

## DUTY OF CARE TASK FORCE – ACTION 8 – RECOMMENDATIONS

February 2018

### INTRODUCTION

In 2014, the High-Level Committee on Management (HLCM) of the Duty of Care Task Force of the United Nations (UN) laid out a series of recommendations to strengthen support to UN staff working in high-risk environments. Of the 13 recommendations, number 8 was assigned (among others) to the World Food Programme: *“increasing bandwidth to ensure robust internal and external communication links in all UN premises and establishing global platform enabling access to existing cross-cutting policies and procedures and training programmes (in coordination with the ICT Network)”*.

For many humanitarians working in high-risk contexts is the norm and with the number, scale, duration and variety of emergencies increasing, the UN system is considering how to enhance support to its staff. Humanitarians work out of “premises” that include all categories of land and physical structures which may (or may not) have adequate connectivity solutions essential to fulfill UN’s Duty of Care.

### ALIGNMENT

Recommendations on connectivity outlined by Working Group (WG) 8 has been aligned with recommendations suggested by WG 4 (*“Identification of consistent standards on working and living conditions for staff deployed in high risk environments”*). Connectivity will enable the implementation of Recommendation 6 (*“Implementation of a systematic health support planning”*) and is in line with Recommendation 13 (*“Review of compensation, benefits and entitlements for locally recruited staff serving in high risk environments from a duty of care perspective”*).

### DEFINITIONS

#### STAFF

In line with the general direction of the HLCM, *staff* includes both International Professionals and locally recruited (local) staff. It is assumed that staff deployed or working in high-risk locations are in reasonably good health, otherwise they are not deployed to or evacuated from these destinations.

#### CONNECTIVITY

Connectivity entails solutions including hardware, running cost (e.g. services) and expertise required to assess, install, transfer knowledge and maintain a varied range of standardised solutions. Solutions are dictated by operational needs and, specifically, by the physical premises where they need to be installed/provided.

Generally, connectivity solutions depend on existing infrastructure, type of services required and available, number of users and size of the area. Connectivity is to be flexible and adapt to the changing environment: for example, in case of a security incident or a pandemic, users may call their families more often. In most locations, connectivity solutions might be available through local service providers. The service quality might vary, but the cost of services might be reasonably priced and therefore the preferred option. The problem with these solutions is vulnerability: they will likely be overloaded or shut down by local authorities during an emergency. Therefore, depending on the

situation, an independent back-up solution is recommended to be deployed and maintained. It can also be assumed that when using the backup solution, the service levels might be reduced to voice calls only.

---

## HEALTH & RESILIENCE

Maintaining good health and wellbeing while working in high-risk context is important. Staying healthy includes nutrition, hygiene, self-behavior (e.g. abuse of substances) and habits (e.g. driving habits). Connectivity is an enabler to accessing the information portals.

Resilience is a core competency for stress management and, while decreasing levels of depression and increasing staff productivity, it allows facing difficult situations in a constructive manner. Resilience can be strengthened by giving people in high-risk countries tools adequate to the context (e.g. training, communication with families).

---

## PREMISES

The characteristics of the premises vary greatly and some differentiating criteria are:

- **Purpose:** accommodation (guesthouses, hotels, tents, containers, lodges, community centres) or offices (office buildings, containers, warehouses, airports, ports, tents).
- **Existence:** already built (may/ may not be operational, may/may not need structural enhancements) or to be built (obsolete, non-existent, not adequate).
- **Durability:** permanent (to be used for extended period) or temporary: to be used for short period (e.g. emergency, beneficiaries' registration).
- **Size:** may depend on number of staff or geographical area.

## ASSUMPTIONS

The recommendations of WG8 are based on assumptions that will be validated during the next Task Forces:

- Minimum standard of connectivity is calculated per staff, to allow the provision of Duty of Care services.
- The provision of security communications is out of scope of this WG.
- Solutions depend on pre-existing infrastructure, available services and operational needs.
- Not all Duty of Care services are to be made available to all users in equal measure at all times. For instance, during emergencies, family communication may increase, while training may be de-prioritised.
- Services are to be managed effectively and efficiently (e.g. sessions with doctors may be scheduled).
- Composition of connectivity packages (e.g. data pools, management, allocation) will be defined when use cases will be detailed with the participants of Duty of Care Task Forces.
- In case where the amount of connectivity is restricted, a minimum allocation of 4GB connectivity / month, to access the Duty of Care services would be recommended. This allocation would be linked to the individual staff member and increase proportionally.
- If possible, getting connectivity from a UN office would often provide a higher service level, redundancy / independence and possibly lower the cost. The same bandwidth that are used during office hours can continue to be used for Duty of Care services during off hours. Reconfiguration of the network might be needed to provide the services.
- Above all in urban areas, solutions will be provided primarily through public services, like local Internet Services Providers (ISPs), however these services may collapse during emergencies.

