workforce in 2000 to 1,061 or 16.63 % of the workforce in 2003. The year 2002 marked a high with 1,105 cases or 18.1 % of the workforce in that year. Staff growth thus increased the UNHCR Medical Service workload by 19.33%. As no increase of UNHCR Medical Service staff occurred during this period work pressures increased, while already insufficient time for preventive medicine activities in particular in the field further declined, as further commented on in the chapters of this report reviewing the pattern and numbers of field missions carried out by the medical service and the results of the field questionnaire which clearly define a number of field tasks to be accomplished.

Sick leave among UNHCR staff

62. UN Staff Rules and Regulations require that a medical certificate justify every interruption of work of over 3 days. The certificate does not necessarily state the illness or condition of the staff member and is routinely transmitted to the UNHCR Medical Service, which may, in particular if the sick leave exceeds five days, request a medical report giving medical diagnostic details from the treating physician. Such correspondence is covered by medical confidentiality. There are cases where either the staff member or his/her physician does not cooperate. This occurs mainly when a staff member lacks confidence in the UNHCR Medical Service. Only scrupulous professionalism on the part of the UNHCR Medical Service, including strict protection of medical information and regular communication with individual staff members building up their trust in the Medical Service will allow to reduce this number further.

63. For the UNHCR Medical Service the collection of medical data is essential to establish reliable statistics on morbidity and mortality, to establish timely curative and preventative health measures in regard to illnesses and accidents in the work place or working and living environments in the field, particularly where these are challenging.

64. The reliability of the statistics on morbidity and mortality depends furthermore on the quality of the cooperation of administrative staff in the field and at HQs. The work of the UNHCR Medical Service shall however be significantly facilitated by implementation of RECOMMENDATION 10, making the UNHCR Medical Service 's medical record management part of the Management System Renewal Project / People Soft system that is being set up in DHRM, while providing data security for the portions of information relating to medical information and precluding Medical Service staff from having access to personnel data that doesn't concern them.

Analysis of sick leave statistical data (Annex II-1)

65. For the purposes of this evaluation EPAU has examined medical statistical data for the years 2000 to 2003 included. While it was possible to calculate the numbers of staff and the gender distribution of the total staff by year, broken down between HQs and in the field, there is no gender information available in respect of the numbers of sick leave days or cases of illness prior to 2002. For the sake of comparison therefore the gender aspect in this analysis is of limited value. The analysis uses at a macro-level the year 2000 as the baseline year, comparing the subsequent years with 2000 an increase in staff is observed with 5,215 staff (of which 59.60% males and 40.40% females and 15.72% at HQs and 84.28% in the field) in the year 2000 against a total of 6,379 staff in 2003 (of which 62.38% males and 37.62% females and 13.83% at HQs and 86.17% in the field).

66. The total number of recorded sick leave days in 2000 was 27,381 of which 11,484 or 41.94% at HQs and 15,897 or 58.06% in the field. The 27,381 sick leave days in 2000 represent 2.39% of the total number of workdays, based on an annual number of workdays of 220. The 2.39% is divided as 1.00% at HQs and 1.39% in the field. Given the ratio of staff at HQs (820) versus the field (4,395) it results that on average individual staff at HQs are 3.87 times more on sick leave than on average individual staff in the field are. In terms of the numbers of sick leaves on average individual staff at HQs take 7.58 times more sick leaves than on average individual staff in the field. The duration of sick leaves of individual staff at HQs during 2000 is on average about 51.05% or half as long as sick leaves taken by staff in the field.

67. The total number of recorded sick leave days in 2001 was 23,152 of which 9,164 or 39.58% at HQs and 13,988 or 60.42% in the field. The 23,152 sick leave days in 2001 represent 1.99% of the total number of workdays, based on an annual number of workdays of 220. The 1.99% is divided as 0.79% at HQs and 1.20% in the field. Given the ratio of staff at HQs (839) versus the field (4,444) it results that on average individual staff at HQs are 3.47 times more on sick leave than on average individual staff in the field are. In terms of the numbers of sick leaves on average individual staff at HQs take 8.71 times more sick leaves than on average individual staff in the field. The duration of sick leaves of individual staff at HQs during 2001 is on average about 39.83% of the length of sick leaves taken by staff in the field.

68. The total number of recorded sick leave days in 2002 was 28,276 of which 11,182 or 39.55% at HQs and 17,094 or 60.45% in the field. The 28,276 sick leave days in 2002 represent 2.11% of the total number of workdays, based on an annual number of workdays of 220. The 2.11% is divided as 0.83% at HQs and 1.28% in the field. Given the ratio of staff at HQs (866) versus the field (5,228) it results that on average individual staff at HQs are 3.95 times more on sick leave than on average individual

staff in the field are. In terms of the numbers of sick leaves on average individual staff at HQs take 7.52 times more sick leaves than on average individual staff in the field. The duration of sick leaves of individual staff at HQs during 2002 is on average about 52.53% or just over half as long as sick leaves taken by staff in the field.

69. The total number of recorded sick leave days in 2003 was 25,167 of which 9,979 or 39.65% at HQs and 15,188 or 60.35% in the field. The 25,167 sick leave days in 2003 represent 1.79% of the total number of workdays, based on an annual number of workdays of 220. The 1.79% is divided as 0.71% at HQs and 1.08% in the field. Given the ratio of staff at HQs (882) versus the field (5,497) it results that on average individual staff at HQs are 4.09 times more on sick leave than on average individual staff in the field are. In terms of the numbers of sick leaves on average individual staff at HQs take 7.80 times more sick leaves than on average individual staff in the field. The duration of sick leaves of individual staff at HQs during 2003 is on average about 52.44% or just over half as long as sick leaves taken by staff in the field.

70. The general conclusions as regards sick leaves over the 4-year period reviewed are as follows:

- On average individual staff at HQs are between 3.5 to 4 times more on sick leave than on average individual staff in the field.
- On average individual staff at HQs take between 7.5 to 8.7 times more frequently sick leave than on average individual staff in the field.
- Consequently the average duration of sick leaves taken by staff at HQs is 1.9 to 2.51 times shorter than those taken by staff in the field.

71. Various further questions arise from the above:

- Are all field offices systematically complying with the requirement to file sick leave requests and are these systematically transmitted to the Medical Unit at HQs?
- Are staff members in the field generally healthier as their work demands them to be and/or they enjoy their work more?
- Does the staff contingent at HQs contain a larger proportion of staff members medically unfit for service in the field?
- Does the open-space office layout at HQs contribute to increased stress levels and is staff therefore more prone to illness?
- What are the reasons for the persistent low staff morale at Headquarters?⁶

72. The latter questions are not as frivolous as might be thought if one notes that in the period 2000-2003 the first cause of illness at HQs psychiatric in nature, whereas in the field during the same period this is but the fifth cause. Further exploration of

⁶ Staff members at HQs are generally more aware of breaches of integrity and unethical conduct, arbitrariness, as well as the insufficiencies and inequities of the disciplinary system, having created a pervasive sense of injustice and impotence

these reasons and the relationship with comparator data of other Geneva based organizations fall beyond the scope of this evaluation, but needs to be undertaken.

- Recommendation 12: Individual staff members at HQs have between 2000 and 2003 been between 3.47 and 4.09 times more on sick leave than UNHCR staff in the field. The investigation of the reasons for this phenomenon and the relationship with comparator data of other Geneva based organizations needs to be independently studied by a team of medical experts and their report shared with the staff at large.

73. Disaggregating the sick leave statistical data between male and female staff members the following elements emerge:

- Male staff in 2000 stood at 3,108 or 59.6% of the total workforce. Male staff members generated 424 sick leave requests or 33.9% of the total against 66.1% of the total number of sick leave requests generated by female staff who constituted in 2000 40.4% of the total work force. The picture for 2001 and 2002 is essentially the same and it changes slightly in 2003. For brevity's sake male staff in 2003 were 3,979 or 62.4% of the total workforce. Male staff generated 450 sick leave requests or 31.7% of the total, against 68.3% of the total number of sick leave requests generated by female staff who constitute in 2003 37.6% of the total work force.
- The average length of a sick leave of male staff members was 31.4 days for 2000 or 48.6% of the total number of sick leave days. For 2001 this is 27.88 days or 62.9% and for 2002 and 2003 respectively 27.6 days or 61.7% and 21 days or 56.8%.
- The average length of a sick leave for female staff members was 17.03 days for 2000 or 35.2% of the total number of sick leave days. For 2001 this was 16.44 days or 37.1% and for 2002 and 2003 respectively 17.13 days or 38.3% and 16 days or 43.2%.
- Male staff account in 2000 for 48.6% of the total number of sick leave days with 59.6% of the workforce. In other words individual female staff members have in 2000 been 1.63 times more frequently on sick leave than individual male staff members. For brevity's sake it is confirmed that the years 2001 and 2002 and 2003 show fairly similar trends, with for 2003 the male staff accounted in 2003 for 37.8% of the total number of sick leave days with 62.4% of the workforce. In other words individual female staff members have in 2003 been 2.8 times more on sick leave than individual male staff members.

74. The significant increase between 2000 and 2003 of 1.63 to 2.8 of sick leave days taken by female staff when compared with their male counterparts raises again very serious questions about the reasons for this phenomenon within the picture described above. The exploration of these reasons and the relationship with comparator data of other Geneva based organizations fall beyond the scope of this evaluation.

- Recommendation 13: Individual staff female members have between 2000 and 2003 been between 1.63 and 2.8 times more on sick leave than male UNHCR staff members. The study of the reasons for this phenomenon and

the relationship with comparator data of other Geneva based organizations needs to be independently examined by a team of medical experts and their report shared with the staff at large.

Illnesses among UNHCR staff (Annex II-2)

75. From 2000 to 2003 the numbers of absences on sick leave for “unspecified causes” are the highest. This category of unspecified causes however groups a wide range of conditions from a fever to any illness not covered under the specific illness categories that are being monitored.

