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Annex 2. Duty of Care Monitoring and Evaluation Framework

Objective: To monitor the implementation of Duty of Care deliverables (as per CEB/2018/HLCM/5/Rev.1).

The Secretariat to the cross-functional Task Force on Duty of Care will follow up on the implementation status with organizations and relevant stakeholders starting immediately and thereafter before each HLCM meeting.

Note: For the purposes of this monitoring matrix, the terms "high-risk environments", "staff" and "personnel" are defined below. (This matrix refers to personnel or staff, depending on the context).

- **high-risk environments** refer to duty stations eligible for danger pay, as determined by the International Civil Service Commission (ICSC)[1].

- **Staff** refer to all individuals holding letters of appointment in accordance with staff regulations and rules of the UN organizations (including both international and locally-recruited staff), regardless of their type of appointment.

- **Personnel** refer to all staff, as defined above, and other individuals with contractual relationship with the Organizations (e.g. consultants, individual contractors, interns UN Volunteers), in line with the definition used in the UN Security Management System.

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
Pre-deployment guide The Task Force asks the HLCM to adopt the comprehensive pre-deployment guide, including the resilience briefing, as a standard. (Adoption 1)	Each organization to embed the guide in their pre-deployment induction starting May 2018. (Action 1.a.)	Organizations	Immediately	Number of organizations that provide a pre-deployment guide to personnel as part of the induction.	At each HLCM.	[Please provide your response here]
				Number of organizations that provide resilience briefings to all personnel deployed to high-risk locations.	At each HLCM.	[Please provide your response here]
	Each Country Team is provided with information on the minimum elements that need to be included in the country specific fact sheet.	TF Secretariat	Immediately	Country Teams have been provided the minimum elements that need to be	At each HLCM	[Please provide your response here]

[1] International Civil Service Commission, Danger Pay, https://icsc.un.org/secretariat/hrpd.asp?include=dp.

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
				included in the country specific fact sheets.		
	Each Country Team under the leadership of the RC to ensure that the country-specific fact sheet is updated annually (or more frequently if the risk environment changes). (Action 1.b.)	UNSDO	TBD discussion with UNSDO	Number of Country Teams in high-risk duty stations that have developed the country-specific factsheet and made it available to all personnel.	At each HLCM.	[Please provide your response here]
		UNSDO	TBD discussion with UNSDO	Number of Country Teams that have updated their country-specific factsheet annually (or more frequently if the risk environment has changed) and made it available to all personnel.	Annually (or more frequently if the risk environment changes).	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
Training for Managers The Task Force asks the HLCM to agree that the work on additional content for the training for managers continues in the next phase of the Task Force. (Adoption 2)	Continue to develop the training materials for managers in high-risk locations. ➢ Further develop the curriculum and include any other key principles and inter-agency content for managers in high-risk locations based on the approved draft prepared by the UN Emergency Preparedness and Support Team (EPST). ➢ Discuss what platforms will be used to disseminate the training materials e.g. in each organization/inter-agency/involvement of UN Staff College.	Working Group (WFP, UNHCR, UNICEF)	May 2018.	Additional content for the management training (for all personnel) is developed and endorsed by the HLCM.	Oct 2018: Provide draft additional content for the training materials to the HLCM. Spring 2019: Finalize and present training materials and proposed platform to host the training for endorsement by HLCM.	On-going. As of 20 Aug: Preliminary discussions held to assess the situation i.e. what exists in respective Organizations and discuss possible collaboration. Currently in the process of identifying consultant to further develop curriculum and platform to host the training.
		Organizations	After Spring 2019 HLCM.	The mechanism(s) for disseminating the training material has been established in organizations.	Spring HLCM and thereafter, if needed.	[Please provide your response here]
	Organization to put in place mechanisms to provide continuous support to managers who are serving in high-risk environments, as per Training Programme for Managers in High-Risk Environments (Annex 6). (Action 2)	Organizations	After Spring 2019 HLCM.	Number of organizations that have incorporated inter-agency content in existing support/training for managers in high-risk environments.	At each HLCM after Spring 2019 HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
Health Risk Assessment and Health Support Planning Following adoption by HLCM in September 2017 of the Duty Station Health Risk Assessment Methodology and Tools, the Task Force asks the HLCM to adopt the Referral Hospital Assessment Manual as a standard for the UN. (Adoption 3)	UNMD to continue the health risk assessments with focus on high-risk duty stations in Afghanistan, Cameroon, Central African Republic, Chad, Ethiopia, Iraq, Kenya, Libya, Mali, Niger, Nigeria, Pakistan, Sudan, Syria and complete by end of 2020. (Action 3.a.) *DS-HRA was already conducted in four high-risk duty stations (DRC, South Sudan, Somalia, Yemen).	UNMD	On-going. (Health Risk Assessments in all 18 high-risk environments to be completed by end of 2020).	Number of DS-HRA completed in all 18 high-risk environments.	At each HLCM.	[Please provide your response here]
		UNMD	After the completion of DS-HRA in each location.	Findings of the DS-HRA for all 18 high-risk environments are made available to organizations.	At each HLCM.	[Please provide your response here]
	Each UN Country Team is informed of the outcome of the Duty Station Health Risk Assessment and the recommendations for Health Support Plans[2].	*UNMD*	*After the completion of each Duty Station Health Risk Assessment.*	*Number of Country Teams informed of the outcome.*	*At each HLCM.*	*[Please provide your response here]*
	UN Country Team, under the supervision of the Resident Coordinator, to implement the Health Support Plan based on the recommendations provided by UNMD following the Duty Station Health Risk Assessment.	*UNSDO*	*After the completion of each Duty Station Health Risk Assessment.*	*Status report on the implementation of the Health Support Plan. The report should indicate whether the Health Support Plan are implemented fully, partially or not implemented and include foreseen impact of the (non)implementation.*	*At each HLCM.*	*[Please provide your response here]*

