



**Chief Executives Board
for Coordination**

CEB/2019/HLCM/19

26 March 2019

HIGH-LEVEL COMMITTEE ON MANAGEMENT (HLCM)

Thirty-Seventh session, 3-4 April 2019

UN Volunteers, Bonn

Cross-functional Task Force on Duty of Care Report, April 2019

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Executive Summary

1. The Task Force, as requested in its revised terms of reference, continues to strive towards mainstreaming Duty of Care in the UN system. In order to integrate Duty of Care in all environments where UN operates, the Task Force presents the below **for discussion by the HLCM**:

Draft vision statement for Duty of Care in UN system	The United Nations, in fulfilling its organizational mandates, aims to provide a healthy, safe and respectful working environment that promotes greater accountability, efficiency and commitment of its workforce.
Duty of Care Core Draft Principles	<ol style="list-style-type: none"> 1) Risk awareness and transparency 2) Safe and healthy living and working environment 3) Inclusion and respect for dignity 4) Caring for consequences of risk 5) Accountability at all levels
Draft Duty of Care Framework for Affiliate workforce	This Framework is based on Duty of Care Core Principles and details what all organizations must adopt when contracting affiliate workforce personnel. Prior to deployment, the roles and responsibilities of the parties must be codified in an appropriate agreement.

2. This report further describes: The Task Force's findings regarding the Duty of Care risk management framework and the achievements to date. In addition, the Task Force continues to monitor and evaluate the implementation of Duty of Care action points in each UN organization. The findings are presented as a dashboard in Annex 3.
3. The Task Force will present in the final report to the HLCM in Fall 2019: results of the review of Duty of Care measures for various categories of personnel, additional guidance and tools for the draft Duty of Care risk management framework, an update on the Mutual Accountability Framework (MAF) and the integration of Duty of Care into RC's portfolio, and the implementation status of Duty of Care action points in organizations and proposal for a future monitoring mechanism.

Integrating Duty of Care in the UN system

1. Since its last progress report to the High-Level Committee on Management (HLCM) in Fall 2018, the Duty of Care Task Force (“Task Force”) has focused on several interrelated work streams underpinned by its phase two Terms of Reference which are oriented toward a better integration of Duty of Care throughout the UN system. They include: expanding Duty of Care to all environments and to all personnel, the continued development of a risk management framework, and the monitoring and evaluation of the implementation of the Duty of Care action points for high-risk duty stations already endorsed by the HLCM in April 2018.
2. A Duty of Care Task Force workshop was conducted from 4-6 December 2018 and hosted by UNICEF in New York. The aim of the workshop was to bring the Task Force members together to develop a methodology for Duty of Care throughout the UN system based upon a risk management approach but without compromising the impact of the first phase of the group’s work focusing on high-risk duty stations.
3. The results of this workshop and the ensuing work of several informal groups post-workshop, particularly on expanding Duty of Care to all personnel and developing a Duty of Care risk management framework, are outlined in the following sections of the report. The Task Force intends to finalize its work by the Fall 2019 HLCM session and present how its efforts will be sustained and perpetuated within the new and evolving UN reform process.

Definitions

4. For the purpose of the Task Force and this report:
 - a) **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.*”¹ The Task Force views the Duty of Care as employer’s Duty of Care to address foreseeable risks arising from the workplace.²
 - b) **High-risk environments** refer to duty stations eligible for danger pay, as determined by the International Civil Service Commission (ICSC)³ and the countries declared by the Inter-Agency Standing Committee (IASC) as Level 3 health emergency locations⁴.

¹ CEB/2016/HLCM/11.

² CEB/2018/HLCM/5/Rev.1.

³ International Civil Service Commission, Danger Pay, <https://icsc.un.org/secretariat/hrpd.asp?include=dp>.

⁴ IASC Transformative Agenda, <https://interagencystandingcommittee.org/iasc-transformative-agenda>.

- c) **Staff members** 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).
- d) **Affiliate workforce/non-staff personnel:** individuals with direct contractual relationship with the organizations, including but not limited to consultants, individual contractors, holders of Service Contracts, Special Service Agreements (SSA), interns⁵, UN volunteers, fellows, UNOPS contractors (e.g. Local Individual Contractors (LICAs) and International Individual Contractors (IICAs) etc.
- e) **Locally-recruited staff members** refer to staff members in the General Service and National Professional Officer categories.

Draft vision for Duty of Care: Expanding Duty of Care in all environments

- 5. The Task Force agreed that the overall aim for the UN is to foster a culture which is conducive to Duty of Care to its personnel. As such, a draft global vision statement was developed which articulates the high-level goals which the UN aspires to in fulfilling its Duty of Care:

“The United Nations, in fulfilling its organizational mandates, aims to provide a healthy, safe and respectful working environment that promotes greater accountability, efficiency and commitment of its workforce.”

- 6. It was also determined that a foundation of Duty of Care Core Principles (“Principles”) was needed to provide a working guide that would articulate the approach for Duty of Care throughout the UN system. This is consistent with several other entities, including non-UN international organizations and NGOs, which have developed similar guidelines. These Principles would not create additional legal obligations that have not been approved by the respective governing bodies of the UN entities, would be overarching and value-based, and would communicate the UN system’s vision on Duty of Care through a holistic, systems and risk management approach.
- 7. The Principles, with their accompanying objectives, should be the foundation for review of any new or existing policy to ensure that organizational concerns are taken into account in terms of Duty of Care for UN personnel. They can also be used as a communications tool both internally and externally to illustrate the commitment of the UN system to providing a

⁵ “Interns” are gratis personnel and are not financially remunerated by the organization for their services but may be entitled to a stipend as contributions towards basic subsistence cost. Please also see the report of the HLCM informal working group on internship programmes in the United Nations System.

healthy, safe and respectful working environment that promotes greater accountability, efficiency and commitment of its workforce.