76. The unspecified causes amount to 51.3% of all cases in 2000, but represent only 9.11% of the sick leaves with an average duration of 4.16 days. For 2001, 2002 and 2003 unspecified causes amount to 498 cases or 54.79%, 530 cases or respectively 47.96% and 569 cases or 53.63% of the total numbers of cases. The average length of sick leave for unspecified causes varies as follows. 2000:4.16; 2001: 4.13; 2002:4.4 and 2003:4.5 i.e. an increase of 8.17% by 2003 if compared with 2000, which needs to be read against a staff increase of 22.32% and therefore represents a decrease registered over the period.

77. The second biggest group of illnesses in 2000 were osteopathic and trauma conditions, frequently resulting from accidents, amounting to 109 cases or 2.09% of all cases in 2000. After a rise to 152 cases or 2.49% in 2002 the number blissfully reduced to 87 cases or 1.36% in 2003, reducing it to the fourth cause of sick leave in 2003. Road accidents remain a major hazard for UNHCR staff, speed being the first cause of such accidents. Hence, besides improving driving habits, the Recommendation 24 contained in Chapter III of this report suggesting that all UNHCR vehicles be equipped with First Aid Kits and that all international staff assigned to the field or on mission follow obligatory First Aid and First Aid Refresher courses.

78. Considering the staff growth of 22.32% in 2003 against the baseline year 2000 the evaluators have examined the relative growth or decline of groups of illnesses during the same period. The most significant growth is with cancer reaching in 2003 160% of the level of 2000, followed by Neurological disorders with 143.48%, by Back problems with 136.36%, by digestive and liver conditions with 130.61% and by cardiologic conditions with 125%. All other conditions, including HIV/AIDS among staff - while still significant -have proportionally regressed. In regard to HIV/AIDS such results contrast with the progression of HIV/AIDS in the environments in which may UNHCR staff are operating and is therefore a clear indicator of the impact of the HIV/AIDS prevention activities undertaken by many, including specifically the UNHCR Medical Unit. Such HIV/AIDS prevention activities must therefore continue and possibly further targeted in light of what the medical and social data collected over the years would suggest.

Part III. UNHCR health care in the field

79. UNHCR being essentially a field-based organization the UNHCR Medical Service's focus has to be largely on the field. A review of the missions undertaken however clearly reflects a reactive pattern, as missions are decided upon in response to an emerging problem.

JMS UNHCR Unit Field Missions										
Country	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Afghanistan			X						XX	
Albania						XX				
Angola				X						
Australia						X				
Bangladesh				X						
Bosnia-Herzegovina				X						
Burundi				X						
Croatia				X						
Djibouti					X					
East Timor						X	X			
Eritrea								X		
Ethiopia					X					
Georgia				X						
Greece						XX				
Guinea			X				X			
Indonesia						X				
Iran									X	
Ireland										
Italy						XX				
Ivory Coast			X				X			
Kenya	X			X						
Kosovo							XXX	X		
Kyrgyzstan										
Macedonia						XX				
Myanmar				X						
Pakistan			X							
Rwanda	X			X						
Senegal			X							
Somalia					X					
South Africa				X						

UNHCR'S MEDICAL SERVICE

JMS UNHCR Unit Field Missions										
Country	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Sri Lanka										X
Sudan								X		
Tajikistan			X							
Tanzania	X			X						
Thailand				X						
Turkmenistan										
Uganda				X						
Uzbekistan			X							
Yemen										X
Yugoslavia, Fed. Rep. of				X				X	X	
Zaire	X									
41/55	4	0	7	14	3	11	6	4	4	2

80. The above table shows that 55 missions were undertaken to 41 countries between 1994 and 2003, of which 14 in 1997 and 11 in 1999 or 45% just between just these two years. For the period from 2000 to 2003 the number of missions declined from 6 in 2000 to 4 in 2001 and 2002 and only 2 in 2003. With UNHCR some 270 offices in 170 countries and 62.53% of staff in C, D, E, U and M duty stations where medical conditions are frequently of poor quality this reactive approach remains unsatisfactory.

81. For any health scheme to work, it is indispensable that UNHCR Medical Service missions be programmed and carried out systematically to E, D and C duty stations over a 3 to 5 year time-frame. This will ensure at all these duty stations are properly evaluated from a medical perspective, including resuscitation capacities. New "hot spots" will of course take priority, but the less high-profile duty stations also require regular attention. The medical service tried in the past to establish a list of all the facilities used in the field by the staff by sending a questionnaire to each office. Answers have been lacking and often of poor quality. This, among other things, necessitated the questionnaire sent out by EPAU. The questionnaire could become a tool for this process of periodic evaluations (see further under Part III).

82. Furthermore, the Medical Service should be in possession of a clear picture of the living and working conditions, the pathological environment, the different risk factors and the level of medical facilities available at each duty station. Regular visits to the most critical duty stations help develop this. However a more comprehensive picture can be obtained from the compilation of answers to an all-inclusive checklist the Medical Service should prepare and send to the various duty stations. The study and analysis of the data compiled will help for the prioritization of the field visits. The Terms of Reference of each field mission should be standardized and targeting seven elements:

- Working conditions and living environment,
- The pathological context,

- The staff health and medical needs,
 - Assessment of the existing medical structures,
 - Analysis of the security risk factor and its impact on the mental health,
 - Review the medical evacuation plan,
 - Assessment of compliance with annual medical reporting, administrative and programming requirements.
- Recommendation 14: The field activities of the medical service should be much more structured and carried out very systematically. The field visits should be planned in advance on a two years cycle, with an average of 4 to 6 per year according to criteria of priority approved by the Senior Management.

Medical conditions in C, D and E duty stations

62.53% of staff in C, D, E, U and M duty stations

83. As mentioned above, by 31 October 2003, in UNHCR the aggregate field staffs outnumber Geneva-based staff with 62.53% for C, D, E, U and M duty stations and a combined 19.96% for A and B duty stations against 17.45 % for H. In addition the UNHCR Medical Service has some responsibilities for 8,860 dependents in C, D, E, U and M duty stations (73%) and 3,287 dependents in H, A and B duty stations (27%).

UNHCR STAFF STATISTICS FOR 10/2003									
Duty station category	H	A	B	C	D	E	M	U	Total
ALL STAFF									
Males	438	278	390	516	588	1,258	176	335	3,979
Females	676	328	278	350	296	370	43	59	2,400
Total	1,114	606	668	866	884	1,628	219	394	6,379
Dependents	1,462	775	1,050	1,728	1,768	4,038	482	844	12,147
INTERNATIONAL STAFF									
Males	311	79	101	130	109	168	16	16	930
Females	263	71	63	78	58	91	12	13	649
Total	574	150	164	208	167	259	28	29	1,579
Dependents	886	245	272	391	329	513	49	50	2,735
LOCAL STAFF									
Males	127	199	289	386	479	1,090	160	319	3,049
Females	413	257	215	272	238	279	31	46	1,762
Total	540	456	504	658	717	1,369	191	365	4,800
Dependents	576	530	778	1,337	1,439	3,525	427	789	9,412

Other information of medical relevance: Questionnaire

84. In the light of these statistics the focus of the UNHCR-Medical Service itself explicitly includes the field. EPAU therefore drew up a questionnaire to collect systematically information of medical relevance, but not covered in the traditional annual reports to the Joint Medical Service.

85. This questionnaire is attached (Annex III-1) and was sent to some 180 field offices (RO, BO, SO or FO) in categories C, D, E, M and U. Representatives and Bureaux were requested to verify that the list of addressees was correct as far as their area of responsibility was concerned. In total 79 out of these 180 or 44 % were completed, electronically, by 31 January 2004. Questionnaires received thereafter have not been included in the analysis presented in this report. While a 44% return rate may be satisfactory for an average questionnaire, for operational purposes a 100% return rate would be required, as the questionnaire was designed to serve as an instrument to assess in very specific terms the medical situations both at a local and at a global level and to draw from there conclusions for specific actions that are required.

86. The questionnaire contained where possible structured the "drop-down" lists to make subsequent data processing as accurate as possible. Besides the structured "drop-down" lists there was ample space for free text information and comments. A number of offices have used this possibility; others have given the bare minimum of information.

87. It must be noted that some Field Offices were not able to fully complete the questionnaire due to technical problems or limited computer skills in the office. Others provided information in a way which was not conforming to the structured questionnaire. It has been determined, that in a few cases, some of the information on the questionnaires received was not accurate or credible and therefore such information is subject to verification in a follow-up exercise.

UNHCR Medical Service database on field health conditions

88. The answers to the questionnaires have been used to generate this key segment of the report. Besides the report, the questionnaires have been used to produce an embryonic UNHCR Medical Service Field Conditions Database in MS Access. This database, in particular once all offices will have answered the questionnaire, can in the future serve in identifying lacunae and assist in setting future UNHCR Medical Service priorities with a view of attaining global medical minimum standards for all UNHCR staff in remote locations.

89. This database is restricted to information on medical conditions in C, D and E Duty Stations, it being considered that staff in H, A and B duty stations do have local access to appropriate medical services.

90. It is proposed that the UNHCR Medical Service inherit the database created for this research and elaborates on it with the help of ITTS. Many of the questions should be answered by Field Offices on an annual basis to assist the Regional Bureaux and the UNHCR Medical Service to target their attention and resources to the most

critical situations and to improve the balance between a curative and a more preventive modus operandi.

91. Any comments below therefore refer to the 73 responses received: 18 Cs, 23 Ds, 29 Es and 3 Us (undetermined status, but akin to E). Any future operational conclusions therefore may have to be modified as new responses come in. It is however considered that this would need to become a routine administrative function of the Medical Service, to help it being constantly as up-to-date as possible on the prevailing situation in each specific duty station and to establish its strategic priorities, focusing its attention and resources, to plan missions, to alert management to emerging patterns of health issues that may require early corrective action.