[2] Italicized items were added following consultation with the relevant stakeholders, after the circulation of the framework to HLCM members on 24 August 2018.

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
	Organizations should establish a process for their Country Offices to request support to implement the measures in the health support plan within the recommended timelines. Measures which cannot be implemented should be included in the Duty of Care risk management framework. (Action 3.b.)	Organizations	On-going.	Number of organizations that have a process for Country Offices to request and receive support to implement the health support plans.	At each HLCM.	[Please provide your response here]
		UNSDO and UNMD	On-going.	Number of UNCTs/countries that have implemented the health support plans within the recommended timelines.	At each HLCM.	[Please provide your response here]
Streamlining insurance processing mechanism The Task Force asks the HLCM to adopt online claiming for medical insurance as a standard. (Adoption 4) The Task Force asks the HLCM to adopt the principle that, in any duty station, administrative measures should be devised to allow personnel to receive the	Organizations to implement online claiming for medical insurance. (Action 4)	Organizations	On-going.	Number of organizations that have implemented online claiming for medical insurance for staff.	At each HLCM.	[Please provide your response here]
	Organizations governed by the UN Staff Regulations and Rules are to improve communication to staff with regards to Appendix D claims processing, by ensuring that the revised Appendix D, manager's guide and the online form are made available in the organization's intranet site. (Action 5.a.)	Organizations	Immediately (by October 2018).	Number of organizations that have made information on the revised Appendix D, manager's guide and the online forms available on the organization's intranet.	At each HLCM.	[Please provide your response here]
	Organizations appoint an Appendix D focal point and make their name and contact	Organizations	Immediately (by October 2018).	Number of organizations that have appointed an Appendix D focal point and made	At each HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
necessary medical services from any type of UN clinic, including DPKO clinics. (Adoption 5) The Task Force asks the HLCM to adopt measures to ensure that payments to beneficiaries are made within 60 days of receipt of all documents, as a minimum standard. (Adoption 6)	details available on the intranet site. (Action 5.b.)			their names and contact information available on the organization's intranet.		
	Ensure payments to beneficiaries are made within 60 days of receipt of all documents.	Organizations	On-going.	Percentage of payments to beneficiaries that are made within 60 days of receipt of all documents by organization.	At each HLCM.	[Please provide your response here]
	Organizations to devise measures (e.g. establish agreements/MoUs with clinics, streamline insurance plans etc.) to allow personnel to receive medical services from any type of UN clinics, including DPKO clinics.	*Organizations*	*Immediately*	*Number of organizations that have developed administrative measures to allow all personnel to receive the necessary medical services from any type of UN clinics, including DPKO clinics.*	*At each HLCM.*	*[Please provide your response here]*
	Organizations ensure effective measures to assist staff to update their beneficiaries form as applicable. (Action 6.a.).	Organizations	Immediately (by October 2018).	Number of organizations which have developed measures and/or communication efforts to assist staff to update their beneficiaries forms.	At each HLCM.	[Please provide your response here]
	Organizations to establish an internal process on claiming for compensation under the Malicious Act Insurance Policy. (Action 6.b.)	Organizations	Immediately (by October 2018).	Number of organizations that have established internal processes on claiming for MAIP compensation.	At each HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
	Organizations to have an internal process to verify the insurance coverage of non-staff personnel, prior to deployment to high-risk environment. (Action 7)	Organizations	Immediately (by October 2018).	Number of organizations that established a process to verify that non-staff personnel have insurance coverage prior to deployment to high-risk environment.	At each HLCM.	[Please provide your response here]