- Redundancy solutions are required and may be provided through satellite communication (ie satellite phone), with low hardware cost and high running cost.
- Based on the services listed and the assumption that the user will not use more than one service at the time, a connectivity speed of 444 Kbps (Kilobits per second) per user would be sufficient. The total Kbps does not increase proportionally with the number of staff, but depending on how connectivity is packaged and services are managed. A table with estimated speed requirements is below.

N of Users	Required speed (in Mbps)
1	0.444
3	1
5	1.5
10	2.7
30	7
100	20

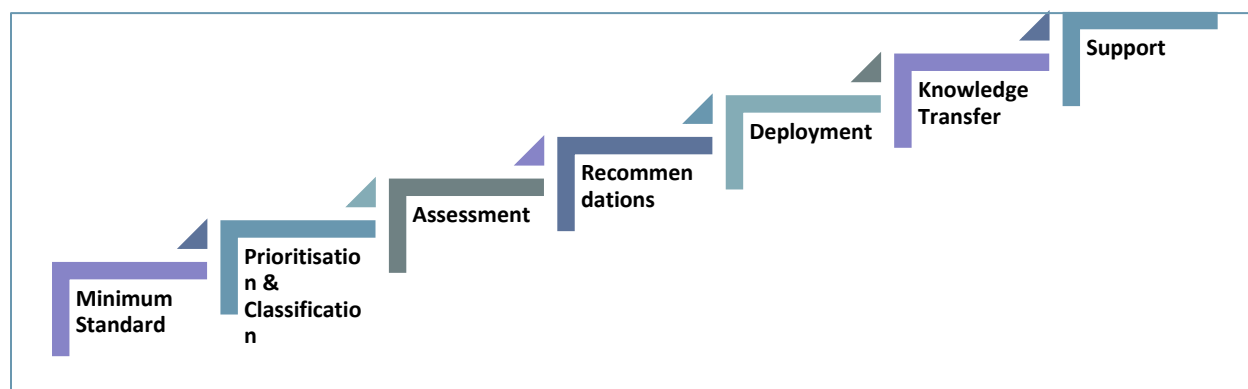
## RECOMMENDATIONS

It is recommended to the HLMC to provide a baseline of connectivity in the premises identified by Working Group (WG) 4, to support UN staff health and resilience, specifically to obtain: **1/ Telehealth services, 2/ Portals of information and policies, 3/ Training and 4/Family communication**. More details are in the Scope of Work below. In 2017, WG 4 identified 236 UN-provided accommodation and 415 UN offices. Implementation of Recommendation 8 involves the following process:

1. **Minimum standard:** definition and agreement of minimum standard of connectivity for UN staff (speed and amount of data per capita) for Duty of Care services, depending on type of premise.
2. **Prioritisation and classification of premises for roll-out:** agreement on criteria and premises to be connected and services (criteria, batches, classes).
3. **Assessment:** needs and existing infrastructures, services in premises.
4. **Recommendations:** presentation on most suitable solutions (build – rebuild – upgrade), including hardware installations and software configurations.
5. **Deployment:** of personnel and equipment, contracting of services.
6. **Knowledge transfer:** transfer of manuals, licenses, equipment, and handover.
7. **Support:** definition of maintenance and support schedule and responsibilities.

The cost of solutions depends on existing infrastructures, available services, number of staff serviced, security situation and geographical premise.

### Process of Deployment of Duty of Care Services – Connectivity



### “DUTY OF CARE” SERVICES – FOUR CATEGORIES

#### 1/TELEHEALTH

Telehealth enables humanitarians to go through medical diagnosis, consultations and monitoring from remote. The services that will be provided are two: store-and-forward and real-time / interactive services. *Store-and-forward telehealth* allows acquiring medical data via internet (like medical images) from remote premises to doctors at a convenient time for assessment offline. This method does not require the physical nor virtual presence of the patient and provider in the same place nor at the same time. *Real-time interactive telehealth* allows interactive consultations via videoconferencing and Voice over IP (VoIP) solutions.

