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Cross-functional Task Force on Duty of Care for personnel in high risk environment Report, April 2018

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Executive Summary

1. During its 31st session in March 2016, HLCM established a cross-functional inter-agency Task Force ('the Task Force'), chaired by UNHCR and UNICEF to develop implementation plans for the 13 recommendations, covering areas of psychosocial, health, human resources and administration and safety and security, that emerged from the Working Group on "Reconciling the duty of care for UN personnel while operating in high risk environments" (2014-2015).
2. This report presents and describes: i) achievements to date and the ongoing implementation status of the deliverables using the sequence of deployment (pre-, during and post-phases of deployment); ii) their expected impact on personnel; and iii) the principles and measures for HLCM's consideration and decision.
3. Below is a list of the principles and measures for HLCM's endorsement:

Pre-deployment	The Task Force asks the HLCM to adopt the comprehensive pre-deployment guide, including the resilience briefing, as a standard.
Training for managers	The Task Force asks the HLCM to agree that the work on additional content for the training for managers continue in the next phase of the Task Force.
Duty Station Health Risk Assessment	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.
Insurance processing	The Task Force asks the HLCM to adopt online claiming for medical insurance as a standard.
	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 necessary medical services from any type of UN clinic, including DPKO clinics.
	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.
Living and working standards	The Task Force asks the HLCM to adopt the UN minimum working and living standards.
Bandwidth	The Task Force asks the HLCM to adopt the principle that personnel in the high-risk environments have adequate bandwidth to connect with their families and for tele-health services, as per parameters provided in Annex 12.
Locally-recruited staff	The Task Force asks the HLCM to adopt access to essential health services as a standard for UN personnel.
	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 Officials if additional security measures for locally-recruited staff are required.
	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.
	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.
Duty of Care risk management framework	The Task Force asks the HLCM to adopt the six mandatory health support elements as the standard for the Duty of Care Risk Management framework, which will continue under the guidance of the Task Force.

4. As HLCM members expressed strong appreciation and support for this work during its session in September 2017, and adopted the Secretary-General's recommendation to continue the work of the Task Force, the next phase of the Task Force will focus on the following objectives:
 - Continue the implementation phase focusing on monitoring and evaluation;
 - Continue the development of a risk management framework for Duty of Care;
 - Review and extend the applicability of the deliverables in all environments; and
 - Develop implementation plans for providing Duty of Care to non-staff personnel.

Enabling us to “Stay and Deliver” in high-risk environments

1. The United Nations system (UN), today, routinely faces multiple crises simultaneously across the globe. The High-Level Committee on Management (HLCM) has thus committed, with a sense of urgency and determination, to build on the experience of increasing tragic events to strengthen management in organizations to preserve the system’s ability to deliver on its programmatic mandates – the UN’s *raison d’être* – while at the same time, ensuring that UN personnel remain physically and psychologically safe.
2. Therefore, in 2014, HLCM established a Working Group on “Reconciling Duty of Care for UN personnel while operating in high-risk environments” (hereinafter called “**Working Group**”) to launch a holistic examination (including fact finding missions)¹ of the programmatic need to “Stay and Deliver”, to assess how to achieve an appropriate balance between carrying out essential work in high risk environments and at the same time, preserving the safety and security of personnel delivering in those environments.
3. Following the work of the Working Group, in March 2016, HLCM established a cross-functional inter-agency 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 implement the recommendations that had emerged from the previous stages of the work² (hereafter called “**Task Force**”).
4. The goal of the Task Force is to enhance guidance and strengthen actions in the functional areas of psychosocial support, health, human resources administration and safety and security in the preparatory, incumbency, and post assignment phases of deployment.

Duty of Care: The Responsibility to Inform and Act

5. An important element of the UN’s Duty of Care to personnel is the responsibility to inform personnel of the (residual) risks prior to their assignment or deployment.³ The information that should be provided to discharge the responsibility to inform includes: operational environment and tasks; threats and related risks; mitigating measures; and crisis management planning and redress measures.⁴

¹ CEB/2016/HLCM/11, March 2016.

² CEB/2017/HLCM/6, March 2017.

³ See Standard 3: Informed Consent of the Voluntary Guidelines on the Duty of Care to Seconded Civilian Personnel. While the concept of “informed consent” in the strict sense of requiring the agreement of personnel prior to any deployment/assignment does not apply in UN system due to the Secretary-General’s authority to assign staff to any activity or office of the UN under UN Staff Regulation 1.2(c), the spirit of the principle and basic premise that individuals should be informed and agree to undertake an assignment may be met in the UN context through the responsibility to inform UN personnel of any risks.

⁴ See Standard 3 of the Voluntary Guidelines on the Duty of Care to Seconded Civilian Personnel on informed consent.

6. It is the organization's responsibility to brief its personnel proactively, continuously and fully, on the basis of the best available information which cannot be implicit or assumed. The responsibility to inform may not be met by an understanding that the concerned personnel could have obtained relevant information by him/herself.⁵ This organizational responsibility to inform extends to all UN personnel, including locally-recruited staff and standby partners, for whom the releasing entities may have shared responsibility.
7. The Working Group concluded that Duty of Care constitutes "*a non-waivable duty on the part of the organizations to mitigate or otherwise address foreseeable risks that may harm or injure its personnel and their eligible family members.*"⁶ This cross-functional Task Force views the Duty of Care as employer's Duty of Care to address foreseeable risks arising from the workplace.

Definitions

8. For the purpose of the Task Force:
 - a. **high-risk environments** refer to duty stations eligible for danger pay⁷, as determined by the International Civil Service Commission (ICSC) and the countries declared by the Inter-Agency Standing Committee (IASC) as Level 3 health emergency locations⁸.
 - b. **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 types of appointment (fixed term, continuing/permanent, temporary appointment).
 - c. **personnel** refer to all staff, as defined above, and other individuals with a contractual relationship with the Organizations (e.g. consultants, individual contractors, interns, UN Volunteers), in line with the definition used in the United Nations Security Management System.

The report refers to personnel or staff, depending on the context.

- d. **stand-by partners** refer to individuals deployed by external entities (e.g. the Stabilisation Unit of the United Kingdom, the Expert Pool for Civilian Peacebuilding (SEP) of the Swiss Directorate of Political Affairs, the Center for International Peace Operations of Germany (ZIF), CANADEM) to the UN.
- e. **locally-recruited staff** refers to staff members in the General Service and National Professional Officer categories.

⁵ Voluntary Guidelines on the Duty of Care to Seconded Civilian Personnel.

⁶ CEB/2016/HLCM/11 (15 March 2016).

⁷ International Civil Service Commission, Danger Pay, <https://icsc.un.org/secretariat/hrpd.asp?include=dp>.

⁸ IASC Transformative Agenda, <https://interagencystandingcommittee.org/iasc-transformative-agenda>.

The Thirteen Deliverables

A. Background

9. The Working Group⁹ identified a set of 13 deliverables (please see Annex 1) that have since been streamlined to 9, which comprises of the four streams of the system-wide Duty of Care covering psychosocial support, health, human resources and administration and, safety and security.
10. The deliverables cover the preparation, incumbency/during and post phases of deployment. For the purpose of this report, the sequence of deployment will be used to present and describe the deliverables and their expected impact on personnel. Many of these Duty of Care deliverables as they apply to personnel in high-risk environments fall under the umbrella of occupational (workplace) safety and health. They are naturally a part of the system outlined in the HLCM's Occupational Safety and Health Framework.
11. The deliverables are applicable to all UN personnel, unless otherwise noted. For example, some deliverables are only applicable to UN locally-recruited staff.

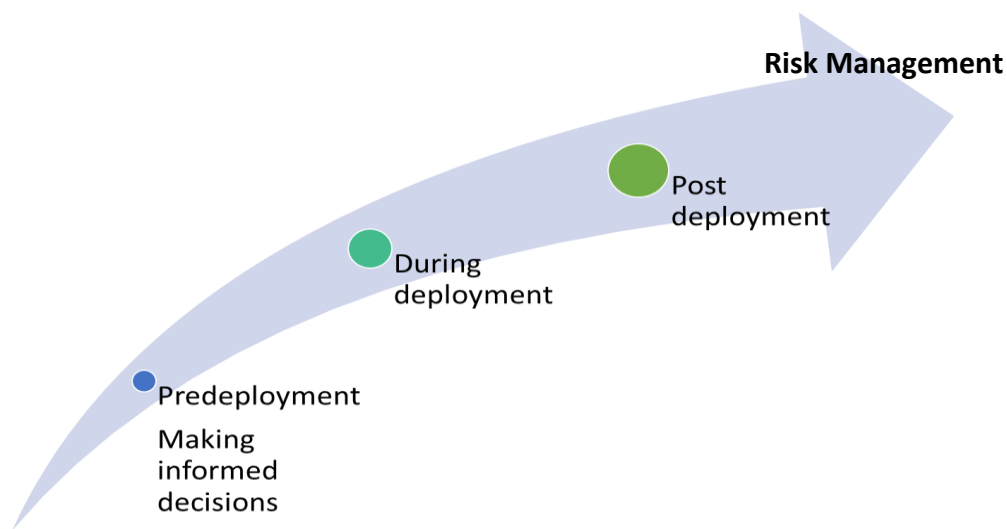


Figure 1. Phases in deployment

⁹ HLCM Working Group on "Reconciling Duty of Care for UN personnel while operating in high risk environments;"; CEB/2016/HLCM/11.

B. Achievements to date

12. **Mental Health Strategy (Annex 2):** During its 34th session in September 2017, the HLCM discussed and approved the Mental Health and Well-Being Strategy (hereinafter “Mental Health Strategy”), a system-wide five-year action plan to ensure that services and support for mental health and well-being are available and accessible for all staff members, including locally-recruited staff. In recognizing the need for this comprehensive strategy to be consistently applied across the UN system, the General Assembly, in December 2017, approved a P-5 post in New York to coordinate the work on the implementation of the Mental Health Strategy.
13. **Duty Station Health Risk Assessment Tool (Annex 3):** Following the recommendation of the HLCM during its 31st session in March 2016, a standardized and validated tool and associated methodology for the assessment of health risks in a given duty station (hereinafter “Duty Station Health Risk Assessment”) has been developed.
14. The Duty Station Health Risk Assessment tool is currently being piloted in 27 locations in 14 countries (Angola, Comoros, Djibouti, DPR Korea, DR Congo, Haiti, Honduras, Jamaica, Madagascar, Nepal, Somalia, Western Sahara, Yemen and South Sudan).
15. The pilots have been instrumental in closing UN clinics in, for example Dar es Salaam in Tanzania and Pyong Yang in Democratic Republic of Korea and redistribute the resources to be used in Kasulu, in Tanzania, near the border with Burundi, where there are no essential health services. In addition, it has helped DPKO rationalize its health resources in Haiti.
16. **Assessment Standards for Referral Hospitals (Annex 4):** The UN Medical Directors and DPKO have defined quality standards for referral hospitals thus enabling an objective assessment of centres of UN medical evacuation.
17. **Online medical insurance claim processing:** 7 out of 10 organizations who responded to the survey from the Task Force Secretariat reported institution of online claiming for medical insurance. The benefits of online claiming include: saved time and costs for the claimants, easier claim tracking and improved fraud detection.
18. As for non-staff, the Insurance and Disbursement Service at the UN Secretariat (IDS) partnered with Orion International Insurance Services to provide travel medical insurance. Orion, a global leader in providing high quality travel insurance, expatriate medical and international group insurance policies, has built an easy-to-use website for the UN that allows non-staff personnel to obtain quote, buy coverage online, receive an email confirmation of their coverage, access 24/7 multi-lingual assistance and access a member website.
19. **Danger Pay¹⁰:** In the course of 2017, the Human Resources Network (HR Network) conducted intensive consultations with the ICSC to improve the conditions of service for locally-recruited staff.

¹⁰ ICSC website on Danger Pay, <https://icsc.un.org/secretariat/hrpd.asp?include=dp>.

20. In result, in its Resolution on the UN Common System of December 2017, the General Assembly accepted revised levels and the adjustment methodology for danger pay (a special allowance established for internationally and locally recruited staff who are required to work in locations where very dangerous conditions prevail) for locally-recruited staff, while the danger pay level for international staff remained the same.
 - a. Danger Pay levels for locally-recruited staff were adjusted to 30 percent (from the 25 percent proposed by ICSC) of the midpoint of the applicable salary scales and the reference salary scales were updated from 2012 to 2016.
 - b. The GA endorsed the ICSC decision, therefore the increased amounts are payable as of January 2018.
21. Based on these changes, all duty stations where danger pay is applicable will see increases in the annual payment to locally-recruited staff, for instance in Yemen and Afghanistan by approximately 25%, Iraq by 11%, and DR Congo by 41%.
22. As agreed in the 34th HLCM session in September 2017, organizations have started implementing some of the requested actions, e.g. pre-deployment briefing.