92. The analysis of the responses to the questionnaires received is structured as the questionnaire itself, but remains meager for the sake of brevity of this report. Particular emphasis is placed on responses to key questions which have a direct and critical impact on staff concerning medical services available C to E duty stations.

- Recommendation 15: UNHCR Medical Service should develop UNHCR Medical Service Field Conditions Database and receive the required IT assistance to do so. The database should be updated on an annual basis as part of the Country Operations Plan and Operational Review process. With the regular inputs from Field Offices, the Regional Bureaux and the UNHCR Medical Service should target their attention and resources to the most critical situations and improve the balance between a curative and a preventive modus operandi.

The questionnaire

93. The questionnaire contains series of questions under each of the following broad headings:

- 1 About the duty station
- 2 Characteristics and field presence
- 3 Numbers of unhcr / un staff
- 4 Medical environment at the duty station
- 5 Local health issues.
- 6 Administrative arrangements
- 7 Medical evacuation
- 8 First aid
- 9 JMS activities in the field.
- 10 Comments and questions (free text)

94. The analysis of the answers to the questionnaire:

Medical environment at the duty station

Presence of a local UN physician at the duty station:

95. From the responses received, 37 Offices (52%) mainly in C to E duty stations responded negatively to the question of the presence of UN physician at the duty station. The duty stations in this sample where a UN physician is present are 8.4% in C, 14% in D and 25% in E.

96. The selection of UN examining physicians is made formally by the Medical Service in New York. Whereas no doubt a number of the UN examining physicians are dedicated and competent, the function appeals not least as a steady source of (hard currency) income from an international clientele, as well as from periodic medical examinations paid for by the organization. In addition a certain prestige seems to be attached to the designation. An increased capacity on the part of the UNHCR Medical Service would enhance its capacity to properly evaluate the services of the UN examining physicians and suggest improvements or change. Such capacity is particularly required for duty stations where the mainstream agencies, in particular UNDP, are not present, of which there are many. In these cases, unless UNHCR take the initiative action is particularly slow in coming.

97. One must point out that from the responses received on hospitals in this field survey, there were 22 instances or 31 % where hospitals were considered to be substandard, where there is neither access to a local UN examining physician, nor to local facilities with well functioning resuscitation equipment, including a local trained resuscitation capacity. The duty stations in this sample lacking both a UN examining physicians and local facilities with well functioning resuscitation equipment are 3% in C, 7% in D and 20% in E.

98. Most duty stations from the C and D categories had the services of a General / Provincial Hospital at a distance of up to 5 km or 30 minutes or less to reach. Six duty stations in the E and D category had at least 20 km to cover, whereas one in the E and three D category duty stations had at least 50 km to cover to reach medical services.

- Recommendation 16: A more detailed review of the performance of local medical facilities and their categorization needs to be undertaken, in particular in the aforementioned more isolated duty stations. Such more detailed information would permit the definition of a health programme for staff adapted to each duty station. Given the volume of work involved, and the need for consistency of standards applied, this may initially be undertaken in the form of a "special project" with qualified consultants.
- Recommendations 17: Identification of a suitable UN physician in duty stations where there is no UN physician should be undertaken as competent and committed UN physicians will be critical in assisting UN staff with health issues and UNHCR Field Offices with the assessment of the locally available medical services. They may also play a crucial support role in cases of medical evacuations.

UN dispensaries

99. The quality of services, as well as types of services offered by the various UN-Dispensaries vary significantly. A small UN-Dispensary may become a dangerous thing if facilities teeter on the edge of incompetence and not meeting demand. A few years ago it was decided by the inter-agency meeting of Directors of Medical Services that all UN Dispensaries should be reviewed. This process seems to be stalled, if not forgotten. Mostly UN-Dispensaries are headed by IUNV doctors and controlled by the UNDP Resident Representative. If UN-Dispensaries are to have a level of credibility, the range of essential services, as well as quality of services needs to be reassessed and this will require the cooperation of UNDP and the Director of Medical Services in New York. Again, an increased capacity on the part of the UNHCR Medical Service would enhance its capacity to properly evaluate the services of the UN- Dispensaries and suggest improvements or change

- Recommendation 18: The quality of services, as well as types of services offered by the various UN-Dispensaries needs be reviewed systematically, in cooperation with UNDP and the Director of Medical Services in New York. This activity could possibly be combined with implementation of Recommendations 16 and 17.

Local management of health emergencies

100. From the responses received, there were 30 duty stations (42%) from C to E where a plan for local management of health emergencies for UN staff did not exist. However it was also noted that in 41 duty stations from C to E such a plan did exist. A key characteristic of the 41 duty stations is that 11 of them have more than 10 international staff and 50 national staff members working in these offices.

- Recommendation 19: As 42% of offices in C, D and E duty stations seem to operate without a plan for local management of health emergencies, the systematic establishment of such plans, and their annual updating, should be initiated as part of the submission of the annual Country Operations Plan, as a matter of highest priority.
- It is furthermore recommended that hand-over notes prepared by a Head of Office and an Administrative Officer for their respective successors should include a paragraph or more on the current status of the plan for local management of health emergencies. Incoming Heads of Office and Administrative Officers should within the first month of their arrival in a duty station have made familiarization visits to the principal local medical health care facilities. Instructions to that effect must be issued.

101. Annex III-1 highlights the Offices in C to E duty stations where the above mentioned plan does not exist.

Local health issues

102. With regard to local health issues, 53 responses (67%) confirmed that their duty stations were in a zone of high prevalence of a communicable disease. From all duty

stations, 47 replies (59%) concerned Malaria⁷. Annex III-2 shows the list of Offices with malaria as a disease with the highest incidence.

103. Additionally, there were indications of other diseases such as HIV/Aids (11 responses, 14%), hepatitis (18 responses, 23%), intestinal infections (23 cases, 29%), and further mention of diseases such as STDs, eye infections and skin disorders.

Guidelines on health hazards

104. A total of 50 offices (63%) stated that no guidelines on health hazards were available at their duty stations. These encompass duty stations that have, amongst others, a high prevalence of malaria. Annex III-3 gives a list of all offices that are in the abovementioned category. It is also noted from the responses, that there were 57 cases (72%), which pointed to the fact that malaria awareness sessions were not organized periodically. These sessions are meant to cover matters on prevention, early diagnosis and prompt treatment. Additionally in the area of malaria prevention, 64 cases (81%) reported that there was no provision of insecticide treated nets to all staff in their respective duty stations.

- Recommendation 20: Guidelines on Health Hazards, including malaria, HIV/AIDS, hepatitis, intestinal infections, STDs, eye infections and skin disorders should be made more widely available, not least to local staff and, where appropriate, in the local language. Other UN or international programmes may be sources for such materials. Such guidelines need to be complemented with periodic awareness training for all working regularly at UNHCR premises, as further steps in the prevention and treatment of highly communicable diseases.

Vaccinations

105. In keeping with international norms all staff members need to be appropriately vaccinated for the mission area they travel to and work in. It remains the individual responsibility of the staff member to ensure his / her personal compliance with this requirement, as well as that of their dependents that may accompany them. Systematic vaccinations have proven their efficacy in terms of reduction of vulnerability to communicable diseases and are therefore highly « cost effective ». Informing staff members of the health risks of a given mission or assignment and offering them all possible preventive measures, including vaccinations, show to the staff in an obvious aspect of how the organization fulfills its obligation of care towards them.

106. In terms of vaccinations, 61 offices (77%) do not keep a record to monitor pre-deployment vaccinations. 49 offices (62%) lack safe vaccination stocks and syringes.

- Recommendation 21: The UNHCR Medical Service in Geneva maintains up-to-date records of vaccinations, in respect of all staff. However the degree to which this can be accomplished depends on individual staff members

⁷ The questionnaire asked offices to rank diseases by importance. However it likely that this request was not accurately followed, nonetheless the information provided about communicable diseases in general is accurate.

sending photocopies of the relevant pages from their certificates to the UNHCR Medical Service. All Heads of Office and Administrative Officers are urged to remind staff members of their responsibility in this regard. Offices in C, D and E duty stations should keep locally safe vaccination stocks and syringes.

Reproductive health

107. The UNHCR Medical Service plays an important role in medical appraisal and health of pregnant staff members in the field, both as regards the administrative application of related rules and regulations and eventual medical evacuation where required. HIV/AIDS testing and monitoring is important in this connection to prevent or reduce the risk of the mother to child transmission of the virus.

Sexually Transmitted Diseases (STDs)

108. Concerning HIV/AIDS prevention and awareness activities on location, 22 offices (28%) responded with a "No". Under half of these negative responses come from E duty stations, and over a quarter each are from C and D stations. Additionally it was also noted from responses that 24 cases (30%) of C to E duty stations, did not have on location PET kits and UN staff were not aware of the usage and location of PET Kits. Annex III-4 attached shows the list of offices reflecting the above information under STDs.

109. As a matter of further information, there were six offices (7.5%) in mainly E duty stations, that did not have on location easy access to condoms or emergency contraceptives and 27 offices in C to E duty stations that did not have easy access to emergency contraceptives. Availability of PET (post exposure treatment) in case of accidental contamination with HIV infected blood or post rape or any other form of exposure is a very important safe guard for the staff at large. The UN Resident Representative will no longer be the custodian of these kits and UNSECOORD has accepted on behalf of all security advisers that the latter will now be the custodian of the stocks. It is very important that the UNHCR Medical Service brief security advisers on their new responsibilities, including when and how they should liaise with the UNHCR Medical Service.