UN living and working standards The Task Force asks the HLCM to adopt the UN minimum working and living standards. (Adoption 7)	Ensure UN minimum working and living conditions are adopted as a standard.	Organizations	May 2018.	Number of organizations that have policies, procedures or guidance reflecting UN minimum working and living conditions for all personnel endorsed by the HLCM	At each HLCM.	[Please provide your response here]
	All new accommodations and office premises are built based on the minimum standards. (Action 8.a.)	Organizations	May 2018.	Number of organizations that are implementing UN minimum living and working conditions for their new accommodations and office premises in high-risk environments.	At each HLCM.	[Please provide your response here]
	Existing accommodations and office premises are retrofitted/renovated to bring into compliance with UN minimum working and living standards, as applicable. Regular monitoring of the status of	Organizations	May 2018.	Number of organizations which have established a plan to renovate existing accommodations/office premises to bring into compliance with UN minimum working and living conditions.	At each HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
	working and living standards. (Action 8.b., 8.c.)	Organizations	May 2018.	Number of organizations that are monitoring the status of working and living conditions in high-risk duty stations on at least an annual basis.	At each HLCM.	
	Mechanisms and tools are developed to facilitate implementation of UN minimum working and living standards in organizations.	Working Group (Lead: WFP)	July 2018	Specific mechanisms and tools that are developed to facilitate implementation of UN minimum working and living conditions in organizations.	At each HLCM.	[Please provide your response here]
Ensuring adequate bandwidth Adopted the principle that personnel in high-risk environments should have adequate bandwidth to connect with their families and for tele-health services, as per parameters provided in Annex 12. (Adoption 8)	Existing accommodations and office premises are brought into compliance with bandwidth parameters provided in Annex 12. Regular monitoring of the status of bandwidth for personal and tele-health services for all personnel. (Action 9.a., 9.b.)	Organizations	May 2018.	Number of organizations which have established a plan to bring existing accommodations/office premises in compliance with bandwidth requirements for all personnel.	At each HLCM.	[Please provide your response here]
		Organizations	May 2018.	Number of organizations that are monitoring the status of bandwidth in the duty station for personal and tele-health services on at least an annual basis.	At each HLCM.	
Mental Health Strategy	UN Mental Health Strategy is implemented (Strategy adopted in September 2017).	UNMSD	July 2018.	The implementation strategy is developed and endorsed by the	At October HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
				HRN for submission to HLCM (Oct 2018).		
		UNMSD	July 2018.	A team dedicated to work on the implementation of the Mental Health Strategy led by the P5 is established.	At October HLCM.	[Please provide your response here]
		UNMSD	July 2018.	The governance structure defining the reporting line vis-à-vis the HLCM, HR Network, UNMD and the Duty of Care Task Force is established.	At October HLCM.	[Please provide your response here]
		Organizations	Spring 2019	Number of organizations that have adopted and have begun implementation of the Mental Health Strategy.	According to the proposed timeline. Regular update to the HLCM from HRN.	[Please provide your response here]
Medical travel The Task Force asks the HLCM to adopt access to essential health services as a standard for UN personnel. (Adoption 9)	Organizations to review their policy on medical evacuation in light of this principle and conduct the necessary actuarial studies to make decisions. (Action 10.a.)	Organizations	May 2018.	Number of organizations that have conducted the necessary actuarial studies to make decisions.	At each HLCM.	[Please provide your response here]
				Number of organizations that have established or revised policies regarding medical travel for staff and families to secure essential medical care	At each HLCM.	