C. For Adoption and Action by High-Level Committee on Management

Pre-deployment Phase

Pre-deployment package and resilience briefing (Deliverables 1 and 2)

23. From the fact-finding missions, it became clear that many personnel and managers did not know what to expect in the field. Some organizations noted that there was fear amongst personnel about deployment to high-risk locations, which was aggravated by the varied pre-deployment assistance between agencies. Currently, Basic Security in the Field, Advanced Security in the Field and the Safe and Secure Approaches in Field Environments (SSAFE) trainings are the only systematic trainings provided to deployed personnel. In addition to the lack of comprehensive pre-deployment information, some expressed concerns about sharing information about their deployment to high-risk environments with their families.

Case Study: One UN organization is piloting webinar sessions, designed for applicants that have applied to positions in high-risk locations so that they are informed of the situations in those duty stations e.g. security, housing, medical facilities, living standards, education etc.
24. The combined fear about deployment to high-risk environments and the lack of systematic pre-deployment assistance result in personnel not willing to be deployed to such duty stations, which in turn makes it difficult to fill posts in high-risk environments, causing protracted staffing gaps in often key operations.

25. The Task Force, therefore, developed a comprehensive pre-deployment package for personnel and their families including a system-wide resilience briefing (please see Annex 5). The pre-deployment package, entailing technical input from medical, security, psychosocial and human resources experts, enables personnel and their families to have access to up-to-date information, which helps them to make informed decisions about deployment.
26. The package includes a model fact sheet for country specific information and UN Country Teams in high-risk environments are expected to keep up-to-date information on these factsheets. The country specific information will be shared, on an annual basis, with the Secretariat of the Chief Executives Board for Coordination (CEB).
27. The package also includes an implementation manual and a guide for personnel on how to discuss deployment with their families. Organizations need to provide a platform whereby personnel can relay queries from their families.
28. There are multiple possible modalities for delivering the package (e.g. online, face-to-face, webinars or a blended approach). Each organization will need to make their own context specific decisions on how best to deliver. Nevertheless, the broad content of the package is considered a minimum standard. However, as some actions require resources unavailable at this time, these are to be considered best practices to be attained by organizations.
29. The development of such a package ties in with the organizations' duty to inform so that deployed personnel can assess and knowingly accept the risks associated with their deployment. While there are quite a number of efforts to inform/prepare international staff for their deployment, the same has to be offered to locally-recruited staff and also other non-staff personnel. There is also a shared responsibility between the UN organization and the seconding entity to inform the stand-by partners.

Adoption 1	The Task Force asks the HLCM to adopt the comprehensive pre-deployment guide, including the resilience briefing, as a standard.
Action 1	1.a) Each organization to embed the guide in their pre-deployment induction starting May 2018
	1.b) 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).

Training for Managers (Deliverables 3 and 11)

30. The accountability for providing Duty of Care is delegated from the head of the organization to the line managers and how they address all facets of Duty of Care has a huge impact on the safety and psychosocial resilience of personnel. Hence, the preparation for managing in high-risk environments is crucial and managers need ongoing support beyond normal technical supervision.
31. Due to the exceptional circumstances, managers in these locations are often entrusted with more responsibilities than those in other locations.

32. In May 2017, the UN System Chief Executives Board endorsed the UN Leadership Framework, which highlights the imperatives of leadership in managing change and creating culture¹¹. The Framework is based on the eight defining characteristics of UN leadership, that it was norm-based, principled, inclusive, accountable, multi-dimensional, transformational, collaborative, and self-applied, and the Task Force notes that these principles are essential for modelling the behaviours of managers in high-risk environments, including providing self-care.
33. In addition to the principles as stated in the UN Leadership Framework, organizations should ensure that managers are trained on key emergency management principles that are essential to lead in high-risk environments. In these contexts, as an example, managers should be trained to ensure the following characteristics to their risk and threat management practices¹²:
- a. **Comprehensive:** Consider and take into account all risks, phases, stakeholders and impacts relevant to adverse events. Managers must have the capacity to make decisions in crisis situations, understand what kind of occupational hazards there may be and how to manage/mitigate them;
 - b. **Progressive:** Anticipate potential risks and take the preventive and preparatory measures to build mitigation plans and resilient teams/communities. Managers must understand how to assess threats and risks and reduce vulnerability;
 - c. **Risk-driven:** Familiarize with the Security Risk Management Framework, to include, the ability to identify threats, determine the likelihood and impact of threats, assess the situation, and determine the programme criticality in order to make decisions and assign priorities about the operations on the ground. It is imperative for managers in high-risk environments to understand that monitoring the risks, implementing the risk management measures and what residual risks they are accepting is an overriding responsibility that they need to attend to in these locations;
 - d. **Integrated:** Collaborate with various stakeholders including officials at all levels of the host government, individuals of the local community and the secondees from standby-partners;
 - e. **Collaborative:** Create and sustain broad and sincere relationships among individuals and organizations to encourage trust, advocate a team atmosphere, build consensus, and facilitate communication. When it comes to people management, managers are required to be particularly mindful given the exceptionally high co-dependence amongst personnel and managers and the different individual needs for resilience;
 - f. **Coordinated:** Synchronize the activities of all relevant stakeholders to achieve mandate delivery;
 - g. **Flexible:** Utilize creative and innovative approaches in addressing risks and other challenges to ensure that the personnel can 'stay and deliver' in a healthy and safe environment; and

¹¹ Actions on UN System Leadership Framework, CEB Secretariat, <https://www.unsystem.org/content/action-un-system-leadership-framework>.

¹² Principles of Emergency Management Supplement, US Federal Emergency Management Agency (FEMA), September 2017.

- h. **Professional:** Value a knowledge-based approach based on education, training, experience, ethics, public stewardship and continuous improvement while giving due regards to inclusion, gender and diversity.
34. While it is important to manage risks, it is also imperative for organizations to acknowledge that leading a team in a high-risk environment is highly stressful and that managers need to be equipped with the capability to self-assess and manage their own resilience. For example, to take their rest and recuperation (R&R) as this in turn makes it easy for others to take such measure as well.
35. It is recognized that many personnel and managers in high-risk environments shy away from raising personal matters with their supervisors as they fear that this may be perceived as an inability to cope or an indication of poor performance. Therefore, organizations may consider providing senior managers from the Country Teams or in the field offices support in terms of professional coaching, external to the organization.
36. Work has started, on identifying key content that would be important to cover in the guidance/training programme for managers, particularly with regards to ensuring that managers are familiar with the security management system, UN operational frameworks, policies and procedures and issues related to leadership in a high-risk environment, maximizing performance and resilience of personnel and personal resilience and well-being (please see Annex 6). While such information can be integrated in each organization's training model immediately, the Task Force notes work remain to be done with regards to developing content which would cover other management principles listed above.
37. The work should be conducted in collaboration with relevant stakeholders such as the UN Staff College and Staff Development and Learning Managers Network to: i) develop a common checklist with standards of training appropriate for different levels of managers (regional directors, country directors, heads of offices, and anyone that has supervisory responsibilities); and ii) incorporate the key management principles into the existing training materials.
38. The UN Staff College in collaboration with UN OCHA, for example, currently offers a course for humanitarian candidates to support potential managers in humanitarian contexts in enhancing their understanding of the managerial competencies (as Regional Coordinators). In addition, the UN Department of Safety and Security (UN DSS) provides training for Designated Officials (DO) and Security Management Teams (SMT), while UN Medical Directors (UNMD) is engaging with country teams to understand the Duty Station Health Risk Assessment. The proposed inter-agency training tool/curriculum will supplement the existing materials for managers. Each UN organization may decide to roll out additional specific trainings depending on the needs of their operations.

Adoption 2	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.
Action 2	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).

Development of a Health Risk Analysis Tool and Methodology & Implementation of a Systematic Health Support Plan (Deliverables 5 and 6)

39. Ensuring the survival of an acute life threatening medical event is a core element of duty of care and is a recurring concern for personnel in high-risk locations. Such concern creates additional burden for managers, as they are often unaware of the measures that would best suit the circumstance. While humanitarian organizations depend heavily on peacekeeping operations medical facilities, there are notable gaps in the chain of survival when they operate away from the support of the UN Department Peacekeeping Operations (UN DPKO). Many host communities do not have adequate essential medical services, suited for threat environment. The 40 UNDP-managed UN clinics do not cover all the high-risk environments nor do they alone become a risk mitigating factor.
40. One of the main issues is the lack of consistency in defining necessary health support and the attendant quality standards, including time standards. The UN Medical Directors (UNMD), thus developed a methodology for Health Risk Analysis (Duty Station Health Risk Assessment, DS-HRA), based on the UN Enterprise Risk Management Framework, which identifies six mandatory health support elements as well as a tool for assessing the impact and likelihood of context specific issues (please see Annex 3 for the Duty Station Health Risk Assessment Guide, the tool and supporting documents).
41. The UN is committed to providing a consistent level of high quality care to all mission personnel, regardless of the country, situation or environment. In many countries, the UN contracts with hospitals outside of the UN system to provide care for UN personnel. These hospitals are a valuable resource for the UN to ensure every patient has the care they need when they need it and are assessed periodically to ensure they meet the UN Standards of care. To aid this assessment UNMD has built on the work of the UN Medical Service Division (UNMSD) at the UN Secretariat in developing the “United Nations Assessment Manual for Referral Hospitals” that sets out Healthcare Quality and Patient Safety standards to be met in order to be considered for use as a Referral hospital. In addition, a companion Health Facility Service Capability Form has also been developed. Please see Annex 4.
42. Within 2018, UNMD will finalize a similar manual for assessing primary health care facilities which will be part of the DS-HRA methodology. Work has also been done by UNMSD on the development of “United Nations Manual for HealthCare Quality and Patient Safety” which will be used to implement these standards in all the Level I +, Level II and Level III hospitals in the UN system for both military personnel and civilians.

43. In medical research, it is evidence-based that the risk of death or permanent disability is significantly reduced if people are treated as soon as possible after the onset of a life-threatening injury or illness. Based on this evidence, it is of utmost importance that appropriate life, limb and eyesight saving procedures are provided within specific timelines along with the survival chain appropriate for the event. This has become known as the 0-10-1-2 timeline.
44. The Survival chain in line with this timeline is described as follows:

0	Represents immediate self or buddy aid, to stop major hemorrhage, or commence CPR. This target can only be achieved if all personnel have adequate training in self/buddy aid.
10	Represents the recommended maximum time, in minutes, to provide the necessary advanced lifesaving measures at POI after the onset of injury/illness. This is often referred to as the 'Platinum 10 Minutes', and is the standard of care delivered by ETB responders.
1	Represents the recommended maximum time that necessary damage control resuscitation procedures are provided by emergency medical personnel. This should be completed within 1 hour of the onset of injury/illness and is often referred to as the 'Golden Hour'.
2	Represents the recommended maximum time that necessary Damage Control Surgery (DCS) is provided. This should start within 2 hours of the onset of injury/illness.

Figure 2. Timeline for the survival chain

45. This agreed upon standard aids in assessing the fitness for purpose of emergency response in high threat environments. It builds on Inter-Agency Security Management Network (IASMN) work on setting standards for first responders in various environments¹³.

¹³ Inter-Agency Security Management Network (IASMN) CRP 8 26th Session Annex A, Montreux, 20-22 June 2017.