110. It is noteworthy that in certain countries the use of part of the PET kit formally is forbidden for religious, political or legal reasons. The PET kit custodians in these countries are under instructions to remove such forbidden elements from the kits and destroy them! It is equally important that all security incidents be reported to the UNHCR Medical Service, as service incurred health implications must be recorded in the staff members file for the Service to follow up with the Compensation Claims Committee where necessary.

- Recommendation 22: The UNHCR Medical Service should undertake systematic briefings of security advisers on their new responsibilities as custodians of PET supplies.
- Recommendation 23: All security incidents must be reported to the UNHCR Medical Service, as service incurred health implications must be recorded in

the staff member's dossier and for follow up with the compensation claims committee where necessary.

- Recommendation 24: General HIV/AIDS prevention and awareness activities and the provision of PET kits as well as information about their use and location should be stepped up to cover all duty stations.

Medical evacuation

111. Medical evacuations are regulated by the MEDEVAC scheme instructions placing the responsibility / authority with the Head of Office, the person on the ground, who consults the UNHCR Medical Service.

112. There is a distinct difference between regular medical evacuations where the staff member or dependent can travel by regular air service and medical evacuations where use of emergency chartered medical evacuation services are imperative (International SOS). In practice the UNHCR Medical Service (7/7 and 24/24) is always being consulted to confirm which form of evacuation is justified and to receive appropriate medical guidance.

113. There were 39 respondents (55%) from C to E duty stations who indicated that they didn't have a Medical Evacuation Plan. Annex III-5 shows the list of Offices. On the subject of SOS medevac contacts and whether a back up system was in place in the absence of the Head of Office, there were 34 respondents (48%) from C to E duty stations, who responded there was not.

114. Distances to the airport for duty stations C to E in the context of Medevacs were also recorded. It was noted that there were 12 locations where staff have to cover a distance of approximately 50 km or needed an hour or more to reach the airport to carry out a medevac, a time consuming and life threatening exercise, compounded in cases by bureaucratic delays in negotiations, flight scheduling, frequent and sudden changes in flight timings and availability of aircraft, taking into account the type of airfield to be used.

115. To make the process of medical evacuations more efficient it is recommended that the UNHCR Medical Service and the Emergency Service develop one standard medevac checklist for each type of situation (regular and emergency), with an action sequence and spelling out of the designated responsibilities, with phone numbers .

116. Heads of Offices should become formally responsible for updating the duty station's medical evacuation plan. This updating could be included in the annual Country Operations Plan submissions in March and copies thereof provided to the UNHCR Medical Service and the Emergency Preparedness and Security Service for their perusal and comments.

- Recommendation 25: The development and maintenance of Medical Evacuation Plans should be extended to all Offices in C, D, E, M and U categories. This includes a back up system to cover for situations of absence of the Head of Office and standing arrangements for stabilization of patients and strher transport to the airport. The Medical Service should file annual compliance reports in respect of these and Heads of Office be held accountable therefore.

First Aid

117. The Medical Service organizes, since 1999, on a monthly basis, first aid training courses. On average 100 UNHCR staff are trained annually by qualified trainers from the Service. Close links have also been established with EPRS and Medical Service personnel have provided First Aid trainings or medical briefs at the Emergency Management Training for staff who enter the emergency roster.

118. A Memorandum of Understanding between UNHCR and the IFRC was signed in 1999 at the initiative of the UNHCR Medical Service and quite a number of offices have availed themselves of this local first aid training possibility. Yet many duty stations will have only one or not even one staff member familiar with first aid practice. Certified completion of first aid training and regular refresher courses need to become obligatory for all international and national professional staff working in the C, D and E duty stations, whether assigned there or just on mission.

- Recommendation 26: The UNHCR Medical Service and the Staff Development Section should develop a plan to have all international and national professional staff working in the C, D and E duty stations, whether assigned there or just on mission, complete a basic first aid training course by end 2006, and to have them attend refresher courses thereafter regularly. Certified completion of first aid training and regular refresher courses need to become obligatory for all international and national professional staff working in the C, D and E duty stations, whether assigned there or just on mission.

« *Standardized health kit* » and MOMS

119. The UNHCR Medical Service needs to create a « standardized health kit » containing not only training material but also list of minimum operating medical standards (MOMS) and equipment that all offices should have, including a list to keep the stocks current and a selection of suppliers. This package has been in the concept stage of development within the UNHCR Medical Service for quite some time and will require a level of commitment from the UNHCR administration and corresponding financial support, if it is to be applied globally. Each Head of Office should formally be held responsible for maintaining, under the ABOD, the standardized health kit complete, as well as ordering timely replacements of perishable or dated elements.

120. A positive aspect noted from the responses was the availability of First Aid Kits in most duty stations. The availability of First Aid Kits in vehicles used at these stations was also encouraging. However, there were 18 cases (7.5%) of duty stations mainly in the D and E categories, which did not possess these First Aid Kits either in their offices or in their vehicles. To facilitate quick remedial action Annex III-6 shows the offices that do not have First Aid Kits in their offices or in vehicles.

121. In response to the question regarding familiarity with the usage of traditional First Aid Kit contents, there were 22 negative responses (31%), in addition to 43 (60%) cases responding with a “No” when asked on whether training was carried out regularly on PET and First Aid Kits.

- Recommendation 27: Availability of complete and up-to-date First Aid Kits in all UNHCR offices and all UNHCR vehicles is a basic requirement that should be paired with regular First Aid Training. This basic requirement should be extended to all Offices. The Medical Service should file annual compliance reports in respect of kits and training and Heads of Office held accountable therefore.

Conclusion

122. Maintaining the health of UNHCR staff in remote locations where medical services are limited or even completely absent should be a top priority of the Office as a whole.

123. Within the context of very considerable organizational growth and persistent general human resource and budgetary restrictions this concept has evolved from a service of a nurse only, to a service with one medical doctor, one nurse and one secretary to at present a staff of twelve (ten and a half), comprising two medical doctors, two and a half nurses, three laboratory technicians, three (medical) secretaries and one administrative assistant.

124. Yet the top priority of maintaining the health of UNHCR staff in remote locations where medical services are limited or even completely absent is not as comprehensively addressed as it should be. With the regularization of all of the above staff as UNHCR staff members and the addition of one extra medical doctor, one extra nurse, one extra medical secretary and a corresponding budget revision, the UNHCR Medical Service should be able to focus the required attention on building up and maintaining "minimum operational medical standards".

125. These minimum operational medical standards would consist of a composite system of agreements and logistical arrangements to provide an essential level of care for staff in the remotest, most deprived duty stations, as well as other identified high risk duty stations. This will require to the extent possible the use of medical resources existing in the field, to be identified through answers by offices in the field to specific questions, be in the context of the annual programme review, or in the follow-up to the questionnaires used for this evaluation. In addition ongoing systematic missions to the field must be undertaken to periodically review available services and existing arrangements, and to explore the possibilities for cooperation and cost-sharing with in particular UNICEF and WFP who also have a major presence in the field.

126. The results from the analysis of the questionnaire clearly demonstrate that this is a long overdue issue that needs to be given immediate attention by the UNHCR Medical Service, as well as the additional resources required to accomplish this goal. The UNHCR Medical Service should, with external support, develop its proposals for inclusion in the ORB sessions of May 2004, and if not feasible, soonest thereafter.

127. In this context health should not just be defined as the absence of illness, but rather as maintaining an optimal physical and psychological condition that allows for a high level of judicious productivity.

128. Standards would both be purely medical and go somewhat beyond to assist staff in maintaining their level of fitness, intellectual alertness, a proper work – personal life balance . Tools to be developed and deployed would be a “standard health kit”, generalized First Aid training, local exercise or sport options, and also various rest and recuperation schemes beyond annual leave as already in existence.

- Recommendation 28: The UNHCR Medical Service should complete its work started on MOMS (minimal operational medical standards) and be reinforced to enable it to roll the MOMS out to the field, giving priority attention to the remotest, most deprived duty stations, as well as other identified high risk duty stations.

Part IV . Administrative and financial management

129. The current staffing table of the UNHCR Medical Service is as follows

Post	Contract type	Current grade
1 Chief Medical Officer, Head of Service	FT	P5
1 Deputy Chief Medical Officer	TA	P4
1 ½ Clinical Nurses	FT	G7 and G6
1 Clinical Nurse	TA	G6
1 Chief Laboratory Technician	FT	G6
1 Laboratory Technician	FT	G5
1 Laboratory Technician	TA	G5
2 Medical Secretaries	FT	G4
1 Medical Secretary	TA	G3
1 Administrative Assistant	FT	G6

130. As recommended above it is critical that the staff complement be enhanced with one medical doctor, one clinical nurse and one medical secretary if the recommendations contained in this report are to be implemented, in particular as regards health coverage in the remote field duty stations.

131. During its interaction with personnel of the UNHCR Medical Service, the evaluation team observed that work and personal relations between staff of the service are very good, that the group is animated by a strong team spirit and dedication to its mission under the committed leadership of the Chief Medical Officer, Head of Service. Staff members are perceptibly proud of their work. All standard administrative and management practices are being observed as best they can be under the permanent work pressure with frequently unforeseeable interruptions. Information within the service flows to everyone's satisfaction, while a strict code of medical confidentiality is stringently respected.

132. All staff members have endured the uncertainties resulting from the prolonged institutional crisis of the Joint Medical Service managed by WHO. Their loyalty clearly lies with UNHCR and its staff with whom they identify, their link with WHO never having been more than essentially administrative. Staff hope for speedy and equitable incorporation into UNHCR. This is indeed in UNHCR's interest as the persons concerned are confirmed specialized staff and collectively they are the office's institutional medical memory.

- Recommendation 29: Full incorporation of the UNHCR Medical Service staff into UNHCR, as recommended in Recommendation 3 will require the Medical Service posts to be classified and included into the CMS - PAR system.