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
				for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station.		
	Regional area of care (RAC) Committee to formalize Terms of Reference and standard operating procedures, in consultation with the Duty of Care Task Force. (Action 10.b.)	RAC Committee	May 2018.	The Terms of Reference and SOPs are developed by the RAC Committee.	Fall 2018 HLCM.	[Please provide your response here]
Locally-recruited staff: Residential safety and security The Task Force asks the HLCM to adopt the principle that, as part of the security management process, the SMT in high-risk environments should review and advise the Designated Official if additional security measures for locally-recruited staff are required. (Adoption 10)	Organizations should make the necessary administrative and financial support available to Country Representatives where the Designated Official has made decisions to provide additional security measures for locally-recruited staff. (Action 11)	Organizations	May 2018.	Number of organizations that have established a mechanism to provide administrative and financial support to their Country Representatives to provide additional residential safety and security measures for locally-recruited staff upon SMT recommendation.	At each HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
Locally-recruited staff: Compressed time-off The Task Force asks the HLCM to adopt, as a standard, where it is feasible, to allow locally-recruited staff in high-risk environments to accumulate up to 5 working days of their compressed time-off to be taken consecutively. (Adoption 11)	Agree on an inter-agency compressed time off schedule with a view toward aligning schedules between organizations. (Action 12)	Human Resources Network	June 2018.	Organizations have established a common inter-agency compressed time-off schedule for locally-recruited staff.	At each HLCM.	[Please provide your response here]
Locally-recruited staff: Affordable and safe transportation The Task Force asks the HLCM to adopt, as a standard, safe transportation from residence to office for locally-recruited staff, subject to the local security condition, as advised by SMT. (Adoption 12)	Organizations to make the necessary administrative and financial support available to their Country Representative where SMT has made decisions to provide additional measures for locally-recruited staff. (Action 13)	Organizations	May 2018.	Number of organizations that have established a mechanism to provide administrative and financial support to their Country Representatives to enable them to provide additional measures to ensure safe transportation for locally-recruited staff upon SMT recommendation.	At each HLCM.	[Please provide your response here]

Deliverables	Expected Action	Responsible actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
First-aid and medical essentials kit	Provide the necessary first-aid and medical essentials as per Medical Services and/or SMT recommendation. (Action 14)	Organizations	May 2018.	Number of organizations that provide first-aid and medical essential kits in high-risk environments as per Medical Services and/or SMT recommendation.	At each HLCM.	[Please provide your response here]
Duty of Care: non-staff Review the Duty of Care for non-staff personnel	Review and develop measures to provide Duty of Care to non-staff personnel (e.g. UN Volunteers, individual contractors, consultants, interns, fellows, standby personnel, etc.). Review the measures based on the different contractual status.	Human Resources Network	Immediately	Measures developed and endorsed by HR Network members	Oct 2018: Interim progress report to the HLCM on work of the HR Network on Duty of Care for non-staff personnel. Fall 2019: proposed measures for non-staff personnel by HR Network to HLCM for approval	[Please provide your response here]