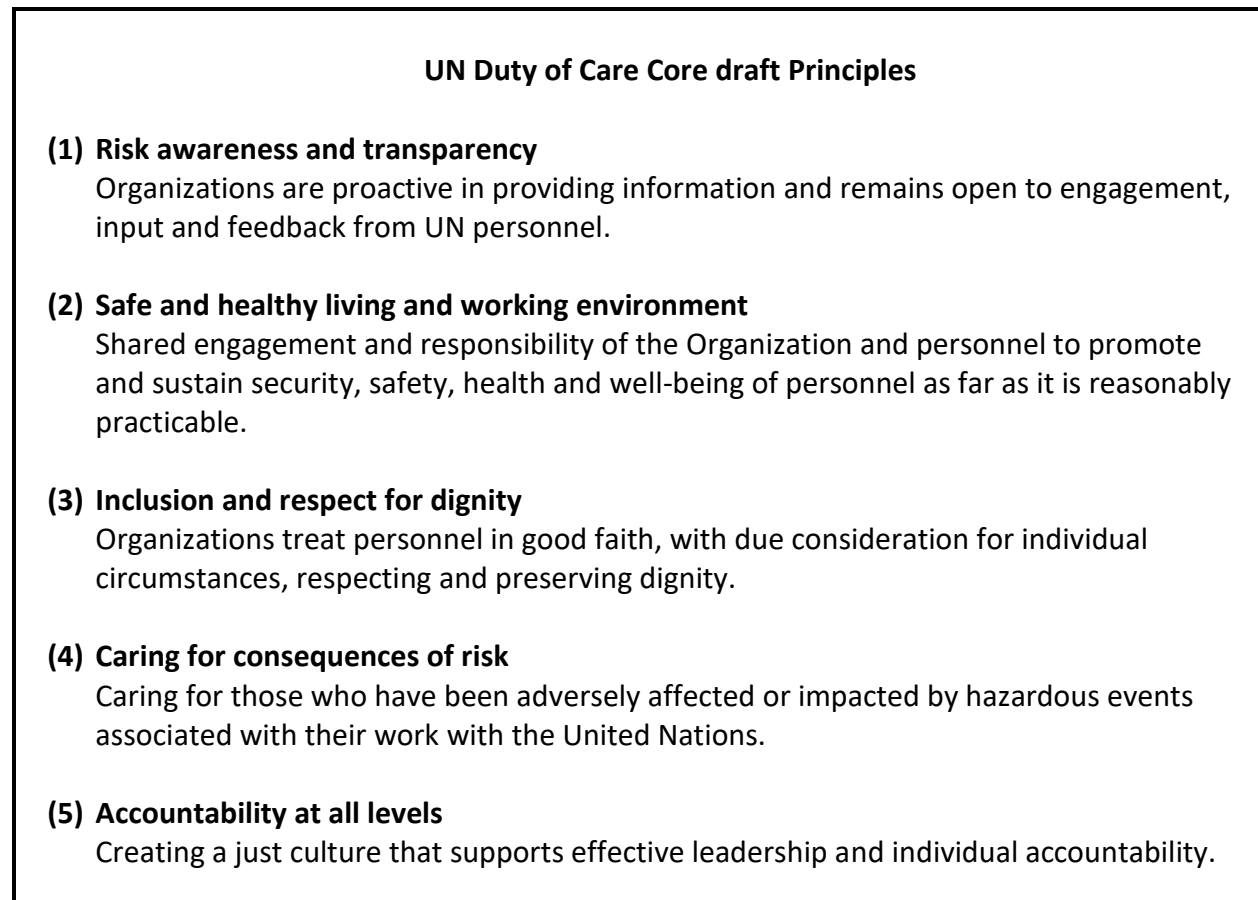


Figure 1. UN Duty of Care Core draft Principles

8. **The draft vision statement for Duty of Care in the UN system and the Duty of Care Core draft Principles are presented for HLCM’s discussion.**
9. A number of associated actions, related to each of the Principles, were also defined which relate either to Duty of Care action points that have been or will be endorsed by the HLCM under the mandate of the Duty of Care Task Force, or to actions resulting from other HLCM initiatives/UN bodies. The full list of Duty of Care Core draft Principles, objectives and their associated actions are provided in Annex 1.
10. It should be noted that the Principles have been used as the basis for the framework of new proposed actions to enhance Duty of Care to affiliate workforce which is described in the next section on “Duty of Care for all personnel”.
11. As described in the Fall 2018 report to the HLCM, the Task Force also considered the application of the action points already endorsed by the HLCM for high-risk duty stations to all other environments. The section on “Reporting on implementation in UN organizations”

highlights where UN organizations are already expanding these action points beyond high-risk duty stations or have plans to do so.

12. Finally, progress on expanding Duty of Care to all environments is dependent on the integration of Duty of Care, which is about addressing risks which may harm personnel, into enterprise risk management processes in all locations where the UN operates. By identifying, prioritising and treating risks associated with Duty of Care through risk analysis and management processes, managers and UN Country Teams will, in principle, be ensuring that Duty of Care is expanded in all environments. Further details on the linkages between Duty of Care and the risk management framework are described in the relevant section below.

Progress on Key Deliverables

A. Duty of Care for all personnel

13. The HLCM mandated the Task Force to “[d]evelop measures to enhance Duty of Care to affiliate workforce/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”.⁶
14. The Task Force reviewed all types of personnel such as affiliate workforce, standby partners, third-party contractors, implementing partners, uniformed personnel and government-provided personnel. This report focuses on Duty of Care draft measures for affiliate workforce with direct contractual relationships with an organization that is part of the UN system. The Task Force is also in the process of developing Duty of Care measures for the other types of personnel, including those deployed through stand-by partner arrangements, in consultation with relevant networks e.g. Human Resources, Legal Network and Procurement Network, to be presented to the Fall 2019 HLCM.
15. The Task Force presents to **HLCM for discussion**, the draft **Duty of Care Framework for Affiliate Workforce**⁷. This Framework is based on Duty of Care Core draft Principles and details what all organizations must adopt when contracting affiliate workforce personnel. However, this draft Framework would only be applicable to the individuals, and not to their family members, unless authorised by the respective Organization.
16. The additional costs for implementing these measures cannot be definitively estimated for each agency as the way in which measures would apply to and would be adopted by each agency will vary. For example, some measures, such as medical and security clearance and

⁶ CEB/2018/HLCM/5/Rev.1, Annex 13.