133. The erstwhile JMS located its laboratory services some years back in UNHCR. In effect the laboratory carries out certain services for the other agencies, just as UNHCR staff members used to get their X-rays done at the Palais des Nations.

Meanwhile some agencies i.e., ILO, WTO and WIPO have set up their own laboratories. Given that the services provided by the in-house laboratory are less expensive, at least as reliable, and for certain pathologies more reliable than commercially available laboratory services, it should be concluded that it is in UNHCR's interest to maintain the laboratory. UNHCR would need to examine whether and how to reimburse against present day value the partner agencies that have invested in laboratory equipment. Alternatively UNHCR could continue to provide laboratory services for a fixed period determined by the anticipated value of services rendered during that period.

General administration ABOD (Administrative Budget and Obligation Document)

134. The UNHCR Medical Service will need its own ABOD like any administrative entity in UNHCR HQs, including travel, miscellaneous services, training, temporary assistance and overtime, to cover its own operating expenses that are not covered by the common budget. In addition UNHCR Medical Service will require an operational budget for medical and laboratory equipment and consumable supplies for:

- the regular use of the Service at HQs;
- an emergency stock for dispatch to field offices with unforeseen unmet needs; and
- training activities.

Financial management medical services field

135. The need for medical services for staff, including training (First Aid, HIV/AIDS, vector control), in the field should be identified and managed by the Heads of Offices in the field as part of their own responsibilities and presented annually in a dedicated segment of the Country Operations Plan, having reference to the aforementioned MOMS under preparation by the UNHCR Medical Service. The Medical Service shall examine together with the Regional Bureaux the relevant elements of the submission, seek clarifications as required and advise the ORB on the justified needs of each office. Each office should be allotted the required resources for medical services in their ABODs. Regular operational budget and financial control mechanisms shall apply to the disbursement of the funds concerned.

- Recommendation 30: A regular ABOD needs to be established for the UNHCR Medical Service. Heads of Offices in the field should be instructed to submit as part of their own responsibilities their office's need for medical services for staff, including training. Such needs should henceforth be presented annually in a dedicated segment of the Country Operations Plan.

Annex I-1. Draft ToR for the UNHCR Medical Unit

The UNHCR Medical Unit:

Advises, in its quality of medical authority, the High Commissioner with regard to health policies and implementation thereof in order to maintain the health of UNHCR staff members and their families, wherever posted or on mission, taking into account the conditions and risks inherent in the working environment and based on relevant public health and workplace health recommendations of the WHO and the ILO.

This policy must necessarily be achieved by the simultaneous pursuit of 5 objectives:

1. Evaluation, everywhere, of the principal health risks for staff in their workplace, working and living environment.
2. Evaluation, everywhere, of the medical aptitude (physical and psychological) of each staff member to face up to these risks.
3. Prevention of illnesses and accidents through informing of staff members of health risks and life-style and sanitary education and drawing the attention of the administration to situations which would present increased risks, in order that such risks be weighed in decision making.
4. Medical assistance in the workplace, everywhere, in case of illness or accident.
5. Social protection of staff members through provision of medical assistance or advice in cases of illness, accident, temporary or permanent handicaps:

Liaison with the Insurance Committee of the United Nations for non-work related illnesses and accidents (UNMIS, MIP).

Liaison with the Indemnification Committee of the United Nations for work-related illnesses and accidents.

Liaison with the Invalidity Pensions Committee of the United Nations for UN staff and their family members (UNPF).

Liaison with the Division of Human Resource Management of UNHCR for special education grants for handicapped children of staff members.

Liaison with the Division of Human Resource Management of UNHCR for the protection of pregnant female staff members working in high risk zones and for children of staff members for whom there is no suitable medical facility at the duty station.

The functions under 5 above may include promoting improvements or change as required by evolving medical science and practice and insurance industry norms.

Counsels, orients and provides individual medical assistance to each staff member and to the extent possible in regard to any medical questions.

Counsels and assists during and after regular missions to the field, as medical expert, the responsible Directors, the Representatives and Heads of Office in the field, with regard to implementing all actions required to maintain the health of UNHCR staff under their responsibility in their workplace and working and living environments.

Maintains a close collaboration with the Staff Welfare Unit and the Field Staff Safety Section in the interest of the best possible support of staff in the field.

Under the authority of the Chief Medical Doctor, the UNHCR Medical Unit, based at UNHCR HQs in Geneva, comprises specialized medical staff as well as administrative staff. The medical staff consists of physicians, nurses, laboratory technicians, competent in the area of travel medicine, the medical preparation and international vaccination of travelling and sedentary staff, humanitarian medicine, medical emergencies, and health practice education. The administrative staff on the other hand needs to be qualified to handle confidential medical files and to undertake all other administrative tasks such as budget monitoring and purchasing for the service in general. Both categories of staff need to be familiar with relevant UN rules and regulations pertaining to their area of activity.

The activities of the UNHCR Medical Unit include two key components: 1) activities directed at permanent evaluation of health risks for staff members in the workplace and work and living environments and the evaluation of the physical and psychological aptitude of staff members; 2) activities directed at conceiving and implementing at field level workplace of health education programmes (ie HIV/AIDS, first aid, health maintenance, tropical hygiene), the implementation of risk reduction measures and emergency medical assistance in the workplace.

The medical staff (physicians, nurses, laboratory technicians and medical secretaries) of the UNHCR Medical Unit needs to permanently educate itself, and give itself the means to do so, in order to maintain a high level of medical competence, in keeping with the evolution of medical science and practice.

The staff of the UNHCR Medical Unit must maintain professional links with the different medical services of the United Nations system with a view to better serving UNHCR staff, a better coordination, a harmonization of service and a standardization of medical support provided to staff members in the field. Inter-agency meetings should take place regularly.

The UNHCR Medical Unit carries out all its activities in a spirit of scrupulous respect of medical secrets, respecting confidentiality, neutrality and acting with professional independence. The staff of the UNHCR Medical Unit shall respect the UNHCR Code of Conduct and the mandate of UNHCR.

Geneva, 14 January 2004

Annex II-1. Sick leaves

	2000	2000	2000	2001	2001	2001/ 2000	2001/ 2001	2002	2002	2002/ 2000	2002/ 2002	2003	2003	2003/ 2000	2003/ 2003
TOTAL STAFF															
HQs+field	5,215	100%	100%	5,283	100%	101.30%		6,094	100%	116.86%		6,379	100%	122.32%	
Male	3,108	59.60%		3,172	60.04%			3,848	63.14%			3,979	62.38%		
Female	2,107	40.40%		2,111	39.96%			2,246	36.86%			2,400	37.62%		
HQs	820	15.72%		839	15.88%			866	14.21%			882	13.83%		
Male	328	40.00%		336	40.05%			340	39.26%			350	39.68%		
Female	492	60.00%		503	59.95%			526	60.74%			532	60.32%		
Field	4,395	84.28%		4,444	84.12%			5,228	85.79%			5,497	86.17%		
Male	2,780	63.25%		2,836	63.82%			3,508	67.10%			3,629	66.02%		
Female	1,615	36.75%		1,608	36.18%			1,720	32.90%			1,868	33.98%		
220 Workdays	1,147,300			1,162,260				1,340,68				1,403,38			

UNHCR'S MEDICAL SERVICE

	2000	2000	2000	2001	2001	2001/ 2000	2001/ 2001	2002	2002	2002/ 2000	2002/ 2002	2003	2003	2003/ 2000	2003/ 2003
# SICK DAYS															
HQs + field	27,381	100%	2.39%	23,152	100%	84.55%	1.99%	28,276	100%	103.27%	2.11%	25,167	100%	91.91%	1.79%
Male															
Female															
HQs	11,484	41.94%	1.00%	9,164	39.58%	79.80%	0.79%	11,182	39.55%	97.37%	0.83%	9,979	39.65%	86.89%	0.71%
HQs sick leave	14.00			10.92				12.91				11.31			
Male															
Female															
Field	15,897	58.06%	1.39%	13,988	60.42%	87.99%	1.20%	17,094	60.45%	107.53%	1.28%	15,188	60.35%	95.54%	1.08%
Field sick leave	3.62			3.15				3.27				2.76			
Male															
Female	17.62			14.07				16.18				14.08			
HQs	0.79			0.78				0.80				0.80			
Field	0.21			0.22				0.20				0.20			
HQs/field	3.87			3.47				3.95				4.09			

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	2000	2000	2000	2001	2001	2001/ 2000	2001/ 2001	2002	2002	2002/ 2000	2002/ 2002	2003	2003	2003/ 2000	2003/ 2003
# CASES															
HQs+field	1,350	100%		1,156	100%	85.63%		1,370	100%	101.48%		1,445	100%	107.04%	
Male															
Female															
HQs	791	58.59%		719	62.20%	90.90%		760	55.47%	96.08%		803	55.57%	101.52%	
HQs cases ratio	0.96			0.86				0.88				0.91			
Male															
Female															
Field	559	41.41%		437	37.80%	78.18%		610	44.53%	109.12%		642	44.43%	114.85%	
Field cases ratio	0.13			0.10				0.12				0.12			
Male															
Female	1.09			0.96				0.99				1.03			
HQs	0.88			0.90				0.88				0.89			
Field	0.12			0.10				0.12				0.11			
HQs/field	7.58			8.71				7.52				7.80			
S/L duration	1.96			2.51				1.90				1.90			
	0.51			0.40				0.53				0.53			