Best practices	Expected Action	Responsible Actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
Staff who can no longer cope	Establish an internal process to address the needs of staff who can no longer serve in high-risk environments. (BP 1)	Organizations	May 2018.	Number of organizations that have developed a mechanism to address the needs of staff who	At each HLCM.	[Please provide your response here]

Best practices	Expected Action	Responsible Actors	Start of implementation	Key Performance Indicators	Monitoring frequency	Results (and dates)
				can no longer serve in high-risk environments.		
Locally-recruited staff: Transportation to the nearest urban town or capital city	Organizations to provide transportation for locally-recruited staff based in field offices to the nearest urban town or capital city to allow these staff members to spend their time-off at a location where basic services are available (BP 2).	Organizations	May 2018.	Number of organizations that provide transportation for locally-recruited staff based in field offices to the nearest urban town or capital city to allow these staff members to spend their time-off at a location where basic services are available.	At each HLCM.	[Please provide your response here]
Basic essential supplies	The administrators in the field need to find flexible solutions to provide basic essential and standby supplies that are difficult to obtain in high-risk environments (BP 3).	Organizations	May 2018.	Number of organizations that have developed flexible solutions to provide basic essential and standby supplies to personnel that are difficult to obtain in high-risk environments.	At each HLCM.	[Please provide your response here]

Annex 3

Terms of Reference
Cross-functional Task Force on Duty of Care: Continued

Background

During its 31st session in March 2016, HLCM established a cross-functional inter-agency Task Force (hereafter 'the Task Force'), chaired by Ms. Kelly T. Clements, the Deputy High Commissioner for Refugees (UNHCR) and co-chaired by Ms. Fatoumata Ndiaye, Deputy Executive Director of Management (UNICEF) to develop implementation plans for the 13 recommendations that had emerged from the two-year work of the Working Group on "Reconciling the duty of care for UN personnel while operating in high risk environments" (2014-2015).

HLCM members expressed strong appreciation and support for this work, and during its 34th session in September 2017, adopted the Secretary-General António Guterres' recommendation to:

1. Continue the implementation phase with robust monitoring and evaluation;
2. Continue the development of a risk management framework for Duty of Care;
3. Review and extend the applicability of the deliverables in all environment; and
4. Develop implementation plans for providing Duty of Care to non-staff personnel.

Therefore, the Task Force Secretariat presents the below revised Terms of Reference for the Task Force to incorporate the new tasks and timeline.

Purpose

The Task Force is responsible for conducting work on multi-disciplinary and cross-functional matters related to Duty of Care including the areas of psychosocial, medical, human resources, administration and safety and security, which features prominently in the new HLCM Strategic Plan (2017-2020), has high visibility among Member States and enjoys strong support from the Central Executive Board (CEB).

Going forward, the Task Force will be responsible for monitoring and evaluating the implementation of the action plans presented in its Final Report ("Duty of Care Task Force Final Report") and for developing follow up actions for the new tasks which will focus on providing Duty of Care in all duty stations, and to non-staff personnel. Task Force members and Secretariat will continue to assist the Task Force Chair in presenting consolidated proposals to the HLCM.

Expected Deliverables

While the Task Force has addressed all of the initial 13 deliverables, key work on implementing the deliverables within the organizations as per the Action Points of the Final Report remains to be done. The Task Force, in particular, will:

- Continue the implementation phase and present the implementation status using a monitoring and evaluation mechanism with a list of pre-determined Key Performance Indicators;

- Continue the development of a risk management framework for Duty of Care, by focusing on life-threatening issues and building on the Health Risk Assessment methodology to assess whether the Duty of Care for personnel has been fulfilled in a given location. The risk management needs to be reviewed given due consideration to and coordination with the Occupational Safety and Health (OSH) Framework.