⁷ **Affiliate workforce:** individuals with direct contractual relationship with the organizations, including but not limited to consultants, individual contractors, holders of Service Contracts, Special Service Agreements (SSA), interns, UN volunteers, fellows, UNOPS contractors (e.g. Local Individual Contractors (LICAs) and International Individual Contractors (IICAs) etc.

compensation for service incurred illness and injuries are already implemented by some organizations. Therefore, budgetary implications would be dependent on each organization.

17. Prior to deployment, the roles and responsibilities of the parties (i.e. the UN organization and the individual) would need to be codified in an appropriate agreement (e.g. individual contract, consultancy contract, etc.).

Draft Duty of Care Framework for Affiliate Workforce			
Duty of Care Core draft Principles	Prior to deployment	During deployment	Post-deployment
1. Risk awareness and transparency	<ul style="list-style-type: none"> • Provision of detailed information. 	<ul style="list-style-type: none"> • Ongoing dissemination of security/medical and other relevant information. 	<ul style="list-style-type: none"> • Development and implementation of a mechanism to collect and reflect on the feedback from the personnel.
2. Safe and healthy working and living environment	<ul style="list-style-type: none"> • Medical certificate. • Security clearance. • Secure travel and visa arrangements. 	<ul style="list-style-type: none"> • Inclusion under the security system in place. • Application of minimum standards for accommodation (as approved by HLCM). • Adequate bandwidth provided (as approved by HLCM). • Access to available medical and psychosocial services as well as medical evacuation services and insurance coverage. 	

Draft Duty of Care Framework for Affiliate Workforce			
Duty of Care Core draft Principles	Prior to deployment	During deployment	Post-deployment
3. Inclusion and respect for dignity	<ul style="list-style-type: none"> Reasonable accommodation of disability and other special needs. 	<ul style="list-style-type: none"> Compensation commensurate with the work and working conditions. Protection against sexual harassment, harassment and abuse of authority. Protection against retaliation. 	<ul style="list-style-type: none"> Certificate of service/ successful performance. Timely settlement of final emoluments as provided in the contractual agreement (e.g. last pay, travel cost etc.).
4. Caring for consequences of risk	<ul style="list-style-type: none"> Ensuring appropriate insurance coverage (to be funded by organization or the individual). 	<ul style="list-style-type: none"> Crisis management (e.g. medical and security evacuation etc.). 	<ul style="list-style-type: none"> Follow-up mechanism/ compensation in case of long-term effects of occupational illnesses/ accidents.
5. Accountability at all levels	<ul style="list-style-type: none"> Clear assignment of roles and responsibilities for the parties prior to deployment. 	<ul style="list-style-type: none"> Clear managerial and individual responsibilities for Duty of Care. Clear terms in the contractual agreement regarding access to a dispute resolution mechanism. Appropriate on-going support for the fair assessment of performance. 	

Figure 2. Draft Duty of Care Framework for Affiliate Workforce.

18. Also presented for information, are **Voluntary Guidelines (Annex 2)**, which provide examples on how organizations could operationalize the draft Framework.
19. The Task Force will continue its review of additional Duty of Care measures for other types of personnel and will report the results to the HLCM in its Fall 2019 session.
20. **Support to staff in hardship duty stations not eligible for danger pay:** In its decision adopted in December 2018, (A/RES/73/273), the General Assembly decided “...to grant, on a pilot basis, an amount of 15,000 United States dollars for staff members with eligible dependants in duty stations with E hardship classification conditions”, in the form of a Non-Family Service Allowance (NFSA), which is provided on a monthly basis during a 12-month period. Given that this is a pilot, the ICSC has been requested by the General Assembly to submit a recommendation on this payment, including on its continuation, based on a review of the impact thereof, including workforce planning, in different categories of duty stations, including non-family duty stations, and the actual cost to the organizations, at the 75th session of the General Assembly.

B. Draft Duty of Care Risk Management Framework

21. During the December 2018 Duty of Care workshop, the Task Force identified that the known Duty of Care risk universe is constituted of occupational security, health (including mental health) and safety risks, as per the diagram below.

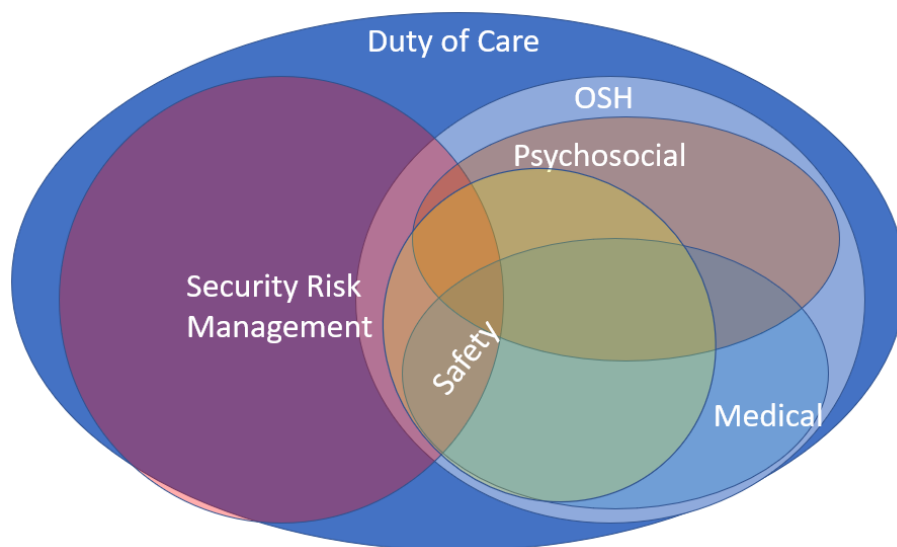


Figure 3. Duty of Care Risk Universe in the UN system⁸

⁸ Note: Fire, Aviation and Road Safety are currently under the remit of the SMS, as is emergency response to all incidents (both safety and security).