Annex II-2. Illnesses among staff

Year	2000	% of Staff	2001	% of Staff	2001% of 2000	2002	% of Staff	2002% of 2000	2003	% of Staff	2003% of 2000
Staff employed at 31/12	5,215	100%	5,283	100%	101.30%	6,094	100%	116.86%	6,379	100%	122.32%
Unspecified cause	946	18.14%	891	16.87%	94.19%	1077	17.67%	113.85%	824	12.92%	87.1%
Average duration in days	2.09	100%	2.31		110.63%	2.20		105.40%	3.12		149.28%
Cumulative Sub-Total	1,975	100%	2,058		104.20%	2,370		120.00%	2,568		130.03%
Ear Nose Throat	37	0.71%	35	0.66%	94.6%	45	0.74%	121.62%	91	1.43%	245.95%
Average duration in days	10.24	100%	7.77		75.87%	8.07		78.75%	9.31		90.87%
Cumulative Sub-Total	379	100%	272		71.77%	363		95.78%	847		217.41%
Psychiatric	75	1.44%	84	1.59%	112.00%	86	1.41%	114.67%	81	1.27%	108.00%
Average duration in days	49.31	100%	59.10		119.85%	65.53		132.91%	42.58		86.36%
Cumulative Sub-Total	3,698	100%	4,964		134.23%	5,636		152.41%	3,449		93.27%
Traumatology	38	0.73%	25	0.47%	65.79%	26	0.43%	68.42%	72	1.13%	189.47%
Average duration in days	27.55	100%	24.44		88.70%	25.62		92.97%	35.67		129.45%
Cumulative Sub-Total	1,047	100%	611		58.36%	666		63.61%	2,568		245.27%
Obstetrics	34	0.65%	22	0.42%	64.71%	14	0.23%	41.18%	49	0.77%	144.12%
Average duration in days	17.18	100%	21.27		123.85%	15.64		91.07%	31.061		180.84%
Cumulative Sub-Total	584	100%	468		80.14%	219		37.50%	1,522		260.62%
Gynecology	23	0.44%	19	0.40%	82.61%	7	0.11%	30.43%	34	0.53%	147.83%
Average duration in days	23.78	100%	18.32		77.01%	21.86		91.90%	30.97		130.22%
Cumulative Sub-Total	547	100%	348		63.62%	153		27.97%	1,053		192.50%
Dorsal	25	0.48%	23	0.44%	92.00%	38	0.62%	152.00%	60	0.94%	240.00%
Average duration in days	80.28	100%	60.39		75.23%	64.05		79.79%	17.55		21.86%
Cumulative Sub-Total	2,007	100%	1,389		69.21%	2434		121.28%	1,053		52.47%

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HIV/AIDS	25	0.48%	24	0.45%	96.00%	16	0.26%	64.00%	22	0.34%	88.00%
Average duration in days	71.4	100%	40.54		56.78%	17.81		24.95%	17.45		24.45%
Cumulative Sub-Total	1,785	100%	973		54.51%	285		15.97%	384		21.51%
Cardiological	6	0.12%	10	0.19%	166.67%	6	0.10%	100.00%	35	0.55%	583.33%
Average duration in days	27.33	100%	34.20		125.12%	27.83		101.83%	52.14		190.77%
Cumulative Sub-Total	164	100%	342		208.54%	167		101.83%	1,825		1112.80%
Neurological	14	0.27%	6	0.11%	42.86%	16	0.26%	114.3%	33	0.52%	235.71%
Average duration in days	21.36	100%	27.00		126.42%	14.63		68.48%	20.79		97.33%
Cumulative Sub-Total	299	100%	162		54.18%	234		78.26%	686		229.43%
Cancer	30	0.58%	12	0.23%	40.00%	17	0.28%	56.67%	48	0.75%	160.00%
Average duration in days	65	100%	68.33		105.13%	94.12		144.80%	50.29		77.37%
Cumulative Sub-Total	1950	100%	820		42.05%	1600		82.05%	2414		123.79%
Digestive	18	0.35%	16	0.30%	88.89%	10	0.16%	55.56%	51	0.80%	283.33%
Average duration in days	23.11	100%	10.00		43.27%	49.90		215.91%	21.80		94.34%
Cumulative Sub-Total	416	100%	160		38.46%	499		119.95%	1112		267.31%
Broncho	13	0.25%	11	1.23%	84.62%	10	0.16%	76.92%	38	0.60%	292.31%
Average duration in days	13.69	100%	9.45		69.05%	13.5		98.60%	15.08		110.13%
Cumulative Sub-Total	178	100%	104		58.43%	135		75.84%	573		321.91%
Dermato	4	0.08%	3	8.57%	75.00%	2	0.03%	50.00%	10	0.16%	250.00%
Average duration in days	34.5	100%	14		40.58%	10		28.99%	14.1		40.87%
Cumulative Sub-Total	138	100%	42		30.43%	20		14.49%	141		102.17%
Total Number of Cases	1250	23.97%	1156	21.88%	92.48%	1370	22.5%	109.6%	1448	22.70%	115.84%
Total No. days of Sick Leave	15,167	100%	12,729		83.92%	14,781		97.46%	20,195		133.15%
Average duration of all Sick Leaves	12.13	100%	13.12	108.13%	108.13%	10.79	88.92%	88.92%	13.95	114.94%	114.94%
Average All Staff Sick Leave against 220 Workdays/Year	2.91	100%	2.41	110%	82.84%	2.43	1.10	83.40%	3.17	1.44	108.85%
Unspecified cause as a % of all cases by year	75.68%		77.08%			78.61%			56.91%		

Annex III-1. Questionnaire

Evaluation of the UNHCR Unit of the Joint Medical Service

Field Health Service Questionnaire (11/03)
(Please complete electronically using Drop-Down Lists
and spaces to the left of the (free text areas))
(Please observe Foot Notes)

I ABOUT THE DUTY STATION:

- I A) Country: (free text area)
I B) Office designation⁸:
I C) Location: (free text area)

II CHARACTERISTICS AND FIELD PRESENCE

II A) Hardship Category of this Duty Station⁹ (Please select) :
Any changes in status during past 5 years? (please specify)
(free text area)

II B) Category of this Duty Station (Family/Non-family):
Any changes in status during past 5 years? (please specify)
(free text area)

II C) Security phase of this Duty Station over the past 2 years:
Any changes in status during past 2 years? (please specify)
(free text area)

II D) Hardship entitlements of this Duty Station ¹⁰:

III NUMBERS OF UNHCR / UN STAFF

III A) Number¹¹ of UNHCR staff present at the duty station:
International:
National:

⁸ Please select from drop-down list

⁹ H, A, B, C, D, E, M, U

¹⁰ MARS, VARI, SOLAR

¹¹ < means less than X, > means more than Y

III B) Number of UNV's with UNHCR present at the duty station:

International:

National:

III C) Number of UNHCR Consultants present at the duty station:

International:

National:

III D) Number of UNHCR dependants present at the duty station:

International:

National (incl. NUNVs):

III E) Other UN Agency present at the duty station (WFP, UNICEF, OCHA,WHO, UNDP, FAO,)

Select one or more:

(free text area)

III F) Other International Agency (ICRC, IFRC, EU, IOM) present at the duty station

Select one or more:

(free text area)

III G) Bilateral Aid Agencies (please specify)

(free text area)

III H) International NGOs present at the duty station (specify)

(free text area)

III I) Other (specify)

(free text area)

III J) Total Number of UN staff present at the duty station:

International:

National:

III K) Total Number of UN dependants present at the duty station:

International:

National:

III L) Is there co-operation on staff health, safety and welfare with other UN agencies?

Select: Yes/ No:

- If No Why not:

(free text area)

- If Yes Frequency:
(free text area)

- If Yes Subjects covered:
(free text area)

- If Yes Types of Activities:
(free text area)

III M) Any cost sharing of health arrangements with other UN agencies:
Select: Yes/ No:

If Yes (please specify)
(free text area)

IV MEDICAL ENVIRONMENT AT THE DUTY STATION

IV A) Presence of a local UN physician:
Select: Yes/ No
If yes, select:

IV B) Closest working (equipped and staffed) local medical structure¹²:
(free text area)

IV B-a) Is there well-functioning resuscitation equipment on location ?
(free text area)

IV B-b) Is there a local resuscitation human resource capacity?
(free text area)

IV C) Distance¹³ from this medical structure

IV D) Latest evaluation of this medical structure¹⁴:
If Yes, Please Specify by Who, Copy of Report?
(free text area)

What were the Main Recommendations?
(free text area)

Have these been implemented?
(free text area)

¹² - General Hospital (Medical and surgical wards, laboratory, X-ray) in urban centre
- Provincial Hospital (Medical and surgical wards, laboratory, X-ray) in rural area
- Dispensary (basic facilities, basic lab)

¹³ < means less than X km or Y min to reach, > means more than X km or Y min to reach

¹⁴ < 1 year, < 2 years, < 5 years, > 5 years

If not, why not ?
(free text area)

IV E) International NGO with medical presence (ICRC, MSF, other):

Select: Yes/ No

If Yes (select and provide some details)
(free text area)

IV F) International NGO Medical Structure at duty station (ICRC, MSF, other):

Select: Yes/ No

If Yes (select)

IV G) Arrangements with the medical NGO (if any) concerning staff health care:

Select: Yes/ No

If Yes (specify and provide details)
(free text area)

IV H-a) Does a plan for local management of health emergencies for UN staff exist?

IV H-b) Is UN international staff aware of this plan ?

IV H-c) Are local staff aware of their inclusion in resuscitation and medical evacuation plans?

V LOCAL HEALTH ISSUES.

V A) Is the duty station in a zone of high prevalence of a communicable disease¹⁵

Select: Yes/ No

If Yes (select one or more and provide some details)

V B) Are guidelines about health hazards or required prophylaxis available / posted?

V C) Vaccinations

V C-a) Does your office keep a record to monitor whether pre-deployment vaccinations up-to-date ?

V C-b) Do you have locally safe vaccination stocks and syringes etc?