Connectivity solutions include hardware and services to take, transfer, store and read images, as well as videoconferencing facilities and VoIP. Telehealth reduces the cost of medical services by increasing speed of service delivery and decreasing cost of transporting patients to and from medical outlets. Among the cons of telehealth, there is resistance to change, which may slow down its adoption, as well as inaccurate diagnoses. Contracting of doctors and specialists to provide telehealth services is out of scope of this paper.

Remote monitoring sensors may be required both for personal use (e.g. hearth-rate monitoring watches) and for premises (e.g. teleradiology equipment). Some sensors might be used on occasional bases, while others, including ambient thermometers and air quality sensors, might be reporting continually. The amount of data used for this will be marginal.

**Assumption: each user requires transmitting one video or image for telediagnosis a month, plus a call / video over VoIP.**

#### 2/PORTALS OF INFORMATION AND POLICIES

Digital platforms (pages, software, websites) provide information to people on health and resilience, providing services otherwise unavailable to staff in high-risk, remote premises. Adequate connectivity to access digital platforms is required. The content of the portals of information and policies are out of scope of this paper.

**Assumption: multiple sessions to access corporate system per day are required. The amount of data used for this will be marginal.**

### 3/TRAINING

Training staff online on safety and security measures enhance staff health and resilience. Depending on the premises and type of training, different connectivity solutions may be required. The content of the training is out of scope of this paper.

**Assumption: one webinar of 30 minutes every month is to be attended per user.**

### 4/FAMILY COMMUNICATION

Communicating with families and loved ones while in high-risk environments enhances staff resilience and ability to cope with stress. Adequate connectivity for VoIP telephony, via smartphones or laptops (of UN agencies or following Bring Your Own Device (BYOD) approach) is required.

**Assumption: one session of 30 minutes call over VoIP per day.**

## SCENARIOS

Few scenarios are outlined below however many more can be envisaged.

### SCENARIO 1: TOWN WITH INTERNET SERVICE PROVIDER

In a town - for example Luanda (Angola) or Damascus (Syria) – there is an Internet Service Provider (ISP) and ISP needs to be contracted. Staff can use the premises of the office to access Duty of Care services.

Narrative	Location with 1 staff	Location with 10 staff	Location with 50 staff
Technical solution for big/small town with infrastructures	ISP ADSL wireless link	ISP ADSL/Fiber/wireless link with local distribution over single Wi-Fi access point	ISP /Fiber/wireless link with local distribution over multiple Wi-Fi access point
Estimated installation cost (staffing and equipment)	US\$ 300	US\$ 2,000 – 5,000 (Assuming local contractor available)	US\$ 5,000 – 20,000 (Assuming local contractor available)
Estimated monthly recurring cost:	US\$ 40-150	US\$ 300 – 600	US\$ 500 - 800
Service 1: Telehealth	Yes	Yes	Yes
Service 2: Access to portals of information and policies	Yes	Yes	Yes
Service 3: Access to training	Yes	Yes	Yes
Service 4: Access to family communication	Yes	Yes	Yes

### SCENARIO 2: NO INFRASTRUCTURE AVAILABLE

No infrastructure is available (for example remote locations in Nepal after the earthquake or a newly established camp location in Iraq). Satellite might be the only option. The assumption has also been that no local contractors are available.

Narrative	Location with 1 staff	Location with 10 staff	Location with 50 staff
Technical solution	Satellite phone	Portable satellite solution with single internal access point	V-sat with local distribution over multiple Wi-Fi access point
Estimated installation cost (staffing and equipment):	US\$ 600 (hardware only)	US\$6,000 (hardware only, staff to be trained off-site to deploy and maintain)	US\$50,000 (hardware and technician / contractor deployed from outside to deploy)
Estimated monthly recurring cost:	US\$ 100-1,000	US\$ 4,000 – 10,000	US\$ 1,000 – 10,000
Service 1: Telehealth	Yes, limited services at high cost	Yes	Yes
Service 2: Access to portals of information and policies	Yes	Yes	Yes
Service 3: Access to training	Yes, limited services at high cost	Yes	Yes
Service 4: Access to family communication	Yes	Yes	Yes

## ACRONYMS

BYOD	Bring Your Own Device
ETC	Emergency Telecommunications Cluster
GB	Giga Byte
HLCM	High Level Committee on Management
ICT	Information and Communication Technology
ISP	Internet Service Provider
Kbps	Kilobit Per Second
UN	United Nations
VSAT	Very Small Aperture Terminal
WFP	World Food Programme.