- Review the deliverables for the 13 recommendations contained in document CEB/2016/HLCM/11 and extend their applicability for all environments. The following deliverables can be considered: Mental Health Strategy, Health Risk Assessment, UN working and living conditions. The curriculum/tool for training managers need further work in order to capture additional key management principles required in high-risk environments.

- Develop measures in order to enhance Duty of Care to non-staff personnel. This work will be conducted in collaboration with the standby partners and any other external entities to the UN that deploy their personnel.

- Establish a plan that clearly outlines how the implementation of these deliverables can be sustained using the newly developed UN coordinator system and with the Country Teams.

Methodology

The Task Force will carry out its work in a holistic, systematic manner. Follow up action on the recommendations will be approached from a Duty of Care risk management framework perspective and embedded in existing enterprise risk management and security risk management frameworks.

A. Risk assessments: Carry out systematic, multi-disciplinary risk assessments using standardized tools (e.g. Health Risk Assessment methodology).

B. Mitigation measures: Define applicable mitigation measures to reduce likelihood and impact of identified risks.

C. Monitoring and Evaluation: Set up a monitoring and evaluation framework, including yearly reporting to HLCM.

D. Accountability: The accountability framework will remain within each agency.

Duration and Timeline

The Task Force, with the extended scope and additional expected deliverables, will continue throughout until the end of 2019.

February 2017 – March 2018	Task Force identifies and develops measures, tools and best practices for UN organizations to implement the recommendations.
April 2018	Report to HLCM; submit the Final report with action plans organizations to adopt; submit the revised ToR for the continuation of the implementation phase.
April 2018 – May 2018	Members of the Task Force are nominated (existing and new).
May 2018 – October 2019	Implementation phase continues within organizations.
Fall 2018	Regular updates to HLCM with focus on the role of the UN coordinator.
Spring 2019	Monitoring and evaluation status of implementation of the 13 deliverables. Update on decision making/risk management framework
Fall 2019	Report on Duty of Care in all environments and for non-staff personnel.

Annex 4

United Nations Occupational Safety and Health Committees
Terms of Reference [SAMPLE]

1. The staff of the United Nations (UN) are its greatest asset, and the UN has a duty to undertake all reasonably practicable actions to prevent occupational accidents and diseases and protect the health and wellbeing of its staff. The UN's ability to deliver its mandate is inextricably linked to the occupational safety and health of its workforce, and is part of its duty of care as an employer.

2. The implementation of the UN's Occupational Safety and Health (OSH) policies and the achievement of its OSH objectives are dependent on the process of consultation and communication by local or departmental OSH Committees and the full and effective involvement of management and staff.

Mandate

3. Implementation of OSH policy is coordinated through local or departmental OSH Committees.

4. A UN OSH Committee is a technical and advisory body. Its work is to be conducted in a co-operative, non-adversarial atmosphere. The OSH committee is not a policy-making body and provides recommendations to senior management in accordance with the provisions and general principles of the UN OSH Policy.

5. A UN OSH Committee is primarily responsible for receiving or identifying safety and health concerns in the workplace, assessing hazards through a sound risk management process, and then recommending how these concerns may be prevented or mitigated. The committee is not responsible for carrying out the necessary changes. Senior management retains the responsibility for occupational safety and health in the workplace, but may delegate certain tasks to the OSH Committee where appropriate (see tasks).

Objectives

6. The objectives of UN OSH Committees are to:

    a. Promote the development of a culture of risk-based safety and health awareness and work processes within the local environment or department.
    b. Provide a mechanism by which safety and health issues affecting the workforce can be effectively addressed in a collaborative, multi-disciplinary manner.
    c. Provide a technical resource for advice on safety and health matters, standards and risk management for staff and managers.

Composition

7. UN OSH Committees for Country Teams shall include representation from participating agencies, and will also include the personnel set out below:

    a. Senior management (Chair);
    b. Staff/Staff unions;
    c. Administrative / Human resources;

d. Medical services (where available);
e. Safety services;
f. Engineering;
g. Psychosocial support services;
h. Security services;
i. Facilities / Environmental management; and
j. Any other group with a role in managing OSH risks locally.