V D) Malaria

V D-a) If in malaria endemic area, are malaria awareness sessions organized periodically ? (prevention, early diagnosis and prompt treatment) (important and avoidable cause of ill-health and absenteeism)

¹⁵ malaria, eye infections, intestinal infections, skin disorders, other

V D-b) Do you have on location a provision of insecticide treated net to all staff (with provision for re-treatment or re-provision every 6 months for standard nets)
(free text area)

V D-c) Do you have on location rapid diagnostic tests and effective emergency malaria treatment after hours ?

V E) Safe Drinking Water

V E) Do you have on location adequate provision of safe drinking water (filters, boiling facilities, appropriate containers, refrigerator) ?
(free text area)

V F) Poisonous insects or snakes

V F-a) Are poisonous insects or snakes a serious threat for the staff in the local environment?
Select: Yes/ No
(free text area)

V F-b) If yes, are necessary guidelines and drugs / anti-dotes accessible to staff?
Select: Yes/ No
(free text area)

V G) Sexually Transmitted Diseases (STD's):

V G-a) Do you have on location HIV/STI prevention and awareness activities ?
(free text area)

V G-b) Do you have on location PEP kits available and are UN staff aware of use & location of PEP kits?
(free text area)

V G-c) Do you have on location easy access to condoms ?
If yes, where? (e.g. health clinic, pharmacy, et..)

(free text area)

V G-d) Do you have on location easy access to emergency contraceptives?

If yes, where? (e.g. health clinic, pharmacy, et..)
(free text area)

V G-e) Are local staff aware of the benefits of MIP (local insurance); in particular, are they aware that they have access to anti-retrovirals for themselves and their families?

(free text area)

V H) Living Conditions

V H-a) Can the living conditions of the staff be qualified as (select one or more and provide some details)¹⁶:
(free text area)

V H-b) Staff housing¹⁷:
(free text area)

V I) Substance abuse prevention and awareness activities (cigarettes, alcohol, minor tranquilisers, other)

(free text area)

V I) Staff behavioral problems caused of aggravated by to living conditions¹⁸:
(free text area)

V J) Accidents

(free text area)

V J-a) Rate of car accidents¹⁹:
Please select:

V J-b) Numbers of car accidents with physical injuries involving UNHCR and UN vehicles during last 5 years:

Agency	1999	2000	2001	2002	2003
UNHCR					
UNICEF					
WFP					
UNDP					

(free text area)

¹⁶ Normal (Running Water, Electricity mostly available, Adequate security)
Difficult (Running Water, Electricity mostly unavailable, Inadequate security)
Socially isolated
Stressful, at risk within context of ongoing civil unrest, war etc

¹⁷ Apartment, villa, compound, "guest house", hotel, tent

¹⁸ None, Alcohol, Excessive Tobacco Use, Drugs, Medicines, High Risk Behaviors

¹⁹ Normal, High, Alarming, Unknown

VI ADMINISTRATIVE ARRANGEMENTS

Please calculate the rates of staff absence on sick leave for international staff as a group and for local staff as a group, as a percentage of total work time including MARS, VARI, SOLAR and regular annual leave.

VI A) Certified sick leave

International Staff

Local Staff

(free text area)

VI B) Un-certified sick leave

International Staff

Local Staff

(free text area)

VI C) Family sick leave

International Staff

Local Staff

(free text area)

VI D) Periodic medical examinations have been arranged locally:

Select: Yes/ No

If Not, why not:

(free text area)

VII MEDICAL EVACUATION

VII A) Is there a medical evacuation plan and do you have a copy?

Select: Yes/ No

(free text area)

VII B) Has the medical evacuation plan been reviewed and approved by FSS and JMS?

Select: Yes/ No

If Yes: When (free text area)

VII C) Closest working Airport²⁰ (please specify):

Select:

(free text area)

²⁰ International 24 hrs /day- 7 days a week, Local 24 hrs /day- 7 days a week , Local day light only, largest type of aircraft able to land ? Landing strip.

VII D) Largest Type of Aircraft able to land (please specify):
(free text area)

VII E) Distance from this airport²¹:
Select:
(free text area)

VII F) Number of equipped ambulances locally available
(free text area)

VII G) What is the name of the local care unit, Doctor in-charge and telephone number ?
(free text area)

VII H) Are S.O.S. medevac contacts(country,telephone) available and do you have a back-up system in place in the absence of Representative / Head of Office ?

VII I) Number of medical evacuations among UN and UNHCR staff

Agency	1999	2000	2001	2002	2003
UNHCR					
UNICEF					
WFP					
UNDP					

(free text area)

VII J) Number of deaths among UN and UNHCR staff in last year

Agency	1999	2000	2001	2002	2003
UNHCR					
UNICEF					
WFP					
UNDP					

(free text area)

²¹ <5km or <30min to reach, <20km or 30min to reach, <50km or 1 hour to reach, >50km or over 1 hour to reach.

VIII FIRST AID

VIII A) Are First Aid Kits available at the office?

Select: Yes/ No

(free text area)

VIII B) Are First Aid Kits available in all vehicles?

Select: Yes/ No

(free text area)

VIII C) Are staff familiar with PET Kit's (HIV/AIDS) contents and use?

Select: Yes/ No

(free text area)

VIII D) Are staff familiar with traditional First Aid Kit's contents and use?

Select: Yes/ No

(free text area)

VIII E) Are trainings about the PET and First Aid Kits organized regularly?

Select: Yes/ No

If Yes, what Frequency

(free text area)

VIII F) When did the last one take place²²?

(free text area)

VIII G) Who is in charge for conducting the training²³?

(free text area)

VIII H) In case of a trained HCR staff; How was he trained²⁴ ?

(free text area)

IX JMS ACTIVITIES IN THE FIELD.

IX A) Did a mission from JMS take place in your duty station?

Select: Yes/ No

If Yes When ? (free text area)

²² This year, Last year, Don't know.

²³ Trained local staff, Trained international staff, Health professional from UN agency, Health professional from international NGO, Health professional from local medical structure.

²⁴ Prior to entry into UNHCR, During the last JMS mission at your location, During a training organised regionally by JMS, By JMS in Geneva, During a previous assignment, Locally through specific arrangement,

IX B) Have you requested a JMS mission to your duty station?

Select: Yes/ No

If yes, what were the main objectives²⁵?

(free text area)

If No, Why not ?

(free text area)

IX C) Was a regional meeting organized recently in your region?

Select: Yes/ No

If Yes When ? (free text area)

IX D) How would you qualify your contact with JMS²⁶?

IX E) Subjects of your contact with JMS²⁷?

.....
.....

(free text area)

X COMMENTS & QUESTIONS (FREE TEXT)

(free text area)

Please add whatever you deem useful. Many thanks in advance and best regards.

²⁵ Training, Guidelines on healthy work environment, Information on specific health hazards (HIV, smoking, drug abuse), Support for negotiation local medical arrangements, Review/ approval of medical evacuation plan, Other.

²⁶ Non-existent, On ad hoc basis, Regular

²⁷ Periodic Medical Examinations, Evaluation local medical services, Supply of Medical Kits, Medical Evacuation, Staff personal mental health issues

Annex III-2

Sample of questionnaire results

The reports below are just a few of a large number of possible reports that the prototype of the UNHCR database of field health conditions can produce. It should also be borne in mind that while this data enables direct corrective action a little over half of the offices have not responded. Therefore a follow-up is required to reach 100% coverage.

List of offices in C to E duty stations where a plan for local management of health emergencies for UN staff does not exist

Hardship category C

Colombia	Apartado	Field-Office	Security Phase:	2
Colombia	Barrancabermeja	Field-Office	Security Phase:	2
Gambia	West Africa	Other	Security Phase:	0
Iran	Tehran	Branch Office	Security Phase:	2
Republic of	Central Asia	Field-Office	Security Phase:	0
Rwanda	Kigali	Branch Office	Security Phase:	0
Saudi Arabia	Rafha	Field-Office	Security Phase:	2

Hardship category D

Angola	Mbanza Congo	Sub-Office	Security Phase:	2
Congo (ROC)	Loukolela	Field-Office	Security Phase:	4
D. R. Congo	Lubumbashi	Field-Office	Security Phase:	3
Eritrea	Barentu	Sub-Office	Security Phase:	3
Guinea	Nzerakore	Sub-Office	Security Phase:	3
Iran	Mashad	Sub-Office	Security Phase:	2
Pakistan	Karachi	Field-Office	Security Phase:	3
Russian Fed.	Vladikavkaz, N.	Sub-Office	Security Phase:	3

Hardship category E

Afghanistan	Jalalabad	Regional Office	Security Phase:	0
Algeria	Algiers	Branch Office	Security Phase:	3
Angola	Luau	Field-Office	Security Phase:	3
Congo (RoC)	Aru	Sub-Office	Security Phase:	4
Sierra Leone	Freetown	Branch Office	Security Phase:	3
Sierra Leone	Kailahun	Field-Office	Security Phase:	4
Sierra Leone	Zimmi	Field-Office	Security Phase:	3
Sri Lanka	Trincomalee	Field-Office	Security Phase:	3
Tanzania	Kigoma	Field-Office	Security Phase:	1

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Tanzania	Kibondo	Sub-Office	Security Phase:	1
Tanzania	Ngara	Sub-Office	Security Phase:	1
Tanzania	Kasulu	Sub-Office	Security Phase:	1

Hardship category M

Sri Lanka	Mannar Island	Field-Office	Security Phase:	3
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List of offices with Malaria as a disease with the highest incidence

Hardship category B

Congo	Betou	Field-Office	Security Phase:	4
Saudi Arabia	Riyadh, Covering	Regional Office	Security Phase:	2