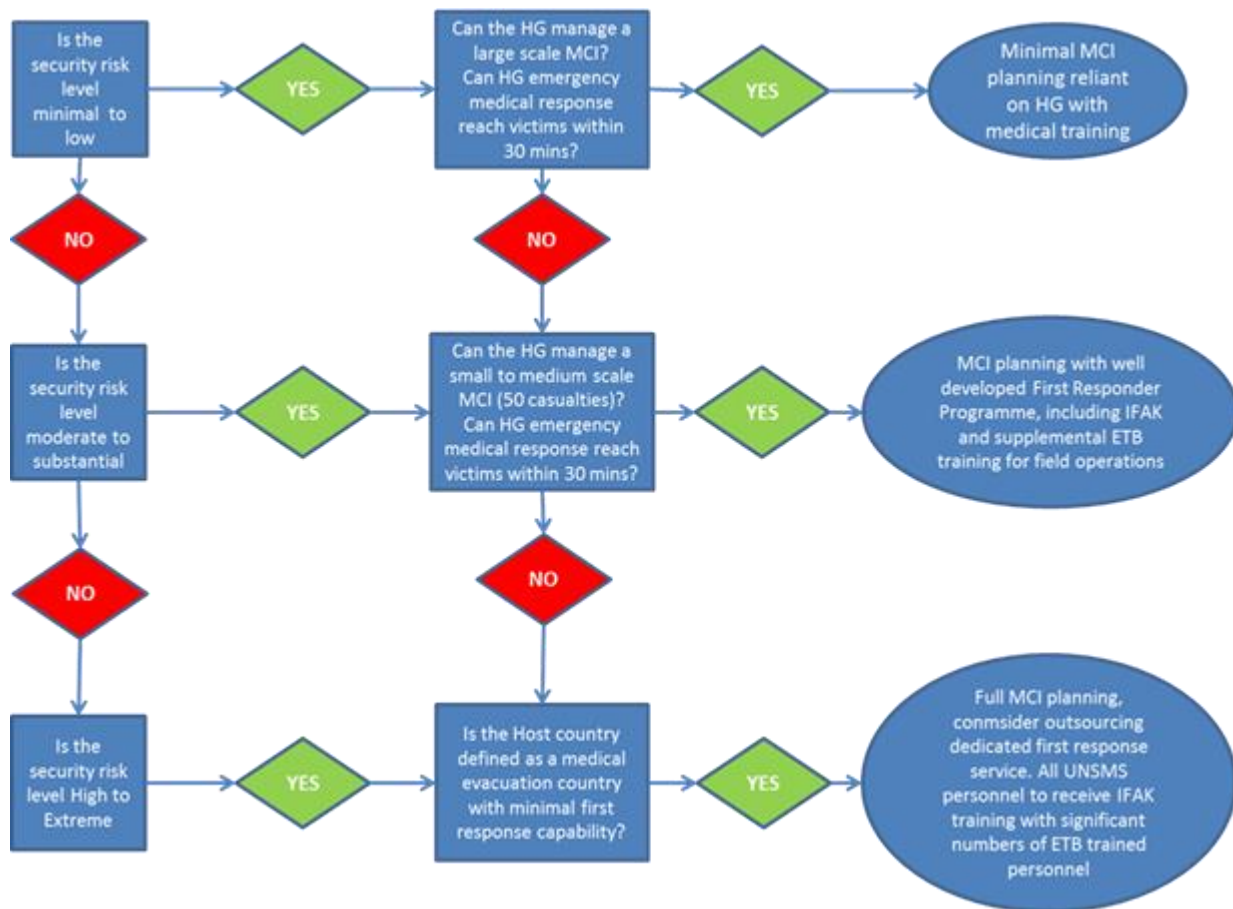


Figure 3. First Responder Programme Planning for Mass Casualty Incidents

46. The aim of the Duty Station Health Risk Assessment (DS-HRA) tool is to assist the country teams in identifying the gaps and to guide them on how to mitigate the gaps, hence providing the necessary action to fulfil their Duty of Care. A DS-HRA is a core element of Occupational Safety and Health (OSH) to prevent or reduce occupation related injuries, illness, and death of the United Nations personnel. The DS-HRA in a duty station helps identify the hazards, evaluate the risks and assess the measures already in place and to be put in place to best prevent and mitigate these risks with the final aim of optimizing the health and safety of the UN personnel in the context of the duty of care responsibility that the UN organization bears towards its personnel. This assessment represents the “health” component of a multidisciplinary approach launched under the umbrella of the 2016 HLCM strategic 2015-2020 planning. This work arises directly from the request of the HLCM, and its strategic focus on Duty of Care (2016).
47. The mandatory health support elements (MHSE) are the minimum health support standards that must be available to personnel at every duty station irrespective of the risk assessment. Having the mandatory health support elements in place will also provide significant mitigation of risks identified during the assessment. The mandatory health support elements should, where possible be provided by external providers. Assessment of local facilities will allow a determination of their suitability for use by UN personnel in the overall duty station Health Support Plan. The mandatory health support elements consist of:

- a. **Primary Care:** For the initial treatment of acute, intercurrent conditions, for health surveillance and preventive services, and for management of chronic conditions. Note that in some countries, primary care cannot deliver obstetric or gynaecological emergency response, or female health surveillance (pap smears, breast examination, mammography), as this is not considered part of primary care. In other countries, this work is core for the primary care physician (PCP), and they are trained to deliver it. The health support plan must have express reference to women's health emergencies.
 - b. **Hospital Care:** Assessment of hospital care level 1 to be further developed, but could be based on UN level 1 plus with oxygen, ventilator, IVI fluids and blood supply; stabilization until possible medevac. Level 2 and above hospital care assessments available via DPKO.
 - c. **Mental Health Services:** Access to Mental health professionals either in person or via telehealth.
 - d. **Mass Casualty Plan:** The Mass Casualty Incident Plan (MCIP) is an internal UN document can have significant reliance on external providers, e.g. ambulances and hospitals. This should be clearly documented, and those providers should be briefed and agree to provide MCI support.
 - e. **Medical Emergency Response:** Individual First Aid Kit (IFAK), Emergency Trauma Bag (ETB), Ambulance providers, Emergency Departments, casevac and medevac.
 - f. **Access to pharmaceuticals (including PEP):** While UN personnel are advised to bring the over-the-counter drugs and their own prescribed medicines, organizations need to have a system to replenish medication, if needed.
48. The healthcare facilities that should be included in the assessment, can be identified by the local UN healthcare team, local senior managers, staff representatives, and/or through a search done by the healthcare assessment team. The assessment of each healthcare facility should be done in a systematic way, following the same formulae for each facility to identify the services that each can or cannot provide in a response to mass casualty and individual health impacts of the hazards for that location.

MHSE Gap Analysis & Risk Controls			Recommended risk controls (joint recommendations from HRA and MSD)	Local Provider available and accessible as needed?	If not/partially covered, can current UN capacity compensate?	Describe basis for rating.	MHSE appropriately addressed?	Actions needed to fully implement Mandatory Health Support Elements	Projected RR Score	Risk Controller
Element Description	Residual Risk Score									
Mandatory Health Support Elements (MHSE)	Primary Care	n/a	n/a	Yes	n/a		yes		n/a, mandatory	RC & MSD
	Hospital Care	n/a	n/a	Yes	n/a	2 identified hospitals-Grande and Norvick- are suitable for this Health Support Element	partial	Procurement & RC to take action to finalize MOU with the 2 hospital providers identified as suitable	n/a, mandatory	RC & Procurement
	Mental Health Services	n/a	n/a	no	No	Appropriate inpatient care is not available and would need evacuation; Outpatient services are very limited and confidentiality is a	No	Identify nearest med eval centres for MH inpatient needs; Confidential MH services are also a challenge in this culture so online resources such as telepsychiatry would be a	n/a, mandatory	RC and Country Team HR leads.
	Mass Casualty Plan	n/a	n/a	Partial	yes	MCP should be built according to the available resources	partial	UNMERT can assist in draft of medical component of the MCIP	n/a, mandatory	Chief Security Advisor
	Medical Emergency Response	n/a	n/a	Partial	No	External providers available and suitable, but currently no contractual relationship with UN.	No	MOU with ambulance companies with skilled paramedics	n/a, mandatory	RC & Procurement
	Access to pharmaceuticals	n/a	n/a	Partial	Yes	External providers available and suitable, but currently no contractual relationship with Cigna/UN insurance	No	Health Insurance Company to visit Nepal and set up proper service agreements	n/a, mandatory	RC
	PEP	n/a	n/a	Yes	n/a	PEP activities in place	yes	Continue with PEP and assure that any onboarded UNEPs are fully trained.	n/a, mandatory	RC

Figure 4. Mandatory Health Support Element Gap Analysis & Risk Controls

49. The result of the assessment is the health support plan listing the mandatory health support elements (MHSE), and the recommended actions for their implementation. It will then list the Health Risk Assessment risk treatments, and the method for delivery. If all of the MHSE are in place and are of high quality, this is likely to address many of the required risk treatments in the DS- HRA.
50. In high security threat environments, the health support plan should have some redundancy (e.g. several options for hospitals or clinics) to plan for the eventuality that one or more services can be rendered inaccessible or inoperable in a hostile environment. There should never be 100% reliance on a sole external provider.
51. A key take home is that the structured discussion based on the tool lends itself to set an agreement on the necessary measures to take.
52. The DS-HRA may be conducted should there be a request from the duty station or should a Medical Director request UNMD for the assessment. Please see Annex 7 for the Standard Operating Procedure on conduct of a DS-HRA, developed by the UNMD.
53. Meeting the mandatory health support elements is an integral part of the risk management framework and is the key to fulfil the Duty of Care requirements for personnel.
54. The result of the health risk analysis would be that each duty station has its own health plan.

Adoption 3	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.
Action 3	3. a) UNMD to continue the health risk assessments with focus on high-risk duty station in Afghanistan, Cameroon, Central African Republic, Chad, Ethiopia, Iraq, Kenya, Libya, Mali, Niger, Nigeria, Pakistan, Sudan, Syria and complete by end of 2020.
	3. b) Organizations should establish a process for their Country Offices to request funding 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.

Streamlining the insurance processing mechanism (Deliverable 12)

55. Personnel and managers expressed inconvenience experienced and time taken in submitting insurance claims in paper format through a pouch system. The Task Force, therefore, reviewed the insurance processing mechanisms for: medical health insurance; compensation for service incurred death, injury or illness; and malicious act insurance policy.
56. On claims processing for health insurance reimbursements for staff (as organizations only provide medical insurance for staff), the Task Force noted that since this deliverable was approved by HLCM in March 2016, most organizations have already instituted online claiming for medical insurance.
- a. Those organizations which have already instituted online claiming reported the following benefits:
- Save time and costs for the claimants: claimant does not have to send the claims through pouch/post (with the risk of losing the claim in the mail). Online tools will automatically fill out personal and payment details and guide the claimants through the process, and remind them which documents to attach. This decreases the possibility of making any mistake in the claim process and hence, delay the payment.
 - Claims tracking: claimants are able to track/monitor the progress/status of their claims.
 - Improved fraud detection: some providers have enhanced fraud approach whereby they do not only look at the claim image or document but have a comprehensive approach with a combination of awareness, pre-payment and post-payment detection, and thorough investigation by a group of experts.

Adoption 4	The Task Force asks the HLCM to adopt online claiming for medical insurance as a standard.
Action 4	Organizations to implement online claiming for medical insurance.

57. It is also recognized that the access to the various medical services, provided by the local facilities or by the UN, is closely linked to the billing arrangements under medical insurance. Medical services are generally paid on fee-for-services basis. There are about 19 different insurance mechanisms for UN staff alone and the number is higher for non-staff personnel and standby partners. This puts barriers on locally-recruited staff and non-staff personnel, using insurance mechanisms other than those used by international UN staff as UN peacekeeping clinics do not accept cash and there might not be mechanism to make direct billing to the insurance company. The UN-managed clinics prefer direct monthly payment from the pre-determined insurance companies or through simplified direct billing from the agencies.
58. When creating a duty station health plan, all local resources, be they UN clinics or peacekeeping clinics, need to be available to all types of personnel. Administrative and financial barriers should not be put in place at point of service and the Country Team needs to work proactively in finding cost sharing solutions. Organizations should put more effort in closing the gap, through agreements with insurance companies, as necessary. All medical facilities in the duty station, including DPKO clinics, should enter into direct payment arrangements with third party insurance administrator (TPAs) of organizations to reimburse medically necessary services that are reasonable and customary. For personnel of stand-by partners, this can be captured in the Memorandum of Understanding (MOU) with standby-partners prior to deployment. Please see Annex 8 for a sample MOU.