22. The UN Security Management System (SMS) developed by the UN Inter Agency Security Management Network (IASMN) is the framework for managing security risks in the UN system. An OSH Framework is its equivalent for the management of risks associated with health, safety and well-being of UN personnel.
23. As the SMS is already operational, the Task Force concentrated on the risks associated with OSH that do not fall within the purview of the SMS for the development of a Duty of Care risk management approach.
24. The OSH Framework was endorsed at the twenty-ninth HLCM session in March 2015, for the UN system to “ensure that the organization has effective tools for minimizing preventable staff harm, and for optimizing the occupational safety and health conditions and working environments of the United Nations’ system’s workforce”. This was followed by the issuance of a Secretary-General’s Bulletin in July 2018 (ST/SGB/2018/5) promulgating an OSH management system in the UN Secretariat. The establishment of and compliance with OSH policies, procedures and management systems is essential for organizations to ensure Duty of Care towards personnel.
25. The core elements of the OSH management system, which is one of the Core draft Principles of Duty of Care in the UN system (see Annex 1), include both agency and country-level components, ensuring that risks are managed at the most appropriate level. They are comprised of:
 - a) At the agency level (Headquarters of each UN organization):
 - A formal OSH policy statement, issued by the head of each UN organization.
 - An occupational safety and health oversight body, i.e. OSH committee, led by senior management, and with representation from managers, staff, medical, staff counselors and other specialized staff. The combination of managerial and technical functions in the committee is necessary to ensure that staff health, welfare and safety are acknowledged as the shared responsibilities of line management and staff and are essential components of daily operations⁹.
 - A risk register and risk management plan, populated either by centrally identified risks or by risks escalated from the field.

⁹ Sample Terms of Reference for an OSH Committee were endorsed by the HLCM (CEB/2018/HLCM/17/Ann.2-5, Annex 4).

b) At the country level (usually, UN country-team (UNCT) or other relevant inter-agency fora)¹⁰:

- A local OSH committee, comprising representation from all UNCT members, and technical expertise.
- A local OSH risk register and risk management plan which takes into account local conditions, hazards and priorities and informed by evidence and actual events as recorded by a UN-wide formal incident reporting system.
- A clear protocol for risk accountability and escalation – to ensure that risks are dealt with locally where possible, within single organizations where appropriate, but at the country team level where risks are shared, and escalated to headquarters where they exceed the local capacity to resolve.

26. There are several ongoing activities which will contribute to populating a risk register for the draft Duty of Care risk management framework:

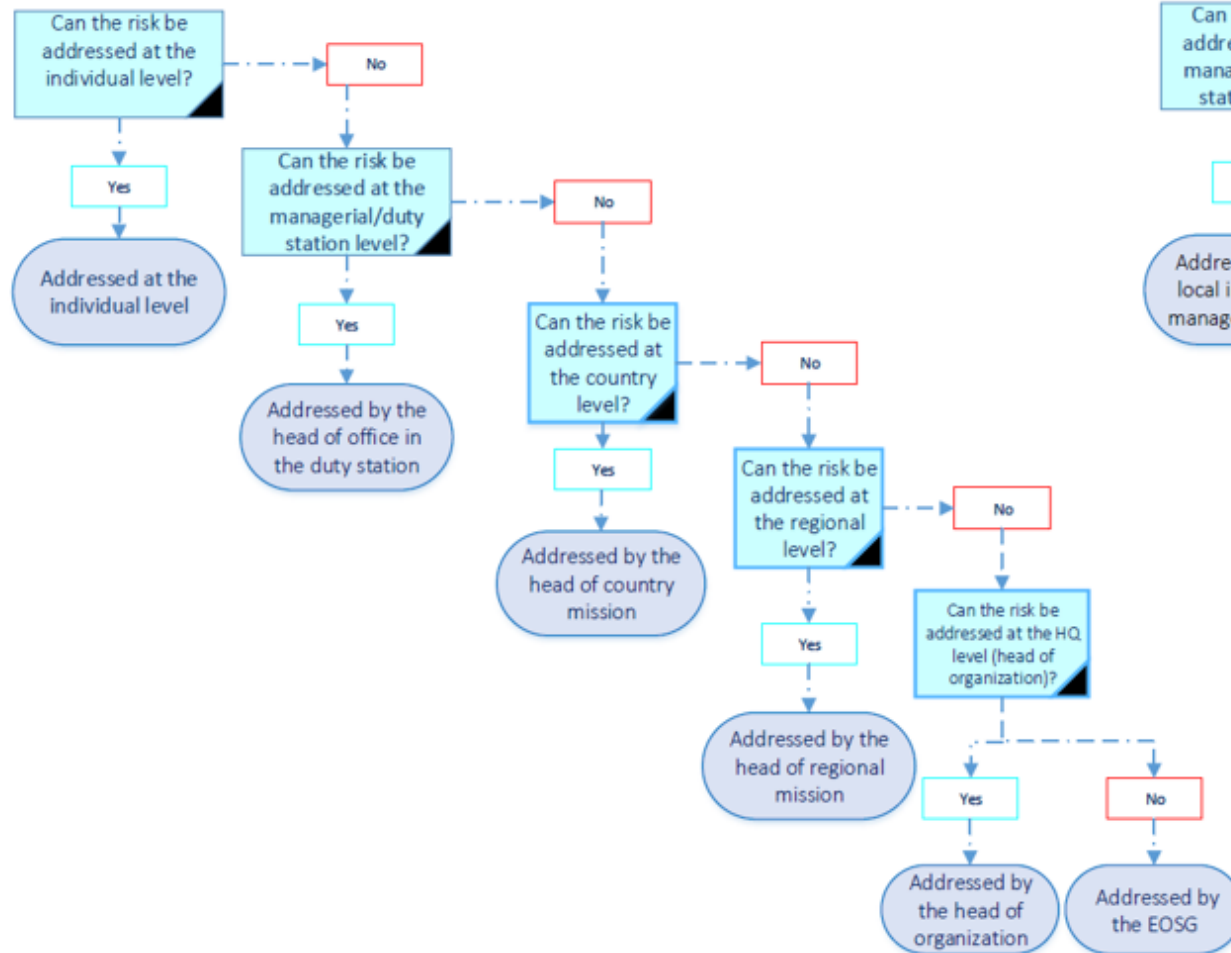
- a) Duty Station Health Risk Assessment (DS-HRA), including the self-assessment tool;
- b) Psychosocial risk assessment (PRA);
- c) Occupationally incurred indicators for all sick leave certification;
- d) Formal incident reporting system (to be rolled out in 2019 by UN Secretariat).