Tasks

8. UN OSH Committees for country teams are to:

    a. Receive issues escalated by individual agency OSH committees, where those exist.
    b. Provide cohesive, coordinated advise on shared areas of OSH, to allow efficient implementation of OSH priorities, with minimal duplication and overlap between individual agency OSH committees.
    c. Advise the Country team on implementing the OSH policy and measurable objectives on health and safety issues in the workplace in accordance with applicable law, UN regulations, policy, guidance and recognized best practice;
    d. Undertake and analyze local accident, illness and injury statistics relevant to understanding of OSH risks and their prevention or mitigation, and where required provide information for system-wide aggregated data;
    e. Provide recommendations on OSH prevention and control measures;
    f. Provide guidance and advice to managers and supervisors on matters related to the safety and health implications of operations and workplaces under their control;
    g. Develop measures to ensure full and effective participation of staff in the OSH matters; and
    h. Develop a communications strategy that promotes a culture of safe working practices and environments, and which includes:

        i. access to OSH policies, instructions and training;
        ii. the role of the OSH Committee;
        iii. the role of Occupational Safety and Health Specialists;
        iv. hazard identification and prevention;
        v. risk assessments and risk reduction or control measures;
        vi. measures to report incidents, accidents and near-misses; and
        vii. the general promotion of occupational safety and health.

Meetings

9. Each UN OSH committee is to set its own meeting frequency, determine its own rules regarding quorum depending on local requirements, and whether to appoint a secretariat for administrative purposes, taking of minutes etc.

Training

10. Members of UN OSH Committees are to be given the opportunity to undertake sufficient training activities to effectively complete their roles

Confidentiality

11. Members of UN OSH Committees have a strict requirement to maintain confidentiality for staff who raise safety and health concerns. Where health impacts are relevant, individual health status of staff is to be anonymized.

REGIONAL AREAS OF CARE FOR THE MEDICAL INSURANCE PLAN (MIP) FOR LOCALLY-RECRUITED STAFF OUTSIDE HEADQUARTERS

Purpose

1. The purpose of this Standard Operating Procedure is to standardize the review and approval process of Regional Areas of Care (RAC).

Background and Definition

2. The Medical Insurance Plan (also referred to as MIP or the plan) is a health insurance scheme for the benefit of locally recruited General Service and National Officer active staff members and eligible former staff members, and their eligible family members serving at designated duty stations. Reimbursement of medical expenses under MIP are based on the reasonable and customary costs applicable in the country of the duty station.

3. A Regional Area of Care is:
    a) Designated solely due to the lack of adequate facilities in the duty station or the country of duty station.

    b) A country or region of a country, generally neighbouring the duty station that is specially designated by the United Nations where staff and covered family members can undergo medical treatment without the need for an approved medical evacuation[1].

    c) The subscriber is responsible for the cost of travel and accommodation to and from the RAC. Such travel cost is not reimbursable, in full or in part, by the MIP.

4. The RAC concept was established under the plan for countries where the quality and breadth of medical facilities prevent local staff and covered family members from accessing quality and adequate health care without the need for a UN-approved medical evacuation. This mechanism was put in place for two reasons:

    a) duty of care towards locally recruited staff members serving in hardship locations where the mandatory health support elements[2] are not available to meet essential health care;

    b) acknowledgment that MIP participation is mandatory for staff even where they are not able to avail of MIP benefits due to inadequate healthcare or lack of medical infrastructures in their country.

5. An approved RAC allows reimbursement under the MIP based on the reasonable and customary costs in the designated country where the service is provided and not on the country of the staff member's duty station.

6. A list of RAC locations is developed by the UN organisations in cooperation with the UN Medical Service and reviewed on a regular basis.

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[1] In some organizations, staff members may require prior approval from their MIP focal point in Headquarters, to be able to benefit from RAC reimbursements.