Adoption 5	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 necessary medical services from any type of UN clinic, including DPKO clinics.
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59. On claims processing for compensation for service incurred death, injury or illness, the Task Force noted that the 2016 report (ref: CEB/2016/HLCM/11) recommended that this deliverable be followed though by the Office of Human Resources and Management (OHRM). As such, this section will focus on UN organizations governed by the United Nations Staff Regulations and Rules and whose claim are administered by the Insurance and Disbursement Service (IDS), Accounts Division, Office of Programme Planning, Budget and Accounts, UN Secretariat with respect to compensation for service incurred death, injury or illness for staff.
- As per the UN Staff Regulations and Rules, claims by staff members for compensation for service incurred death, injury or illness is as stated in Appendix D of the Staff Rules.
 - On 1 January 2017, the first complete revision of Appendix D since 1966 was promulgated by the General Assembly and went into effect.
 - In addition, since 2012, IDS introduced the following measures to simplify and streamline the claim process. Other procedural measures were further introduced in 2016.
 - Institution of monthly Advisory Board on Compensation Claims (ABCC) meetings;
 - Increase of delegation of authority to ABCC secretary;
 - Formalization of ABCC rules of procedure;
 - Implementation of new ABCC database;

- Consultation with, and implementation of action, with UN Medical Services Division (MSD), Department of Field Services (DFS) and United Nations Joint Staff Pension Fund (UNJSPF) to address delays in provision of information, calculation of benefits and medical advice regarding claims;
 - Articulation of legal standards for consideration of harassment/abuse of authority and burn-out cases;
 - Articulation of standards for ABCC and MSD actions, such as certification of medical expenses, criterion for considering sick leave credit and criterion for waiver of deadline of filing a claim;
 - Streamlining processes such as single submission of cases to board for survivor benefits;
 - Instituting new filing system for case files;
 - Revising for clarity, brevity and neutrality the drafting of all ABCC documentation, such as Secretary-General's decisions, minutes and substantive memoranda; and
 - Simplifying the annual certification of beneficiaries.
- d. All UN personnel should be encouraged to ensure colleagues who are injured are aware of their entitlements under Appendix D. Under no circumstances should staff be discouraged from lodging claims.
- e. Further, an updated manager's guide to Appendix D and a new claims form are available online¹⁴.

Action 5	5.a) 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.
	5.b) Organizations appoint an Appendix D focal point and make their name and contact details available on the intranet site.

60. On claims processing for Malicious Acts Insurance Policy (MAIP), the Task Force noted that the 2016 report (ref: CEB/2016/HLCM/11) states that this recommendation should be followed though by the Office of Human Resources and Management (OHRM), this section will focus on the MAIP insurance administered by the Insurance and Disbursement Service (IDS), Accounts Division, Office of Programme Planning, Budget and Accounts, UN Secretariat and organizations participating in the UN MAIP programme. Depending on the coverage requested by the organization, MAIP is applicable to staff and other personnel.
- a. IDS informed the Task Force that the processing of death claims under the UN Common MAIP is generally less than 3 months from the date of claim receipt by IDS. For the very rare cases when payment is made after 3 months, the delay is generally due to issues such as determination of appropriate beneficiary, or the incomplete documentation.
- b. A check list of all documents to be provided is attached as Annex 9.

¹⁴ P-290-E: Claim for Compensation under Appendix D to the Staff Rules, <https://iseek.common.un.org/content/p290-e-claim-compensation-under-appendix-d-staff-rules>.

- c. However, the Task Force notes that the time taken to process the claims should be shorter and standardized, e.g. 60 days, provided that all of the relevant documents are received. Therefore, the UN Secretariat should analyse further why they are currently unable to meet the standards and propose measures to shorten the timeframe.

61. A recurring comment from the fact-finding missions of the Working Group was that locally-recruited staff and international staff receives different compensation under MAIP. The Task Force reviewed this matter and its finding can be found in Annex 10. In summary, with regards to MAIP, the intent of the MAIP is not to compensate the beneficiaries for the loss of life, but to compensate for the loss of income due to the death of personnel. Since Professional and General Service staff do not receive the same salary, hence the loss of income to their families is not of the same level.

Adoption 6	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.
Action 6	6. a) Organizations ensure effective measures to assist staff to update their beneficiaries form as applicable
	6.b) Organizations to establish an internal process on claiming for compensation under the Malicious Act Insurance Policy (MAIP).

62. HLCM should note that a large part of the UN workforce is still not eligible for UN-provided medical insurance and are expected to buy their own.
63. While the previously mentioned contact with the commercial insurance provider, Orion, is an achievement, it does not remove the organizations' Duty of Care to verify that these individuals have adequate insurance provisions that are suitable for high-risk environments, as it is still difficult for personnel in high-risk environments to buy an adequate medical insurance. HLCM also needs to note that most commercial insurances have exclusion criteria for individuals based in high-risk environments. Therefore, future work could be to conduct a joint inter-agency procurement process to establish long-term agreements for medical evacuation, health and life insurance packages to be made available to non-staff personnel to purchase at their own cost.

Action 7	Organizations to have an internal process to verify the insurance coverage of non-staff personnel, prior to deployment to high-risk environment.
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During Deployment Phase

UN Working and Living Standards (Deliverable 4)

64. There is a wide disparity among the UN organizations with regards to working and living conditions/facilities. In many locations, poor living and working conditions add to the stress of serving in high-risk locations e.g. there is lack of privacy from sharing rooms in some locations whereas in other locations, the lack of common space does not allow personnel to de-stress and relax. In addition, in high-risk locations, personnel spend disproportionate amount of time in accommodation facilities with no access to external recreational activities, for security reasons.
65. Therefore, the standards developed by the Task Force will serve as the UN minimum working and living standards that are applied consistently system-wide (please see Annex 11). With the implementation of the standards, personnel will be able to benefit from decent working and living conditions, which is especially important in high-risk locations, where freedom of movement is restricted. This will also build and contribute to the resilience and psychosocial wellbeing of personnel, hence leading to better functioning teams that can stay and deliver.
66. The standards address important areas in providing Duty of Care to personnel from health, safety and security issues to lodging, community facilities, service and administrative practices perspectives. For example, having bedrooms with self-contained bathrooms are not only about convenience and privacy but can be construed as prevention against possible instances of sexual harassment. The ambiguity of personal space boundary is cultural and with a multicultural workforce as the UN, one needs to be sensitive to those needs.
67. Furthermore, UN organizations recognize the importance of making working and living conditions accessible to all personnel, including persons with disabilities. All new constructions should adhere to the standards given that office premises should also provide for people of concern in high-risk environments. Under the Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2007, the UN has committed that it will “take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services”¹⁵.
68. While all organizations should build new accommodations and office premises according to the UN minimum working and living standards, organizations are encouraged to retro-fit as well. The Task Force is conscious that resource issues may limit the retro-fitting, but emphasizes the benefits of upgrading living standards to this end.
69. UN organizations are invited to join a WFP-led global site on UN-provided accommodations which facilitates the search, management and booking of the accommodations and provides relevant information to personnel prior to their deployment.

¹⁵ The Convention on the Rights of Persons with Disabilities and its Optional Protocol ([A/RES/61/106](#)).

Adoption 7	The Task Force asks the HLCM to adopt the UN minimum working and living standards.
Action 8	8. a) All new accommodations and office premises are to be built based on these minimum standards;
	8. b) Organizations to retrofit/renovate accordingly as best practice; and
	8. c) Organizations to monitor the status regularly.

Addressing the issue of bandwidth to ensure robust communications (Deliverable 8)

70. Limited bandwidth impedes the capacity of personnel in high-risk locations to access services that require connectivity. Tele-health services, for example, are key in improving mandatory health support elements, which feeds into the health support planning for the duty station and the implementation of the mental health strategy. In addition, it is important for personnel in isolated locations to connect with their families.
71. As securing adequate bandwidth, technologies for delivering quality bandwidth capacity, budget/resources and conducting appropriate procurement (e.g. in relation to the number of personnel), depend on the managerial responsibilities and capabilities, the impediments experienced due to limited bandwidth (or the lack of bandwidth) translates into the failure to fulfil the Duty of Care responsibilities.
72. Therefore, the Task Force prepared a technical document indicating the scenarios in which robust communications are needed in high-risk environments and the graduated bandwidth needs in relation to different situations and the number of personnel (please see Annex 12). This will serve as a reference for organizations in their procurement.
73. With the implementation and consideration of such information, personnel in high-risk locations are able to stay connected with their colleagues and families and receive the appropriate and necessary tele-health services, enhancing their abilities to stay and deliver.

Adoption 8	The Task Force asks the HLCM to adopt the principle that personnel in the high-risk environments have adequate bandwidth to connect with their families and for tele-health services, as per parameters provided in Annex 12
Action 9	9. a) Organizations to retrofit/renovate accordingly as best practice; and
	9. b) Organizations to monitor the status regularly.

Mental Health Strategy (Deliverables 7 and 9)

74. In 2015, just over 17,000 UN staff members across 11 UN entities completed the Global Well Being survey. Overall findings suggest that approximately half of all UN staff members who responded to the survey reported experiencing symptoms that can be interpreted as being consistent with mental health conditions warranting follow up.
75. These results suggest that UN staff members report experiencing higher levels of common mental health conditions than we would expect to see in the general population, for depression, anxiety, post-traumatic stress disorder and hazardous drinking.

76. Sick leave data from Earthmed, an online platform used by the Medical Services in the UN system, reviewed for three UN entities, showed that the total days lost related to mental health diagnoses made up 14% of the total days lost per year, putting it at number two for lost days in the top ten by diagnostic category.
77. In addition, there are wide disparities among UN organizations on how they provide psychosocial support with some organizations having no in-house staff counsellors and others having multiply country-level presence. Furthermore, there is also a lack of clarity in defining the purpose of the staff counsellors and how they are supposed to work.
78. Recognizing these issues, the Mental Health Strategy (MHS) for the UN system Workplace (2018-23) received strategic support at HLCM meeting on 28th September 2017, followed by feedback at the UN Human Resources Network meeting on 9 October 2017. Please see Annex 2 for more information.
79. The UN MHS proposes a way forward, informed by the current known evidence base for workplace mental health, public mental health and occupational health, data from four UN wellbeing staff surveys, pension and EarthMed sick leave data, expert contributions of mental health strategy working group and consultation with UN personnel, managers and leaders.
80. The four key themes of this five-year workplace mental health plan are to:
 - a. Create a workplace that enhances mental and physical health and wellbeing;
 - b. Develop, deliver and evaluate high-quality services everywhere the UN work;
 - c. Welcome and support those who live with mental health diagnoses and challenges;
 - d. Ensure sustainable funding for mental health and wellbeing services.
81. The MSH working group is analyzing the operational modalities, which will be informed by UN Reform. The UN Secretariat managed to get the General Assembly approval to secure a P-5 level post to be situated in UN Medical Services Division to oversee the implementation of the MHS.

82. The below describes what the MHS will achieve, by demonstrating the level of reach and potential to benefit pyramid:

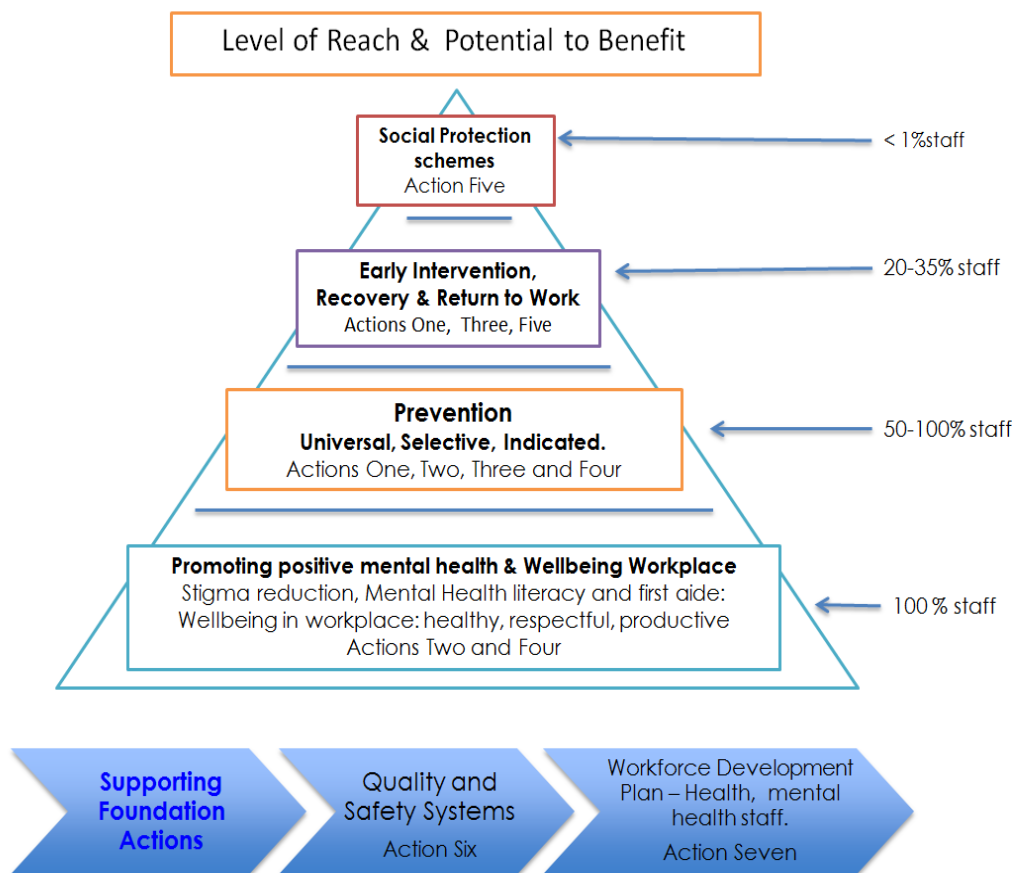


Figure 5. Level of Reach and Potential to Benefit, UN Mental Health Strategy

83. The working group will share the implementation plan by the next HLCM session.

No longer able to serve in high-risk environments (Deliverable 10)

84. Notwithstanding a set of various support provided to staff in high-risk environments, there may be situations where some staff may request to leave the high-risk locations prior to completion of their duties, when they can no longer cope.
85. Noting this is a recurring concern in organizations, the Task Force developed a list of best practices and measures that will give guidance to human resources practitioners and the managers on how to advise these staff and what the effective measures can be.
86. It is noted that, apart from the established processes for circumstances related to medical reasons, some organizations provide various measures such as: reduction of required minimum post incumbency, counselling services, provision of special leave and conducting the rotation exercise. While defining who can cope and who can no longer cope is a fine line and may be determined on a case-by-case basis, the Task Force recognizes that it is important for the organizations to have a process to address this issue.