27. Based on the data from these activities, Enterprise Risk Management (ERM) risk registers of UN organizations can then be adjusted to adequately document, manage and escalate Duty of Care risks.

28. The Task Force has developed the following risk accountability and escalation framework to guide UN organizations and local OSH Committees in managing and escalating risks associated with Duty of Care, including those risks concerning a single organization as well as those shared amongst several organizations requiring an inter-agency approach (such as in the case of epidemics, natural disasters or other critical incidents).

¹⁰ Depending on the organizational footprint and level of risks in a given country, UN organizations may also opt to establish their own additional OSH Committees within the country.

Risk that impact an individual organization



Risk that impact more than one organization

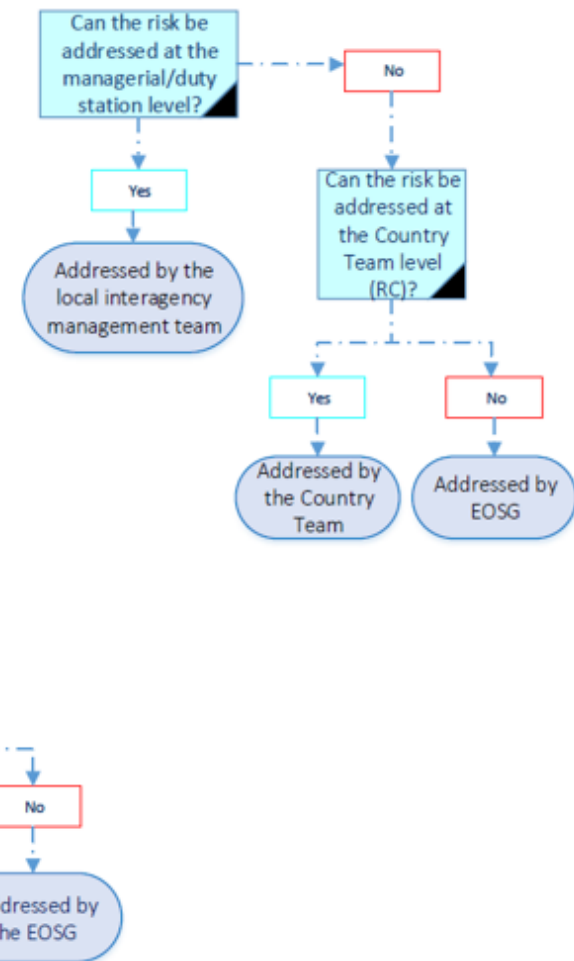


Figure 4. Draft Duty of Care risk accountability and escalation framework

29. UN organizations, with the assistance of OSH committees, should ensure that risks associated with Duty of Care are integrated into their internal Enterprise Risk Management frameworks and addressed through the accountability and escalation framework. While it is noted that organizations use different terminologies and methodologies for their respective risk management frameworks, Duty of Care risks can be easily integrated into organizations' risk registers.
30. As requested by the HLCM, the Task Force will propose additional guidance and tools for the Draft Duty of Care risk management framework at its Fall 2019 session. It should be noted that this work will depend on the establishment of both local and agency level OSH committees to populate the dashboard with meaningful data and provide a forum for the reporting and analysis of these risks. This work will be conducted in close consultation with the HLCM Cross-Functional Task Force on Risk Management and other relevant stakeholders.

C. Mental Health Strategy Implementation

31. At its 34th session in September 2017, the HLCM approved the UN System Workplace Mental Health and Well-Being Strategy (hereinafter "Mental Health Strategy"), a five-year action plan which would ensure services and support for the mental health and well-being of all civilian personnel. The Secretary-General formally launched the United Nations System Workplace Mental Health and Well-Being Strategy in October 2018.
32. The four key themes of the Mental Health Strategy are:
- a) To create a workplace that enhances the mental and physical health and well-being of UN staff;
 - b) To develop, deliver and evaluation high-quality services everywhere that UN staff serve;
 - c) To welcome and support UN staff who live with mental health diagnoses and challenges;
 - d) To ensure sustainable funding for mental health and well-being services.
33. An inter-agency, cross functional Implementation Board was established with purpose of having strategic oversight and providing support to successful and practical operational implementation of the strategy across the UN-System, over the five-year implementation period (2018-2023). It is (discipline) board. Following the inaugural meeting in October 2018, the Implementation Board holds monthly meetings, chaired by the Assistant Secretary-General for Human Resources, UN Secretariat.
34. All UN organizations and relevant representative bodies have been invited to nominate a delegate to the Implementation Board. The organizations that have currently nominated a delegate are, ILO, IOM, UNDP, UNFPA, UNICEF, UNHCR, UNISERV, UNOMS, UN Secretariat, UN Women, WFP, WHO, and WIPO. In addition, representative bodies with a delegate are: CCISUA, CISMU, FICSA UNMD and UNSSCG. All organization without a delegate are encouraged to nominate a representative.

35. As of January 2019, the position of Global Lead (P-5) for the implementation of the Mental Health Strategy is encumbered. This position is funded and hosted by the UN Secretariat. Additional personnel have been recommended and resourcing for the additional positions is underway through options of secondment, JPOs and UNVs.

36. The Mental Health Strategy identifies seven initial priority actions to commence in 2019:

- a) Resource and distribute psychosocial support and mental health services to enable all United Nations staff who need it, especially those at higher risk, to have universal and equitable access to these services within 18 months of endorsement.
- b) Implement stigma reduction and health promotion approaches over the five-year period, to strengthen the knowledge, skills and behaviour of all United Nations staff members with regard to staying psychologically fit and healthy and to ensure that concerns about stigma, anticipated and/or experienced, are not a barrier to achieving good mental health and well-being.
- c) Create systems to enable and oversee the safety and quality of psychosocial support programmes by the end of year one.
- d) Initiate a suite of prevention interventions, informed by best practice and shown to influence positively the protective factors associated with good mental health and well-being, as well as avert or minimize harm from known risk factors, directly and indirectly for the staff member, and/or from the environment in which they work.
- e) Establish a workplace well-being programme, with an agreed charter, practical support, training and recognition awards for teams and managers that enables the achievement of respectful, resilient, psychologically safe and healthy United Nations workplaces over a five-year timescale.
- f) Complete a review of United Nations Health Insurance provision, and United Nations social protection schemes (for disability and compensation) within two years, to achieve equity of coverage for mental health, and ensure that provision is adequate, acceptable and appropriate.
- g) Complete a multidisciplinary workforce development plan, supported by a business case, submitted to the High-level Committee on Management by the end of year one. The business case is informed by a data-supported assessment of the capacity, capability and quality of in-house and external resources.