[2] The mandatory health support elements consist of: primary care, hospital care, mental health services, mass casualty plan, medical emergency response, access to pharmaceuticals (including PEP). For more details, please refer to the Cross-functional Task Force on Duty of Care, April 2018 (CEB/2018/HLCM/5/Rev.1).

Authority to approve RAC locations

7. The Director, UN Medical Services, is the authority to approve RAC locations upon recommendation by the inter-agency MIP Working Group, chaired by the Senior Medical Officer servicing the UN Funds and Programmes along with the participation of representatives from the UN Funds and Programmes under MIP[3] and the UN Secretariat.

8. The inter-agency MIP Working Group will review requests and make recommendations as per below procedures. A quorum of two thirds of the members must be reached to make a recommendation, and to the extent possible, recommendations should be based on consensus.

9. Each organization will be responsible for promulgating and implementing approved RAC in their respective country offices.

10. Ad-hoc RACs which apply to one individual for a specific medical condition are to be reviewed and approved on a case-by-case basis by the respective organization, in consultation with Medical Services and MIP Third Party Administator[4]. The process for such requests is not covered by this document.

Standard Operating Procedure:

11. Requests may be submitted by the Resident Coordinator, the local Staff Association through the Resident Coordinator or by the Head of Office of any of the UN Organization under MIP, further to consultations at the UN Country Team level, and should include the following information:

    a) Details on availability and quality of medical services in the country or duty station;

    b) Proposed RAC location, including reasons for recommending such country, e.g. cost of health care in the RAC compared to the country of duty station, distance of travel to such location, language issues, cultural sensitivities, visas granting, and any other relevant details to be considered by the MIP Working Group.

12. Requests should be reviewed by the inter-agency MIP Working Group who will make a recommendation to the Director, UN Medical Services, taking into the following elements:

    a) Verification on availability and quality of medical facilities in the recommended country of the RAC location based on:
        i. advice from UN Medical Service, MIP Third Party Administrator[4], and any other relevant expert including Medical Services of participating Organizations; and

        ii. the duty station's Health Risk Assessment issued by the UN Medical Directors, where available, with particular reference to the mandatory health support elements.

    b) Verification on availability and quality of medical facilities in the proposed RAC location (or an alternate location proposed by the MIP Working Group), based on advice from UN Medical Service, MIP Third Party Administrator (currently Cigna for UN, UNDP and UNICEF), and any other relevant expert including Medical Services of participating Organizations.

    c) Review of medical evacuations approved out of the country in the last 24 months as approved by the delegated authority (e.g. number, medical conditions) to assess impact of lack of infrastructures on the ground.

[3] Inter-agency MIP Working Group Membership: UNDP, UNICEF, UN Secretariat, UNHCR, Cigna.

[4] Currently Cigna for UN, UNDP and UNICEF.

d) Cost implication analysis of reimbursing medical expenses based on reasonable and customary expenses at the proposed RAC location, based on information provided by the MIP Third Party Administrator (currently Cigna for UN, UNDP and UNICEF) and any other other relevant expert.

e) Any other relevant element mentioned in the request, or brought forward by a representative of one of the MIP organizations, such as distance and ease to travel abd obtain visa to the RAC location, language, cultural sensitivities, that may affect staff and covered family members when availing of care in the proposed RAC.

13. Requests to withdraw an RAC for a specific duty station or country may be submitted by any member organization of the MIP Working Group, who will consult with the Resident Coordinator and verify availability and quality of medical facilities in the recommended country of the RAC location as per paragraph 12.a) to assess whether an RAC location is still justified.

14. The discussions within the MIP Working Group should be strictly confidential.

15. The recommendation of the MIP Working Group to the UN Medical Director may be to decline the request, approve the RAC establishment or withdrawal, or approve an alternate location.

16. Upon receipt of the decision by the UN Medical Director, the Chair of the MIP Working Group will communicate with the Resident Coordinator or the Head of Office making the request and the relevant Third Party Administrator, accordingly. When a request is rejected, a brief explanation should be provided to explain the reason for such decision.