Best practice 1:

- **The Task Force recognizes having a mechanism for staff to inform management that they can no longer cope in a high-risk environment, as a best practice.**
- **Therefore, organizations need to have a procedure for staff who can no longer cope and transparent procedure for HR officers and managers to assess.**
- **Organizations should develop measures to ensure that staff with service-incurred illness or injury receive priority attention for relocation and reintegration.**

Locally-recruited staff (Deliverable 13)

87. The working conditions for locally-recruited staff have changed drastically. They are exposed to the same type of threats and hazards as international staff and it cannot be assumed that working in their own country makes the environment safer for locally-recruited staff. In fact, in certain high-risk environments, it is seen as extra hazards to be known to be working with UN organizations and some locally-recruited staff try to hide this from the local communities. Hence, some of the assumptions underlying previous risk management strategies, where it was assumed that locally-recruited staff are exposed to less threats compared to the international staff, are no longer valid.
88. In addition, in high-risk environments, most locally-recruited staff are serving away from their hometown and families and experience many of the same stressors as international staff.
89. In the Secretary-General Report on “Safety and security of humanitarian personnel and protection of United Nations personnel” (reference A/72/490) it is stated:

*“27. Locally recruited personnel comprise 66 per cent of the United Nations personnel affected by safety and security incidents. While their larger presence in the field, as compared with internationally recruited personnel, has traditionally explained the larger number of incidents affecting them, in 2016, both internationally and locally recruited personnel faced a similar ratio of attacks. **In 2016, 90 per cent of the United Nations personnel who were killed were locally recruited. They were also affected to a greater extent than their internationally recruited colleagues by arrest and detention, abduction and assault.** International personnel were, however, affected to a greater extent than locally recruited personnel by burglary, residence break-in, intimidation, harassment and robbery. **The United Nations needs to take a system-wide approach to supporting the specific needs of locally recruited personnel.**”*

*74. The increase in direct attacks targeting the United Nations poses the gravest concern. During the reporting period, United Nations premises and vehicles came under direct attack 293 times. The number of attacks on United Nations premises rose, once again, to 56 attacks in 2016, making it the worst year on record for such attacks. Moreover, **locally recruited and female personnel were particularly vulnerable to certain types of security and safety incidents.** The steady rise in the number of reported gender-based incidents against United Nations female*

*personnel merits particular attention. **The Organization has a duty to support those who are most exposed to security risks and has a special responsibility towards its locally recruited personnel. “(Bold emphasis added)”***

90. Guided by all of the above considerations and results of the fact-finding missions conducted in 2014/2015 by members of the Working Group, the following measures are proposed for organizations to adopt.
91. The measures are categorized into those: 1) to be considered and implemented by the Executive Heads; and 2) that fall under the purview of the International Civil Service Commission (ICSC).
92. The implementation of these measures will:
 - a. Provide improved protection for locally-recruited staff in alleviating potential risks to their safety and security, medical and psychosocial conditions;
 - b. Enhance the reputation of the organization as a responsible employer; and
 - c. Increase staff morale to stay and deliver.

At the managerial discretion by the Executive Heads:

93. **Medical Evacuation Travel (MET)**

- a. Many of the high-risk duty stations, by their very nature, do not provide access to comprehensive medical services. In particular, follow up to chronic, non-life-threatening disease, including diagnostics, is lacking.
- b. However, the current medical evacuation provisions do not facilitate locally-recruited staff serving in high-risk environments, away from capital cities, from accessing the requisite medical care absent in their duty stations. The current provisions prevent them from even utilizing and accessing existing medical services within the country even if they are insured under the mandatory employer provided medical insurance.¹⁶
- c. UN has recognized that in certain countries under conflict, essential medical services are not available in the country and therefore the inter-agency MIP committee came to establish regional area of care (RAC) in neighbouring countries. However, because this entails travel which might cost more than a monthly salary for a locally-recruited staff, the RAC provision remains as a theoretical benefit.

¹⁶ Noted by OIOS in 2017 audit of MIP plan in UNHCR.

- d. The limitation on travel for chronic diseases, also affects international staff in some organizations. In most UN agencies, international staff and eligible family members are medically evacuated to receive treatment for an acute illness or injury that requires essential medical care or treatment which cannot be secured locally because of inadequate medical facilities. On the other hand, locally-recruited staff and their eligible family members are eligible for medical evacuation only in situations of acute life-threatening emergency when the available local facilities do not offer an adequate response.
- e. One UN organization instituted medical travel for both international and locally-recruited staff, and their eligible family members, in order to facilitate travel for chronic diseases to places where essential care is available within the RAC. The results show that:
- The benefit is primarily for locally-recruited staff and their dependents; and
 - for chronic diseases which are not covered under the medical evacuation travel; and
 - Most of the medical travel was to the capital city within the same country.

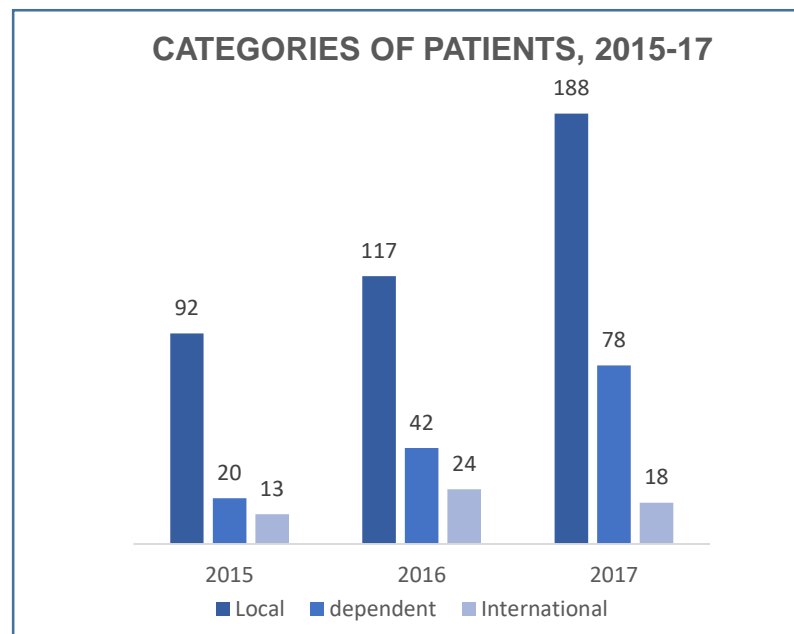


Figure 6. Categories of patients that went on other medical travel ("referred patients")

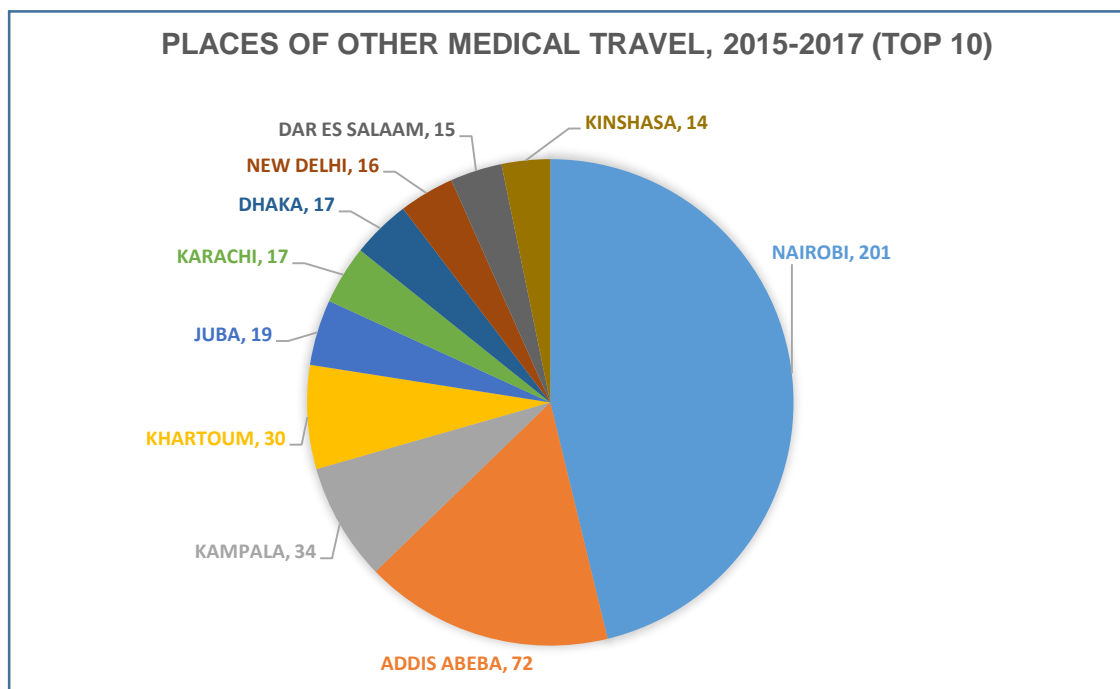


Figure 7. Places of other medical travels (places of “medical referrals”)

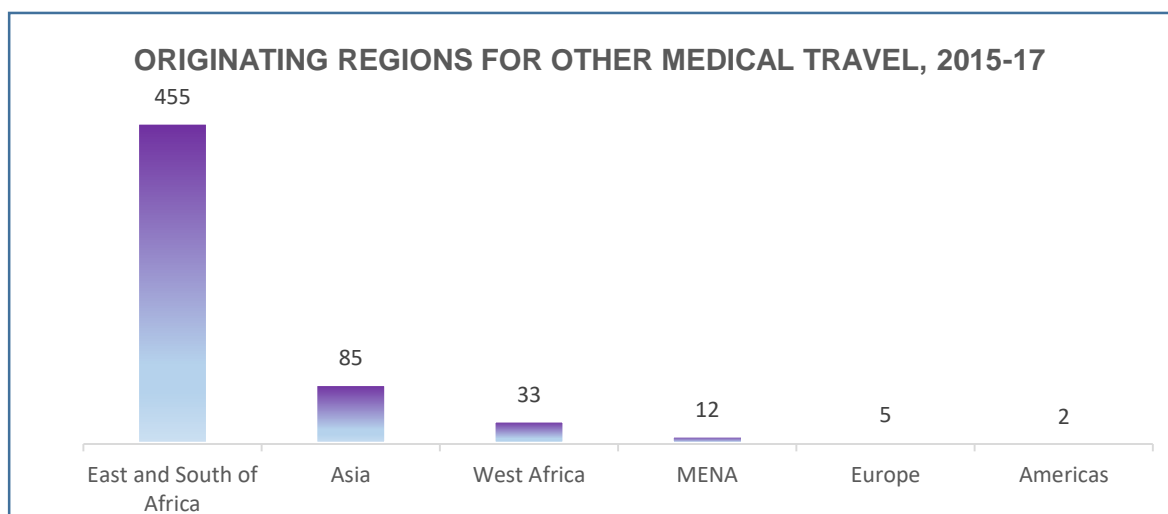


Figure 8. Which regions the patients for other medical travels come from

- f. Such change in the eligibility requirement will increase the cost of medical travel but should have minimal impact on insurance costs, because staff have been able to access this care by funding their own travel within RAC. Introducing medical travel is not creating a new entitlement under the medical insurance plan as RAC has been practiced for many years. The RAC committee needs to formalize a terms of reference (ToR) and standard operating procedure (SoP) to ensure RAC is only used according to its intended purpose. The Task Force believes this is necessary to fulfil the organizations’ Duty of Care to locally-recruited staff (and their families) as well as support international staff for chronic diseases in high-risk environments.