Hardship category C

Bangladesh	Dacca	Branch Office	Security Phase:	0
Colombia	Barrancabermeja	Field-Office	Security Phase:	2
Colombia	Apartado	Field-Office	Security Phase:	2
DRC	Kinshasa	Branch Office	Security Phase:	2
Eritrea	Asmara	Branch Office	Security Phase:	1
Gambia	West Africa	Other	Security Phase:	0
Ivory Coast	Abidjan	Branch Office	Security Phase:	4
Mauritanie	Nouakchott	Branch Office	Security Phase:	1
Rwanda	Kigali	Branch Office	Security Phase:	0
Saudi Arabia	Rafha	Field-Office	Security Phase:	2
Tanzania	Dar es Salaam	Branch Office	Security Phase:	0

Hardship category D

Angola	Mbanza Congo	Sub-Office	Security Phase:	2
Congo	Brazzaville	Branch Office	Security Phase:	2
Congo (ROC)	Loukolela	Field-Office	Security Phase:	4
D. R. Congo	Lubumbashi	Field-Office	Security Phase:	3
Eritrea	Barentu	Sub-Office	Security Phase:	3
Guinea	Nzerakore	Sub-Office	Security Phase:	3
Nigeria	Lagos	Branch Office	Security Phase:	2
Papua New Guinea	Not found	Branch Office	Security Phase:	2
Tajikistan	Dushanbe	Branch Office	Security Phase:	2
Timor-Leste	Dili	Branch Office	Security Phase:	1
Yemen	Sanaa	Regional Office	Security Phase:	0
Zambia	Solwezi, North	Field-Office	Security Phase:	2
Zambia	Mporokoso	Field-Office	Security Phase:	2

Hardship category E

Afghanistan	Herat	Sub-Office	Security Phase:	3
Angola	Luau	Field-Office	Security Phase:	3

List of offices with Malaria as a disease with the highest incidence

Congo, RoC	Aru	Sub-Office	Security Phase:	4
D. R. Congo	Bukavu Goma	Sub-Office	Security Phase:	3
Ethiopia	Assosa	Field-Office	Security Phase:	1
Guinea	kissidougougou	Sub-Office	Security Phase:	3
Ivory Coast	Tabou	Field-Office	Security Phase:	3
Liberia	Monrovia	Branch Office	Security Phase:	4
Myanmar	Maungdaw	Field-Office	Security Phase:	1
Sierra Leone	Kailahun	Field-Office	Security Phase:	4
Sierra Leone	Freetown	Branch Office	Security Phase:	3
Sri Lanka	Jaffna	Field-Office	Security Phase:	3
Sri Lanka	Trincomalee	Field-Office	Security Phase:	3
Tanzania	Kasulu	Sub-Office	Security Phase:	1
Tanzania	Kibondo	Sub-Office	Security Phase:	1
Uganda	Arua	Sub-Office	Security Phase:	3
Zambia	Kawambwa	Sub-Office	Security Phase:	1

Hardship category U

Colombia	Quibdo	Other	Security Phase:	2
DRC	Kimpese	Sub-Office	Security Phase:	2

*List of offices in all duty stations where there are no guidelines on health hazards available, including the most prevalent disease at the station***Hardship category B**

Croatia	Osijek	Field-Office	Security Phase:	0
Croatia	Sisak	Field-Office	Security Phase:	0
Saudi Arabia	Riyadh, Covering	Regional Office	Security Phase:	2

Hardship category C

Bangladesh	Dacca	Branch Office	Security Phase:	0
Colombia	Barrancabermeja	Field-Office	Security Phase:	2
Gambia	West Africa	Other	Security Phase:	0
Iran	Tehran	Branch Office	Security Phase:	2
Mauritanie	Nouakchott	Branch Office	Security Phase:	1
Republic of	Central Asia	Field-Office	Security Phase:	0
Rwanda	Kigali	Branch Office	Security Phase:	0

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Saudi Arabia	Rafha	Field-Office	Security Phase:	2
Tanzania	Dar es Salaam	Branch Office	Security Phase:	0

Hardship category D

Angola	Mbanza Congo	Sub-Office	Security Phase:	2
Armenia	Yerevan	Branch Office	Security Phase:	1
Congo	Brazzaville	Branch Office	Security Phase:	2
Congo (ROC)	Loukolela	Field-Office	Security Phase:	4
D. R. Congo	Lubumbashi	Field-Office	Security Phase:	3
Eritrea	Barentu	Sub-Office	Security Phase:	3
Georgia	Tbilisi	Branch Office	Security Phase:	2
Guinea	Nzerakore	Sub-Office	Security Phase:	3
Iran	Mashad	Sub-Office	Security Phase:	2
Kyrgyzstan	Bishkek	Branch Office	Security Phase:	0
Nigeria	Lagos	Branch Office	Security Phase:	2
Pakistan	Karachi	Field-Office	Security Phase:	3
Papua New Guinea	Not found	Branch Office	Security Phase:	2
Zambia	Mporokoso	Field-Office	Security Phase:	2

Hardship category E

Afghanistan	Mazar-I-Sharif	Sub-Office	Security Phase:	4
Angola	Luau	Field-Office	Security Phase:	3
Congo (ROC)	Aru	Sub-Office	Security Phase:	4
D. R. Congo	Bukavu Goma	Sub-Office	Security Phase:	3
Ethiopia	Assosa	Field-Office	Security Phase:	1
Georgia	Akhmeta	Field-Office	Security Phase:	3
Georgia	Zugdid	Field-Office	Security Phase:	4
Goergia	Gali	Field-Office	Security Phase:	4
Guinea	Kissidougou	Sub-Office	Security Phase:	3
Ivory Coast	Tabou	Field-Office	Security Phase:	3
Pakistan	Quetta	Sub-Office	Security Phase:	2
Sierra Leone	Zimmi	Field-Office	Security Phase:	3
Sri Lanka	Trincomalee	Field-Office	Security Phase:	3
Tanzania	Kasulu	Sub-Office	Security Phase:	1
Tanzania	Kibondo	Sub-Office	Security Phase:	1
Tanzania	Ngara	Sub-Office	Security Phase:	1
Uganda	Arua	Sub-Office	Security Phase:	3

Hardship category M

Sri Lanka	Mannar Island	Field-Office	Security Phase:	3
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Hardship category U

DRC	Kimpese	Sub-Office	Security Phase:	2
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List of offices where there are no HIV/AIDS prevention and awareness activities on location

Hardship category A

Thailand	Bangkok	Regional Office	Security Phase:	0
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Hardship category B

Croatia	Sisak	Field-Office	Security Phase:	0
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Saudi Arabia	Riyadh, Covering	Regional Office	Security Phase:	2
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Hardship category C

Colombia	Apartado	Field-Office	Security Phase:	2
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Colombia	Barrancabermeja	Field-Office	Security Phase:	2
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DRC	Kinshasa	Branch Office	Security Phase:	2
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Gambia	West Africa	Other	Security Phase:	0
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Mauritanie	Nouakchott	Branch Office	Security Phase:	1
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Republic of	Central Asia	Field-Office	Security Phase:	0
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Rwanda	Kigali	Branch Office	Security Phase:	0
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Saudi Arabia	Rafha	Field-Office	Security Phase:	2
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Hardship category D

Iran	Mashad	Sub-Office	Security Phase:	2
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Pakistan	Karachi	Field-Office	Security Phase:	3
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Zambia	Mporokoso	Field-Office	Security Phase:	2
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Hardship category E

Afghanistan	Mazar-I-Sharif	Sub-Office	Security Phase:	4
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Afghanistan	Jalalabad	Regional Office	Security Phase:	0
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Afghanistan	Herat	Sub-Office	Security Phase:	3
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Algeria	Algiers	Branch Office	Security Phase:	3
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Georgia	Gali	Field-Office	Security Phase:	4
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Guinea	kissidougougou	Sub-Office	Security Phase:	3
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Sri Lanka	Trincomalee	Field-Office	Security Phase:	3
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Tanzania	Ngara	Sub-Office	Security Phase:	1
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List of offices in C to E duty stations where there are no First Aid Kits in the office or the cars

Hardship category C

Rwanda	Kigali	Branch Office	Security Phase:	0
Kit in Office:	No	Kit in Car:	No	

Tanzania	Dar es Salaam	Branch Office	Security Phase:	0
Kit in Office:	No	Kit in Car:	Yes	

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Hardship category D

Congo Kit in Office:	Brazzaville No	Branch Office Kit in Car:	Security Phase: Yes	2
D. R. Congo Kit in Office:	Lubumbashi No	Field-Office Kit in Car:	Security Phase: No	3
Kyrgyzstan Kit in Office:	Bishkek No	Branch Office Kit in Car:	Security Phase: No	0
Nigeria Kit in Office:	Lagos No	Branch Office Kit in Car:	Security Phase: Yes	2
Tajikistan Kit in Office:	Dushande Yes	Branch Office Kit in Car:	Security Phase: No	2
Timor-Leste Kit in Office:	Dili Yes	Branch Office Kit in Car:	Security Phase: No	1
Zambia Kit in Office:	Mporokoso No	Field-Office Kit in Car:	Security Phase: No	2

Hardship category E

Afghanistan Kit in Office:	Jalalabad No	Regional Office Kit in Car:	Security Phase: No	0
Algeria Kit in Office:	Algiers No	Branch Office Kit in Car:	Security Phase: No	3
Sierra Leone Kit in Office:	Freetown No	Branch Office Kit in Car:	Security Phase: No	3
Sierra Leone Kit in Office:	Zimmi Yes	Field-Office Kit in Car:	Security Phase: No	3
Sierra Leone Kit in Office:	Kailahun Yes	Field-Office Kit in Car:	Security Phase: No	4
Tanzania Kit in Office:	Kasulu No	Sub-Office Kit in Car:	Security Phase: Yes	1
Tanzania Kit in Office:	Ngara Yes	Sub-Office Kit in Car:	Security Phase: No	1
Uganda Kit in Office:	Arua No	Sub-Office Kit in Car:	Security Phase:	3

Hardship category U

DRC Kit in Office:	Kimpese Yes	Sub-Office Kit in Car:	Security Phase: No	2
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