37. Implementation Plan:

- a) The implementation of the Mental Health Strategy will have both a global (whole of system) and local (organization, duty station, region) focus.
- b) Globally a framework for implementation will be developed along with the relevant tools and resources required that can be utilized across the UN System.
- c) Successful implementation will require a local approach which takes into account the needs of different organizations and the specific context.
- d) Implementation teams/Champions will be identified and provided support by the Global Lead to tailor relevant activities for their setting.
- e) Leadership buy-in is essential for the successful implementation of the strategy.

38. Action that has been undertaken by the Implementation Board and Global Lead:

- a) Project planning with a focus on deliverables and budgets for years 1 and 2. There is currently a shortfall in funding for the implementation of the mental health strategy and a resource generation plan is under development.
- b) Commencement of activity on the first 3 priority actions.
 - resource and distribute psychosocial support and mental health services,
 - implement stigma reduction, mental health promotion and well-being approaches,
 - create systems to enable and oversee the safety and quality of psychosocial support programs.
- c) The establishment of an Advisory Group of Staff who have experience of living with a mental health condition.
- d) The development of a Communication Strategy outlining activities for communicating about the Mental Health Strategy and associated activity to all relevant stakeholders and activities to reduce stigma and raise awareness about mental health.

39. Next steps:

- a) In April 2019 a Mental Health Strategy Implementation Kit will be sent to all Heads of Agencies. This kit will include introductory information and the resources and information required by Heads of Entities to launch the Strategy.
- b) Following this, communication will be sent to all key stakeholders, including HR Directors, Heads of Counselling, UN Medical Directors and Staff Associations outlining initial actions that they can take.

- c) Activities will include initial educational material and implementation strategies with a focus on stigma reduction.
- d) Gather baseline data about stigma and attitudes.
- e) Pilot programs will be developed with a view to evaluating and scaling across the UN System.

D. UN living and working standards

40. Mechanisms and tools have been developed and are in place to facilitate implementation of UN minimum living and working standards in organizations¹¹, as endorsed by the HLCM in Spring 2018. WFP is the leading organization for this stream of work.
41. As of February 2019, the Accommodation Digital Office of the Humanitarian Booking Hub developed by WFP, has been adopted by four UN organizations: WFP, UNHCR, UNICEF and IOM. This represents more than 200 guesthouses in deep field locations of over 24 countries. Pilots are also ongoing with UNFPA and UNDP, with UNFPA confirming recently that they plan to participate in the platform.
42. The Humanitarian Booking Hub represents the largest UN service to offer secure and safe accommodation to the humanitarian community in some of the most remote locations in the world. It also allows booking of UN drivers from the airstrip to the guesthouse, where necessary, thus increasing safety and security of served staff.
43. **Online UN standards assessment:** WFP, along with UNHCR, also developed a Quality Assessment Checklist which is now available on the Maintenance section of the site, accessible to any UN organization that joins the Hub. The digital tool has been designed to easily collect structured information from each guesthouse focal point on the quality of services provided in light of the new UN living standards. The survey is then stored on the platform for easy submission and retrieval by local/central officers in order to assess the compliance to UN standards. In particular, WFP and UNHCR have launched it to their 180+ guesthouses networks with the target to have a comprehensive view of quality standards globally by March 2019.

The information will provide the momentum to address quality gaps and in developing dedicated upgrade plans to meet UN standards, thereby will respond to the action that existing accommodations are retrofitted/renovated to bring into compliance with UN minimum living standards. A next step will be to bring UN premises into the same tool in order to review and improve workplace conditions.

¹¹ Cross-functional Task Force on Duty of Care for personnel in high risk environment Report, April 2018, CEB/2018/HLCM/5, Annex 11 UN Minimum Living and Working Standards (Revised February 2019).

44. **On line safe living conditions training:** WFP has also developed a hygiene training course for safe catering, lodging and sanitation in deep field guesthouses. This course is hosted on the Humanitarian Booking Hub, where local administrators use it together with local labour and external suppliers of catering and cleaning services. UNHCR is considering joining the project in order to jointly develop a coordinated WFP/UNHCR-wide training programme.
45. **On line pre-deployment package:** With approximately 210 guesthouses, 45 UN Clinics, 30 UN counsellors, 285 UNHAS flight destinations and air strip-to-guesthouse driver pick up services where available, the Humanitarian Booking Hub represents the largest UN digital repository of many deep field services to humanitarian staff with information, addresses, contacts, pictures and booking services. This is a critical step in improving access to medical services, as endorsed by the HLCM. The Humanitarian Booking Hub also allows attachments to be added in communications sent to humanitarian staff when requesting a booking for a deep field location. WFP is attaching dedicated country factsheets per location as well as a corporate “Stay healthy before, during and after missions” package. This could be a useful mechanism, particularly at the UN Country Team level, for disseminating pre-deployment information. Other UN organizations in partnership with the Humanitarian Hub are welcome to use the platform capabilities to share dedicated pre-deployment material and/or to co-develop one with WFP.
46. The Task Force Secretariat notes that a number of organizations have updated their internal policies and guidelines to align with the UN living and working standards. As more organizations join the Hub, the UN system will benefit from harmonized information about guesthouses and living and working conditions in the duty station.