Adoption 9	The Task Force asks the HLCM to adopt access to essential health services as a standard for UN personnel.
Action 10	10.a) Organizations to review their policy on medical evacuation in light of this principle and conduct the necessary actuarial studies to make decisions.
	10.b) Regional area of care (RAC) Committee to formalize Terms of Reference and standard operating procedures, in consultation with the Duty of Care Task Force.

94. **Residential security and safety measures**

- a. In an interoffice memo dated 2 November 2017 addressed to all Executive Heads, the Under Secretary-General of the UN Department of Safety and Security (USG/DSS) informed that the Inter-Agency Security Management Network (IASMN) concluded its work on the issue of improving residential security for locally-recruited personnel. It was also noted that *“Locally-recruited personnel make up the great majority of United Nations personnel serving in the field and suffer the most from situations of insecurity and violence,” and therefore the IASMN provided advice to the Designated Officials on ways to address their specific needs.*
- b. There are a number of measures available that support the security of locally-recruited personnel and their eligible family members. This includes following up with authorities through heads of organizations or Designated Officials (DO) and extending all possible support to personnel affected by frequent arrest, detention or harassment by local authorities. Security Risk Management is the key process to identify the specific threats to locally-recruited personnel and recommend relevant security risk management measures
- c. The affected locally-recruited personnel should be included in the process of identifying possible solutions. These may include measures with financial implications such as assisting personnel to relocate to a comparatively safer location, provision of specific equipment/material to support them during the period of increased exposure to risk. In such cases, the DO should apply these solutions equally to affected personnel at the duty station.
- d. Organization headquarters are required to support any DO decisions in this regard, including provision of funds and the necessary administrative instructions, policies or procedures.

Adoption 10	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.
Action 11	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.

95. Flexible work arrangement and compressed time-off for locally-recruited staff, in particular, those who are working in high-risk duty stations

- a. In some countries, and particularly in isolated and/or high risk field offices, locally-recruited staff sometimes live separated from their families, whom they have had to relocate to safer places within the country for security reasons, whilst working in locations with very limited or no social service or infrastructure (including medical) and long working hours, often over the weekends.
- b. Even though flexible working arrangements are available in most (if not all) organizations for locally-recruited staff, policy on compressed time-off is limited to one working day and staff is not allowed to cumulate these days. Given the already difficult working and living conditions in these duty stations as stated above, organizations should allow staff to cumulate up to 5 working days of their day-off to be used consecutively so that they can decompress and travel to e.g. meet their families and/or to take care of their personal affairs.
- c. Further, the application of flexible working arrangements depends largely on managerial style. Executive Heads therefore need to send a clear instruction to foster and support local management to implement this measure.
- d. The implementation of flexible working arrangements, and in particular, compressed time off schedules varies considerably, which gives the perception that Duty of Care is applied differently by organizations. Therefore, while raising awareness about existing flexible working arrangements, organizations should align and come to an inter-agency agreement on a compressed time off schedule

Adoption 11	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.
Action 12	Organizations should align and agree on an inter-agency compressed time off schedule.

96. Affordable and safe transportation: from residence to office

- a. The IASMN Working Group on residential security risk for UN locally-recruited personnel found in its End of Task Report¹⁷ that “travelling to and from work as their [locally-recruited staff] major safety and security worry”. Further, in some high-risk locations, locally-recruited staff found it difficult to get to the office from their residence due to having to go through multiple check-points.
- b. UN Country Teams, in consultation with the Security Management Team (SMT), should determine the safe mode of transportation for locally-recruited staff based on the security situation of the duty station (if they are not living in UN provided accommodation).

¹⁷ Ref: CRP 7 Annex B, Inter-Agency Security Management Network (IASMN) Steering Group, End of Task Report – Information gathering and recommendation phases.

- c. Organization headquarters are, therefore, required to support, including funding and the necessary administrative instruction, when the SMT provides advice.

Adoption 12	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.
Action 13	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.

97. **Affordable and safe transportation: from zone/field offices to the nearest urban town or capital city**

- a. Locally-recruited staff serving in high-risk environments do not necessarily live with their families. While the compressed work schedules provide for rest period, in remote zone/field locations, the lack of affordable and safe transportation for locally-recruited staff precludes them from taking advantage of their annual leave and/or time-off.
- b. It is important for organizations to recognize that providing affordable, safe and less time-consuming methods of transportation enables staff to take time off to recharge and to obtain basic services. Implementing this measure will contribute to a healthy workforce as locally-recruited staff will be able to utilize their time effectively to decompress and rest.

Best practice 2: The Task Force recognizes, as a best practice, for 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.

98. **Provision of first-aid and medical essentials not available at duty station**

- a. The provision of first-aid kits is regarded by some UN entities “low hanging fruit” to discharge their duty of care to their personnel. However, fact-finding missions raised multiple questions regarding the content and the scope of providing first aid kits. In the UN system, there are various models of first aid kits in use. To better understand the current usage and further need of the various models of first aid kits and their purpose, the below descriptions aim to help in informed decision making.
- b. Classic First Aid Equipment:
- It is a general occupational health measure to have first aid kits in offices to be able to address workplace-related injuries, such as clean minor cuts and burns. These office first-aid kits would include bandages, Elastoplast, non-sterile gloves, anti-septic solution and eye-wash. The aim is to rinse an injury and control bleeding until professional help can be obtained. It is a best practice that needs to be encouraged.

- In the UN, all vehicles are supposed to have first aid kits. This is a best practice and that needs to be continued and encouraged. The kits' contents may vary between locations but should have, as a minimum, disposable gloves, bandages and pressure pads to control bleeding.
- c. Individual travel medical kits:
- Until recently many UN organizations issued travel kits for personnel who originate from headquarter locations. The kits included everything from mosquito spray, bandages, over the counter pain relief and other over the counter medication, condoms and sterile needles and syringes. They had great prominence at the start of the HIV epidemic when disposable sterile needles and syringes were not widely available in all countries.
 - That practice has since changed and several UN agencies, the International Red Cross (ICRC) and Médecins Sans Frontières (MSF) just provide a packing list of the most common over the counter medication a person might wish to bring along in case they are not available at duty station. The context of the mission travel and local facilities will determine which option is most appropriate and the agency medical service will advise.
 - All personnel who need ongoing medication are always advised to always keep the required medication stocked up (at least a 3-month supply or enough to last them until their next anticipated R&R, or other travel). In the case of sudden shortage, the UN medical services can send prescription medication by the UN diplomatic pouch, but it is to be avoided unless absolutely necessary.
- d. Specialized First Aid Equipment: Then there are the potential lifesaving first aid kits available in high-risk duty stations and they all require training on the usage.
- Individual First Aid Kit (IFAK): IFAK includes a combat tourniquet to stem catastrophic bleed in case of bomb blast or gunshot. It also includes hemostatic gauze to help control such bleeding. The aim is for colleagues to help injured colleagues and try to control or stop bleeding until help arrives. This is considered as lifesaving in such situations. It needs training to be used properly and such training is integrated into existing UN trainings for high risk environments such as SSAFE training. As part of SRM process, and as identified in the First Responder programme, IFAK may be proposed as a risk mitigation measure for alleviating impact of injuries. The need for IFAK is governed by the SRM process and endorsed by the SMT in country, and approved by the DO.
 - Buddy First Aid Kit (BFAK): Same concept as IFAK but in DPKO it is called BFAK, the Buddy First Aid Kit.
 - Emergency Trauma Bag (ETB): An Emergency trauma bag is part of first response to physical trauma where local host community responses are inadequate to stabilize an injured person prior to transport. ETB are to be used by trained volunteer personnel in line with IASMIN guidance on first responder training. The SRM process determines whether ETB is an appropriate risk mitigation measure. The SRM will endorse the measure and the DO will approve it. Organizations are expected to provide the emergency trauma bags for their personnel and to identify personnel to be trained as volunteers as per the details of the decision of the DO. The ETB training is under the leadership of UN DSS Training and Development Section (TDS).

Action 14	Organizations to provide the necessary first-aid and medical essentials as per Medical Services and/or SMT recommendation.
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- e. While noting it is essential to supply personnel with necessary first-aid and medical essentials, in many high-risk environments, it is also difficult to obtain standby supplies such as water purifiers, torches, solar charges, mosquito nets as well as basic essential items such as toothpaste, female sanitary items, etc. Organizations are therefore recommended, as a best practice, to ensure that personnel are adequately equipped according to different needs and locations. Possible solutions include advising personnel to purchase the essential items prior to deployment or providing an appropriate venue (e.g. nominating a focal point in the location or opening a kiosk) that is equipped with the essential supplies.

Best practice 3: The Task Force recognizes, as a best practice, 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.

Measures under the purview of the International Civil Services Commission (ICSC)

99. Hardship allowance for locally-recruited staff was one of the recurring themes in the fact-finding missions. While there is no separate recommendation for this item, as this is within the purview of the ICSC, below background information is presented for reference.¹⁸

100. **Hardship allowance**

- a. *Issue: In locations where hardship allowance is an entitlement for international staff, why are locally-recruited staff working in the same hardship environment not compensated?*

What is it	At this time, locally recruited staff working in difficult environment (e.g. in the zone offices outside of the capital city) are paid the same as their peers in the capital city. "Hardship allowance" is designated to compensate for the degree of hardship experienced by staff in hardship duty stations.		
Duration	Payable as long as the staff member is based in the hardship duty station.		
Eligibility	Internationally recruited staff on an assignment for one year or more to a B, C D or E category duty station as from their first assignment.		
Hardship category of D/S	Hardship Allowance (annual amounts US\$)		
	Group 1 (P-1 to P-3)	Group 2 (P-4 and P-5)	Group 3 (D-1 and above)
A	-	-	-
B	5,810	6,970	8,140
C	10,470	12,780	15,110
D	13,950	16,280	18,590
E	17,440	20,920	23,250

- b. The Task Force notes that the ICSC will be conducting a review of the local salary methodology in 2018. As such, these issues should be discussed with the ICSC by the HR Network.

¹⁸ Danger pay was another recurring concern expressed by locally-recruited staff. Please see paragraph 19 to 21 above.

Post-deployment Phase

101. Many personnel express difficulty they experience from abnormal circumstances and/or incidents that result from serving in high-risk environments. While personnel may avail themselves of the applicable leave options to relieve themselves of stress and possible burnout, in emergency settings, utilizing these options or other entitlements may be declined due to exigency of service/operational needs, at the request of the supervisors. As for staff moving to their next assignments, it is often the case that the receiving offices do not wish to delay the on-boarding of a new staff in order for him/her to take the accumulated leave and the staff, in turn, will have to forfeit the days.
102. Needless to say, post-deployment processes are important for organizations to keep in mind and have in place, to keep the workforce healthy and remain effective.
103. Therefore, the HLCM requests organizations to review their **exit processes** and if not already in place, establish the below mechanism for the appropriate follow-up of the operations and the psychological well-being of the staff who has completed his/her duty:
 - a. **Ensure adequate operational handover takes place:** In order to allow personnel to properly finish their assignment and ensure operational continuity, it is important that adequate operational handover takes place. It is part of the senior management's responsibility to ensure that there is time and accountability allocated with regards to handover.
 - b. **Ensure personnel that have served in high-risk environments are provided with a systematic exit interview that focuses on psychological effect on them:** Organizations need to design a mechanism to address personnel who are carrying with them the stress from working in high-risk by providing them with the opportunity to discuss with health professional and plan follow-up actions accordingly, as needed. Personnel that serve in high-risk environments suffer from various sources of work volume, work intensity, separation from family, confinement, lack of recreational outlet, direct threat to safety or life and often, such stress continues even when they are no longer serving in such locations. For example, health professionals that were deployed to Ebola affected countries were provided with post-Ebola psychological exit interviews by WHO which gave the individuals opportunities to address and mitigate the stress or difficulty experienced during the assignment. In one UN organization, staff that had served in high-risk locations were offered post-assignment (as well as pre-assignment) discussions with the staff counsellors. These counselling opportunities with a trained professional gives an outlet for staff members to discuss how they felt during a stressful experience and plan follow up actions according to the individual needs to ensure their psychological well-being.

Monitor and Evaluate: Risk Management Framework

104. The Secretary-General, António Guterres, stated on 23 February 2018 at the Senior Management Committee meeting, that “changing from a risk averse to a risk management culture is an operational imperative”. Staying and delivering in high-risk environments presupposes a robust risk management system.
105. The systematic use of a well-developed risk-management framework lies at the core of providing reasonable and practical Duty of Care towards personnel. It is also an essential element of good organizational governance and accountability. Within the UN system, organizations have their own versions of Enterprise Risk Management (ERM) but those have not yet been developed to capture the multidisciplinary aspects of Duty of Care.
106. The HLCM, therefore, assigned the Task Force in September 2017 to start developing a risk management framework for Duty of Care in high-risk environments:

31. In recognition of these multifaceted responsibilities towards personnel in high risk environments, HLCM decided to develop a Duty of Care-specific risk management framework, including a structured evaluation process with a dashboard, standards and indicators, that can give clear information to senior management in the organizations on local hazards and how they need to be addressed.

32. Such risk management framework would aim to look at threat and hazards with associated prevention and mitigation measures; allow for informed decisions on whether to accept the residual risk; provide for adequate communication of that residual risk to staff in high risk locations; and, provide for the staff to accept the residual risk¹⁹.

107. Taking the advice of the Human Resources Network in February 2018, the Task Force decided to concentrate on immediate risks to life and wellbeing, which are, namely, security, medical and mental health. Other elements such as ensuring accommodation standards and providing administrative/technical support are vulnerability reduction measures (which if not managed well, may aggravate the risk), rather than being stand-alone hazards. Acknowledging that the Security Risk Management (SRM) System is already well developed and established with good definitions of the external threat environment, with a reference to the SRM, the Task Force decided to build on the Duty Station Health Risk Assessment tool, to assesses medical and psychosocial health risks in a location. The six mandatory health support elements (MHSE) will serve as indicators to inform senior management where the risks reside, enabling them to make decisions.
108. The SRM process starts with setting the geographical scope and timeframe and assessing the situation, program, threat and the security risk, which establishes a common understanding of the issues.

¹⁹ CEB/2017/5, Conclusions of the Thirty-Fourth Session of the High-Level Committee on Management (HLCM), November 2017.

109. The general and specific threat assessment under the SRM is mirrored in the Duty Station Health Risk Assessment, in its assessment of the existing MHSE and the specific risks identified in collaboration with the country teams and staff surveys. The combined effort will lead to an action plan with prioritised actions for the country teams to implement.
110. What remains to be developed for the Duty of Care risk management framework is how to classify various levels of maturity in achieving the Duty of Care to UN personnel in a particular duty station and developing a framework of accountability.
111. The responsibility and accountability in the SRM, for example, is currently with the Designated Official (DO), who is supported by various individuals and groupings within the Designated Area (DA), within which lie one or more Security Areas (SAs). Above the DO, whether at the level of UN system organization or at UN Headquarters, nominated officials have responsibilities for high-level decision-making, monitoring and review, supported, as appropriate, by their staff.
112. For the multidisciplinary Duty of Care risk management responsibilities and accountabilities, the same approach and levels as used for Security could be adopted. A further study will be required in order to identify what roles and responsibilities should be apportioned to whom and at what level. It is evident that at certain junctures, teams and/or committees with Duty of Care remits will be required to draw the three domains (security, medical and psychosocial) together in order to achieve holistic effect.
113. In addition, what is important to note is that the revised SRM Manual of 2016 recognizes Program Criticality (PC) as a key component in determining acceptable risk in a high-risk environment. The PC Framework lays out the methodology for conducting a PC assessment. The results of this assessment serve to support informed and legitimate decision-making concerning the security of United Nations personnel and help to ensure that all activities involving United Nations personnel are implemented at acceptable levels of risk. Currently, PC is balanced only against the security risk. A Duty of Care risk assessment will become the third leg, in addition to Security risk assessment and Programme Criticality Assessment to provide a holistic view of what is acceptable risk for managers to make an informed decision.

114. The following diagram illustrates the key components of the any risk management process and cycle:

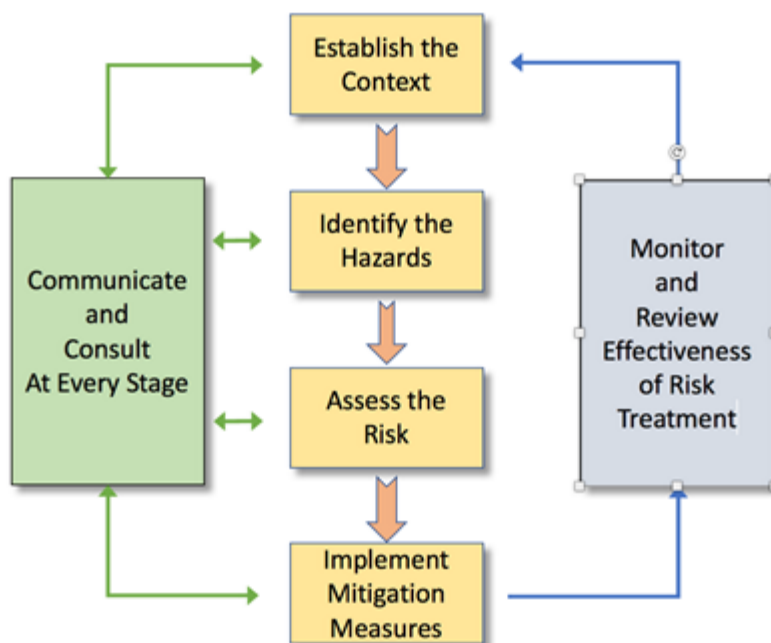


Figure 9. Risk Management Framework: Key Components

115. To summarize, the proposed risk management framework for Duty of Care will entail the below key aspects:

- a. **Mandatory Health Support Elements (MHSE)²⁰:** The six MHSE will serve as the mandatory components for senior management to decide whether a risk exists in a given location or not. The duty station must meet or have all six MHSE to have fulfilled the Duty of Care to eliminate any immediate life-threatening risks. Program delivery or deployment will be limited in/to a duty station where immediate life-threatening risks have not been eliminated. Health support plans will guide how to remove or mitigate a pre-identified risk.
- b. **Assessment of specific threats not covered by the MHSE:** The implementation of risk management measures for these specific threats need to be actively monitored but should not stop the operations on ground.

116. All SRM considerations include factors such as threat categories (general and specific), situational analysis, vulnerability to the threats, likelihood and the impact of the threats (to determine the level and acceptance towards risks), prevention and mitigation, strategies for managing the risk (Accept, Control, Avoid, Transfer), PC, minimum operating standards, which are equally applicable to the Duty of Care risk management that cover medical and psychosocial threats in a location.

²⁰ Primary Care, Hospital Care, Mental Health Services, Mass Casualty Plan, medical Emergency response and Access to pharmaceuticals (including PEP). Please refer to paragraph 47 for more information.

117. It then becomes key for managers both on the ground and within senior management to ensure that they are aware of what risks they are accepting when choosing to remain and deliver in high-risk environments. A clear definition of risk acceptance also aids communication to the workforce who have a right to be informed of what residual risk is left and what risk mitigation measures are in place.
118. Below are the four key principles related to how UN Security Management System deals with the question of acceptable risks:
- Do not accept unnecessary risk.
 - Accept risk when benefits outweigh risks.
 - Make risk management decisions at the right level.
 - Everything reasonable should be done to reduce the risk.
119. In light of the need to establish a Duty of Care risk management framework that assesses the immediate life-threatening risks and the levels of acceptable risk, key attention needs to be paid to the developing role of the new UN Coordinator and in defining what his/her accountability would be for duty of care to UN personnel in a duty station and what resources are to be put in place to support such a function. As the risk assessment requires input from various technical networks, the inter-agency coordination model, such as the Task Force, will be necessary to assist the work of the UN Coordinator.
120. As the new UN Coordinator system is currently being developed, the next phase of the Task Force needs to further develop the modality to capture the indication of risks in light of the MHSE and look carefully into how to anchor Duty of Care in Country Team activities.
121. By presenting a snapshot of what kind of risks there are in certain locations, the Duty of Care risk management framework will serve as a decision-making tool for senior management to enable UN activities while ensuring the safety and well-being of personnel in high-risk environments.

Adoption 13	The Task Force asks the HLCM to adopt the six mandatory health support elements as the standard for the Duty of Care Risk Management framework, which will continue under the guidance of the Task Force.
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Looking Ahead

122. HLCM advised in September 2017 to expand the applicability of Duty of Care from high-risk environments to all locations. This was reiterated by the Secretary-General on 23 February 2018 in the UN Senior Management Group meeting, with a particular focus on accelerating the implementation and focusing on the needs of locally-recruited staff.
123. Member States who supply gratis personnel in standby arrangements to the UN have requested engagement in the shared responsibility between the sending and receiving organizations. It is difficult for them to fulfil their duty to inform on what available resources are on the ground due to the lack of clear communication channels between the UN organizations and the releasing parties.
124. In the OCHA-led humanitarian forum, there is a working group consisting of NGOs and UN organizations that aims to define practical measures. Similarly, there are roundtable discussions under the peace and development pillar, where the Member States and key NGOs engage the UN on implementing their Voluntary Guidelines²¹. This work needs to be consolidated.
125. Increasingly, the UN has come to rely on large numbers of affiliated workforce, consultants, service contractors as well as an increasing number of partnerships with local NGOs. This complexity does not remove Duty of Care responsibilities but calls for a careful analysis and agreement on who holds Duty of Care and for what. One cannot outsource the risk, responsibility and accountability completely by delegating the work to local partners.
126. While the Task Force has addressed all of the initial 13 deliverables, key work on implementing the deliverables within the organizations and, in particular, within the country context of high-risk environments remains to be done. Therefore, an active monitoring and evaluation framework needs to be set up and the Task Force proposes to do this in the next phase so to ensure that the expansion of the focus does not dilute the attention in high-risk environments.
127. In particular, the Mental Health Strategy is a multi-year effort. The Task Force will need to continue the multi-disciplinary, multi-agency engagement that this Task Force represents with rapid ongoing consultations between HRN, UNSSCG, UNMD, IASMN and Ombudsman as well as staff representatives and representative of other relevant entities.
128. The Task Force needs to follow the UN Reform process and the development of the role of the new UN Coordinator to ensure that Duty of Care implementation is firmly anchored in the Country Team roles and responsibilities.

²¹ Maarten Merkelbach, Voluntary Guidelines on the Duty of Care to Seconded Civilian Personnel, Swiss Federal Department of Foreign Affairs (FDFA), Stabilisation Unit (SU) and Center for International Peace Operations (ZIF), 2017.

129. In September 2017, HLCM adopted the Secretary-General's direction to continue the work on Duty of Care to cover all duty stations. While the Chair and the Vice Chair acknowledge that the work needs to continue in high-risk environment, the Task Force will continue its work beyond April 2018 with new terms of reference (see Annex 13).

Adoption 14	The Task Force asks the HLCM to adopt the revised Terms of Reference for the Duty of Care Task Force (Annex 13).
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Acronyms

- Appendix D Compensation for service incurred injuries, illness and death
- CISMU Critical Incidence Stress Management Unit
- FBN Finance and Budget Network
- HRN Human Resources Network
- DFS Department of Field Support
- IASMN UN Inter-Agency Security Management Network
- ICSC International Civil Service Commission
- LGBTI Lesbian, Gay, Bisexual, Transgender and Intersex
- MHS Mental Health Strategy
- MHSE Mandatory Health Support Elements
- MHSWG Mental Health Strategy Working Group
- MAIP Malicious Acts Insurance Plan
- MIP Medical Insurance Plan
- OSH Occupational Safety and Health
- PEP Post-Exposure Prophylaxis against HIV
- UN United Nations
- UNDT United Nations Dispute Tribunal
- UNMD UN Medical Directors
- UNMSD UN Medical Services Division
- UNSSCG UN Staff/Stress Counsellors Special Interest Group
- UNSMS United Nations Security Management System
- WSAT Women's Security Awareness Training

List of References

- HLCM 2017 Briefing Note on the Cross-Functional Task Force on Duty of Care in High Risk Environments (CEB/2017/HLCM/6, 22 March 2017)
- Final Report of the HLCM Working Group on “Reconciling Duty of Care for UN personnel while operating in high risk environments”, (CEB/2016/HLCM/11, 15 March 2016)
- Terms of Reference - Cross-functional Task Force on Duty of Care
- Summary of ongoing work – networks and agencies; responses from organizations and networks, May 2017
- Background documents from the 1st WG (established from 2014 to 2015):
 - Reports from the analytical sub-working groups of:
 - Afghanistan (UNICEF);
 - Ebola (UNMDG) report submitted June 2015;
 - Haiti (DFS);
 - Mali, Somalia (UNSOM);
 - Syria (UNHCR);
 - Terms of Reference and Guidance Notes;
 - Updates to the HLCM;
 - Working Group Meetings minutes;
 - SG report on activities of the Ombudsman and Mediation Services (A/70/151);
 - UNDSS Memorandum titled “High-Level Working Group on reconciling ‘duty of care’ for United Nations personnel with the need to ‘stay and deliver’ in high risk environments”.
- Voluntary Guidelines on the Duty of Care to Seconded Civilian Personnel by Maarten Merkelbach
- Can you get sued? – A Policy Paper on the Legal liability of international humanitarian aid organizations towards their staff by Edward Kemp and Maarten Merkelbach, Security Management Initiative
- United Nations Enterprise Risk Management
- United Nations Security Management System Policy Manual
- United Nations Security Management System, Security Risk Management Manual
- ISO 31000:2009 Global Standard
- United Nations System Program Criticality Framework 2016
- United Nations Common System Occupational Safety and Health (OSH) Framework CEB/2015/HLCM/7/Rev.2, 31 March 2015
- Health Support Plans for Field Duty Stations – Briefing Note by UNMDWG CEB/2016/HLCM/26, 20 Sep 2016
- Status of Recommendations Matrix and Action Plan
- Minimum Standards for Prevention and Response to GBV in Emergencies
- UN Globe Mobility Proposals 2015