E. Duty Station Health Risk Assessments (DS-HRA) & Health Support Plans

47. Since commencing the implementation of the DS-HRA methodology in 2017, 35 Health Risk assessments have been commenced in 20 countries. 18 were discontinued due to resourcing constraints, and 17 were completed. Of the 17 assessments, 12 were conducted through the country team mechanism, North Korea, Nepal, Bangladesh, Kenya, South Sudan, Yemen, Ukraine, Jamaica, Comoros, and 5 were conducted for peacekeeping missions in South Sudan, DRC, CAR, Western Sahara, and Haiti.
48. An evaluation through direct interactions with Resident Coordinators (RC)/Country Teams is in progress to follow up on the recommendations made in DS-HRA reports, which form the health support plans. The informed decision-making lies with the RC/Country Team, based on the recommendation from the UNMD, as part of their Duty of Care. As per the HLCM-endorsed Duty of Care Action 3.b. in CEB/2018/HLCM/5/Rev.1, the heads of organization in the duty station are expected to request their respective headquarters for funding to implement the Health Support Plans.

49. During the past year the emphasis has been on building capacity for assessments. This was achieved; however, it left the lead agencies (WFP, UN Secretariat, WHO and UNHCR) carrying a disproportionate and un-resourced burden of training, mentoring, funding and staffing assessment missions. A sustainable, properly resourced pool of assessors needs to be established as UNMD alone cannot complete DS-HRAs in 18 Danger Pay countries, i.e. a total of over 340 duty stations, by the end of 2020, as requested by the HLCM¹².

50. Way forward:

- a) Pool of Assessors for HRA: UNMD proposes training and certifying a pool of external assessors (consultants). The funding of the assessments should then come directly from the duty station/country team. Internal capacity for assessments will be further enhanced in parallel within the individual organizations when internal work planning and budgeting allows. Whilst a system-level cost-share could ultimately fund this pool, the most efficient way to implement rapidly will be for individual country teams to have access to a pool of consultants for direct commissioning of evaluations.
- b) Self-Assessment tool for the Mandatory Health Support Elements (MHSE): One of the lessons learned was that many health risks are appropriately addressed through the MHSE. The UNMD has commenced a project, funded by the UN Secretariat, to develop a self-assessment and reporting tool. This will support country teams to evaluate the adequacy of their provision of the Mandatory Health Support Elements, increasing the likelihood that all UN duty stations can report on this by the end of 2020. The tool is currently being developed and tested for proof of concept in Republic of Congo, Mozambique and Tunisia. Formal presentation of the self-reporting MHSE methodology, tools and guidelines will follow.

F. Improving access to medical services

51. UN and Peacekeeping clinics:

- a) There are currently 9 Peacekeeping or special political missions with MoUs, or other administrative arrangements, in place to provide access to essential medical services for UN personnel. Of those, 4 have a fee for service/cost recovery arrangement with the participating UN organizations.
- b) These arrangements demonstrate that access is possible if the approach is made and appropriate mechanisms put in place. Given that each UN mission has its own delegated authority, this requires the UN RC and Country Teams to work out their own arrangements with the local Peacekeeping clinics in country. UN organizations need to provide precise staffing counts to ensure accurate charging of fees, which is important to cover overhead costs and consumables.

¹² CEB/2018/HLCM/5/Rev.1, Action 3.a.

- c) Resolving access and financial arrangements does not fully address the issue of access for eligible dependents and affiliate workforce. Most of the Peacekeeping clinics operate in non-family duty stations so they have not been staffed or equipped for paediatric services. Furthermore, some Peacekeeping clinics operate in extreme security threat environments, where clinics are situated behind barriers which do not allow access by affiliate workforce.
- d) One administrative hurdle which remains to be resolved, particularly in UN Country Team-run clinics, is that of billing. UN clinics send one monthly bill to participating UN organizations as an Excel file and do not issue individual invoices or receipts. The UN Secretariat, which administers both the Peacekeeping clinics and the UN Country team clinics, is exploring options for billing modules associated with the current clinical information system, Earthmed, which is now used in all sites.

52. The Task Force will continue monitoring the access to UN and Peacekeeping clinics and the effectiveness of Earthmed in resolving the administrative hurdle related to billing.

53. Furthermore, the Task Force welcomes the recently issued UNMD guidelines on telehealth¹³, which would improve access to medical services for personnel in remote locations.

G. Situating Duty of Care in the reinvigorated UN Resident Coordinator (RC) system

54. Since the Task Force's last report to the HLCM in October 2018, the UN Development System (UNDS) Transition Team has advanced in the development of a country-level Management Accountability Framework (MAF) between UN Resident Coordinators (RC) and organization representatives.

55. As a result of concerted advocacy efforts by a number of UN organizations, the following language has been proposed to be inserted into the new draft Mutual Accountability Framework for UN Resident Coordinators which reflects their responsibility for Duty of Care matters at country level:

*"...The RC promotes and nurtures staff learning and the implementation of staff rules and policies, including on prevention of sexual abuse and harassment, **Duty of Care** and gender parity, in coordination with respective entities."*

56. Based on the approved MAF, this will set the stage for further integration of Duty of Care into the RC's portfolio.

¹³ The UNMD guidelines on telehealth were developed in line with HLCM's strategic plan (2017-2020) Results Framework, CEB/2016/HLCM/15/Add.1/Rev.1.