Annexes

- Annex 1: Overview of 13 deliverables (enclosed)
- Annex 13: Revised Task Force Terms of Reference (enclosed)

ANNEXES 2-12 CAN BE FOUND ON THE LINK: <https://www.unsceb.org/content/duty-care-task-force-report-annexes-2-12>

- Annex 2: Mental Health Strategy
 - 2.A. Mental Health Strategy
 - 2.B. Companion Document
- Annex 3: Duty Station Health Risk Assessment
 - 3.A. Duty Station Health Risk Assessment and Health Support Planning Guide
 - 3.B. Duty Station Health Risk Assessment Tool
- Annex 4: Referral Hospitals
 - 4.A. UN Healthcare Quality and Patient Safety Manual for Referral Hospitals
 - 4.B. UN Referral Hospital Service Capabilities Form
 - 4.C. Final Report UNIFIL Hospital HQ Naqoura Lebanon
- Annex 5: Pre-deployment package
 - 5.A. General pre-deployment information package
 - 5.B. Pre-deployment guide for families
 - 5.C. Country specific factsheet
 - 5.D. Implementation Guide
- Annex 6: Training for Managers – information package
- Annex 7: Standard Operating Procedure on conduct of a Duty Station Health Risk Assessment
- Annex 8: Sample Memorandum of Understanding, UN Clinics
- Annex 9: MAIP insurance processing (see pg.8 for documents to be submitted)
- Annex 10: Task Force findings on MAIP
- Annex 11: UN Minimum Living and Working Standards
- Annex 12: Report on ensuring adequate bandwidth in high-risk environments

Duty of Care Task Force: Status Update on 13 Recommendations

Task Force Secretariat

Recommendations	What was there before	Major improvements	How	When
Recommendations 1 and 2: Development of a comprehensive pre-deployment management package for staff and their families including a system-wide resilience briefing.	Pre-deployment related information and/or training vary across different UN organizations. The only systematic training provided to deployed personnel system-wide are Basic Security in the Field, Advanced Security in the Field and the Safe and Secure Approaches in Field Environments (SSAFE).	Deliverable: A comprehensive and standardized pre-deployment guide, including the resilience briefing, with technical input from the relevant experts (medical, security, psychosocial and human resources) that is available and provided to personnel and families. Benefits: Personnel now have access to up-to-date information, which helps them to make informed decision about their deployment.	UN organizations are expected to take ownership of the comprehensive pre-deployment guide and embed it in their own induction process, fulfilling their duty to inform. Country Teams, through the Resident Coordinators (RC), are expected to update the factsheets with country-specific information, annually (or more frequently if the risk environment changes).	Some organizations have already started; All other UN organizations are expected to start implementation by May 2018. If the format of the guide is approved by the HLCM, the Country Teams are expected to update the information within the next 3 months following the HLCM Session in April (by 15 July 2018) and then annually thereafter.
Recommendations 3 and 11: Development of specific training for managers operating in high risk environments and building support for managers while operating in high risk environments.	While managers are selected for technical competence and managerial skills, feedback from the fact-finding missions (in Phase 1 of the Duty of Care work) showed that some managers were poorly prepared in their people management skills in high risk environment, especially during crisis.	Deliverable: Training package with curriculum and guidelines for each organization to include in their existing materials for training managers, so as to better prepare and support managers. Benefits: The added support provides protective measures for psychosocial health of the managers and personnel, thus creating positive team spirit and relationships with the managers.	Work has started on identifying key content for managers. The development of the training program will continue in the next phase of the Task Force. Once the program becomes available, UN organizations are expected to integrate the deliverable in their own training program for managers.	UN organizations are expected to integrate the deliverable in their existing training program. In addition, Staff College will include this in their training by for the target group humanitarian leadership program.
Recommendation 4: Identification of consistent standards on working and living conditions for staff deployed in high risk environments.	There is a wide disparity among the UN organizations with regards to working and living conditions/facilities. In many locations, poor living and working conditions add to the	Deliverable: Minimum working and living conditions that are applied consistently system-wide. Benefits: Personnel are able to benefit from decent working and living conditions, as this is especially	All new accommodation and office premises are to be built based on these minimum standards; Headquarter locations for each UN organization are to regularly monitor	Effective 1 May 2018 and organizations (who can) are encouraged to retro-fit/renovate accordingly as best practice.

Duty of Care Task Force: Status Update on 13 Recommendations

Task Force Secretariat

Recommendations	What was there before	Major improvements	How	When
	stress of serving in high-risk environments. E.g. there is lack of privacy from sharing rooms in some locations whereas in other locations, the lack of common space prevents the teams from bonding. In certain locations, there are also no place to eat.	important in high-risk locations where freedom is restricted; Such conditions contribute to the resilience and psychosocial well-being of personnel, hence leading to better-functioning teams.	compliance with the standards.	
Recommendation 5: Development of a Health Risk analysis and mapping methodology.	Wide disparity among UN Medical directors on assessing health risk in a given duty station: some focus on needs for trauma, while others may focus on infectious diseases, or the needs of families. Hence it was difficult to come to common description of the problem to solve.	Deliverable: Agreed upon tool to systematically measure the hazards, their likelihood and impact, therefore defining the risk. It also has a standardized measure for prevention and mitigation mechanisms and how effective these are at controlling the identified risks, determining the residual risks. Benefits: both personnel and managers can have better understanding of the inherent risks of a duty station.	UN Medical Directors together across different organizations conduct this risk assessment in conjunction with the Country Teams.	Tool and methodology have been approved by HLCM. Implementation ongoing as per recommendation 6 below.
Recommendation 6: Implementation of a systematic health support planning.	Mismatch of the need and resources. E.g. Some duty stations with no local medical facilities and no UN clinics and whereas other duty stations with adequate local medical facilities have UN clinics. In addition, a UN clinic was seen as the only solution for mitigating risk.	Deliverable and benefits: Based on the above health risk assessment, it becomes easier to judge what are the needed solutions from wide-range of possible solutions, leading to better risk mitigation and cost effectiveness.	The abovementioned health risk assessment leads to a proposed health support plan, along with an implementation timeline, that is agreed upon with the Country Teams.	Pilots started in March 2017, and is on-going. Organizations should make resources available to ensure that measures are fully implemented within the duration as stated in the health support plan.
Recommendation 7: Establishing an overarching UN Psychosocial and	Staff surveys showed that UN staff suffer from a wide-range of mental health conditions.	Deliverable and benefits: A system-wide 5-year action plan with 11 strategic objectives that are translated into 7 priorities actions, including e.g.	The General Assembly, in December 2017, approved a P-5 post, to be situated in UN Medical Services Division,	Mental Health Strategy was approved by the HLCM in September 2017.

Duty of Care Task Force: Status Update on 13 Recommendations

Task Force Secretariat

Recommendations	What was there before	Major improvements	How	When
<p>Healthcare Policy Framework.</p> <p>(Recommendation 9 on periodic visits to staff counsellors and developing anti-stigma awareness campaigns is subsumed under this recommendation)</p>	<p>There are wide disparities among UN organizations on how they provide psychosocial support with some organizations having no in-house staff counsellors and others having multiple country-level presence. In addition, there is also a lack of clarity in defining the purpose of the staff counsellors and how they are supposed to work.</p>	<p>Improved and equitable access to health care, review of the various health insurance programs, improved understanding of mental health challenges and reduced stigma, improved medical counselling experience for staff etc.</p>	<p>New York, to coordinate the work on Mental Health Strategy.</p> <p>The implementation plan and coordination among the existing resources within the UN organizations are yet to be defined.</p>	<p>The implementation plan will be presented at the next HLCM session.</p>
<p>Recommendation 8:</p> <p>Addressing the issue of increasing bandwidth to ensure robust internal and external communication links in all UN locations and establishing global platform enabling access to existing cross-cutting policies and procedures and training programmes.</p>	<p>Limited bandwidth impedes the ability of personnel in high-risk locations to connect with their families; and impedes the medical services and personnel counsellors in providing tele-health services.</p> <p>It is noted that the lack of, or limited bandwidth depends also on the managers' knowledge about procurement (e.g. not knowing how much to procure in relation to the number of personnel members).</p>	<p>Deliverable: A technical document indicating graduated bandwidth needs in relation to the number of personnel, referencing the existing procurement agreement that organizations can reflect.</p> <p>Benefits: Personnel in high-risk locations are able to stay connected with colleagues and families, enhancing their abilities to better perform their functions while also benefitting from tele-services, as applicable.</p>	<p>Managers in high risk environments have reliable reference documents when procuring IT services.</p>	<p>Effective 1 May 2018, based on the proposed requirements.</p>
<p>Recommendation 10:</p> <p>Development of policies, procedures and pre-screening/risk assessment methodologies to address the needs of staff who feel they can no longer serve in high-risk environments.</p>	<p>Some staff wished for a defined way to leave high risk environments before finishing their assignments, when they could no longer cope.</p>	<p>Deliverables and benefits: A collection of current and best practices for organizations to consider. It is noted that because of the different rotational policies and the funding situations in each organization, the adopted solutions may vary.</p>	<p>Organizations will adapt those practices that are possible within their entity.</p>	<p>The consideration and implementation of best practices are expected to commence in May 2018.</p>

Duty of Care Task Force: Status Update on 13 Recommendations

Task Force Secretariat

Recommendations	What was there before	Major improvements	How	When
Recommendation 12: Reviewing insurance processing mechanisms.	Personnel and managers expressed inconvenience experienced and time taken in submitting insurance claims in paper format through a pouch system.	<p>(A) Health Insurance Since the recommendation was approved by HLCM in March 2016, most organizations have already instituted online claiming for medical insurance.</p> <p>(B) Appendix D On 1 January 2017, the first complete revision of Appendix D since 1966 was promulgated by the General Assembly and went into effect.</p> <p>The revision allows for e.g. shortened timeline, increased efficiency of the Sectorian and ensures there are no backlogs and undue delays.</p> <p>(C) MAIP Clear communications with regards to what documents are needed from personnel members, who the focal points are for queries, and how to process the requests for reimbursement.</p> <p>Benefits: Insurance processing mechanism is streamlined making it easier and more efficient for personnel to make claims; Information about the process, relevant documentation and regular updates are provided to personnel members to keep them abreast of the changes/revisions.</p>	<p>Organizations which have yet to introduce online claiming for medical insurance should review the feasibility to do in their new insurance contract (e.g. to include in their next tender).</p> <p>Organizations governed by the UN Staff Regulations and Rules should communicate to personnel about the revision and appoint an Appendix D focal point in the respective organization.</p> <p>Organizations are encouraged to provide communication to keep personnel and officers processing the insurance informed of the process, and any changes to the procedure.</p>	<p>UN Organizations are to implement online claiming for medical insurance in e.g. next tender; or upon expiration of the current contracts; or service becomes available to use, whichever is earlier.</p> <p>Organizations should inform their personnel (e.g. by publishing relevant documents on the intranet) of the revised Appendix D and managers' guide and appoint an Appendix D focal point by 1 May 2018.</p> <p>All communications efforts to be planned and launched accordingly.</p>

Duty of Care Task Force: Status Update on 13 Recommendations

Task Force Secretariat

Recommendations	What was there before	Major improvements	How	When
Recommendation 13: Review of compensation, benefits and entitlements for locally recruited staff serving in high risk environments from a duty of care perspective.	Locally recruited staff members continuously highlighted the 'discrepancy' in the benefits and entitlements across different categories of staff (i.e. with Professional staff category).	Deliverable: List of measures for locally recruited staff that do not fall within the purview of the International Civil Services Commission (ICSC) are collected for organizations to consider.	Organizations to adopt and implement the measures as and when deemed fit.	ICSC will look at local salary methodology at their session in July 2018 (subject to change). Organizations to commence implementing the best practices, as applicable, in May 2018.

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.