Reporting on implementation of Duty of Care in UN Organizations

57. The Task Force Secretariat developed a Duty of Care monitoring and evaluation survey (“M&E survey”), based on the monitoring and evaluation framework endorsed by the HLCM in Fall 2018. Following the first request in August 2018, a second request was made to all HLCM member organizations in February 2019 to provide an update on the implementation of the Duty of Care action points¹⁴. Out of a total of 31 HLCM organizations, 18 organizations responded and provided their input (58 percent response rate). The organizations that have provided their input are: IAEA, IFAD, ILO, IOM, UNAIDS, UNDP, UNEP, UNFCCC, UNFPA, UN Habitat, UNHCR, UNICEF, UNOPS, UN Secretariat, UN Women, WFP, WHO and WTO. See Annex 3 for the consolidated responses on the M&E survey.
58. In addition to the organizations, technical networks including UNMD, HRN and the Mental Health Strategy Implementation Board have provided their input on the status update.
59. While it is acknowledged that the responses to the M&E survey continue to demonstrate that organizations are at various stages of implementing Duty of Care action points, the Task Force Secretariat also notes progress made towards expanding Duty of Care in all environments and to all personnel.
60. **Duty of Care in all environments:** Responses from UN organizations to the M&E survey clearly highlighted where UN organizations are already expanding the action points beyond high-risk duty stations (HRDS) or have plans to do so. This is important for HQ-based organizations as well as those which do not have a presence in deep field locations, as the initial HLCM-endorsed action points were primarily geared toward supporting UN staff in HRDS. The following areas have seen the most potential for expansion to date into all environments:
- a) Pre-deployment guide: A number of organizations have already expanded, or plan to expand, this guide for use in all induction for new personnel. The placing of such a guide on an online portal can facilitate this. It has been suggested that this action point is also relevant for UN Country Teams which could centralise and coordinate this function, thereby leveraging resources and knowledge. The Humanitarian Booking Hub platform developed by WFP could be used to disseminate these guides as well as country-specific factsheets.
 - b) Resilience briefing: Although this action point is primarily associated with psychological preparation for deployment to high-risk duty stations, several organizations have their own staff counsellors, or provide access to external counsellors, for personnel regardless of the location of deployment.

¹⁴ Duty of Care action points to be implemented in the respective organizations, as endorsed by the HLCM in April 2018. Please see CEB/2018/HLCM/5 for more information.

- c) Management training: Training and coaching for managers is generally available for all, either through dedicated modules or through requests to HR or counselling services.
 - d) Living and working standards: Most organizations are already integrating, or plan to integrate, the UN minimum living and working standards across all duty stations.
61. Some organizations noted that a number of action points, such as the provision of essential, standby health supplies, additional security measures and transport for local staff would benefit from joint UNCT collaboration to scale up support and resources. This will need to be addressed in further discussions on the role of the RCs in coordinating Duty of Care initiatives at the country level.
62. Finally, the integration of Duty of Care as a key pillar of an organization's People Strategy, strategic/corporate risk register and codified in Administrative Instructions are additional means to expand Duty of Care in all environments as reported by several participating organizations.
63. **Duty of Care to all personnel**: As UN organizations have made efforts to expand Duty of Care action points to all duty stations, they are also considering extending them further to all UN personnel. Some examples of this are:
- a) Pre-deployment guide: The organizations which have reported that they are now making guides available on their induction portals are automatically making them available to all personnel.
 - b) Resilience briefing: For those organizations which have in-house expertise for staff welfare needs, these counsellors are available for all personnel.
 - c) Access to UN/Peacekeeping clinics: Access to these clinics are, in principle, possible to all personnel, once organizations have developed administrative/finance procedures to ensure payment of fees.
64. The Task Force Secretariat further observed common challenges noted in the responses from the organizations:
- a) **Interagency implementation of Duty of Care action points**: Some organizations have highlighted that it is more effective to jointly implement certain Duty of Care action points. For example, the organizations that have joined WFP's humanitarian hub now benefit from the online platform which displays information about the guesthouses administered by not only themselves but also those administered by other participating organizations. Additionally, UNICEF is making progress on finalizing the training material for managers, which can be easily used by other organizations, using the online tool accessible to the public. The UN system-wide Mental Health Strategy, led by the UN

Secretariat, is also implemented at the interagency level with expertise and contributions from participating organizations.

Other Duty of Care action points for potential joint implementation include: establishing local OSH committees, developing country-specific factsheets (if not, sharing existing materials), enabling access to UN/Peacekeeping clinics and ensuring adequate bandwidth (if the offices are co-located). Collective efforts, such as at the RC/UNCT level, to implement Duty of Care activities would not only enable harmonization of practices across the UN system, but also promote a more cost-effective method of rolling out Duty of Care activities where additional funding has been difficult to obtain at the individual organization and/or technical network level to carry out these activities.

- b) Resource mobilization: As mentioned, some organizations and technical networks have reported difficulties in implementing certain Duty of Care action points due to lack of additional financial and/or human resources support. For example, UNMD has reported that without dedicated allocation of resources, significant delays and/or incompleteness are foreseen with regards to the Duty Station Health Risk Assessments.
- c) HQ vs. field-based operating modalities: Noting that HLCM organizations have varying operating modalities and internal architectures, a one-size-fits-all M&E survey may not correctly reflect the reality vis-à-vis the implementation of Duty of Care action points in respective organizations. As the Task Force commenced its work with its focus on high-risk environments, some of the action points are not applicable in headquarter-based organizations.

65. The Task Force will update the M&E survey to incorporate any additional Duty of Care activities that are identified and to better reflect any differences in the operating modalities of the organizations. The Task Force will provide an update on the implementation status of Duty of Care action points in organizations at the Fall 2019 HLCM session and will propose how this work can continue thereafter.

Next steps

66. As a conclusion of the December 2018 workshop, the Task Force developed the 'Road to Change' diagram (Annex 4) to illustrate the vision, core values and milestones of the Duty of Care Task Force moving forward toward the end of its October 2019 mandate. Following that, Resident Representatives of UN organizations and UN Resident Coordinators should regularly review and address risks which affect the health, welfare and safety of UN personnel as part of their overall risk management processes. This should result in a sustainable culture and environment conducive to Duty of Care, enabling the work of the Task Force to be fully integrated into the UN system.

67. In addition, the Task Force has developed a prototype for a Duty of Care logo, which could be used in/incorporated in future communications on Duty of Care in the UN system.



Figure 5. Proposed Duty of Care logo for communications purposes¹⁵

68. The Task Force will present in the final report to the HLCM in Fall 2019:

- a) Results of the review of additional Duty of Care measures for other types of personnel.
- b) An update on the Draft Duty of Care risk management framework.
- c) Update on the MAF and the integration of Duty of Care into RC's portfolio.
- d) Update on the implementation status of Duty of Care action points in organizations and proposal for a future monitoring mechanism.

Conclusion

69. The Task Force presents a summary of the requests for HLCM's discussion:

Task Force requests the HLCM to <u>discuss</u>:	Draft vision statement for Duty of Care in the UN system The United Nations, in fulfilling its organizational mandates, aims to provide a healthy, safe and respectful working environment that promotes greater accountability, efficiency and commitment of its workforce.
	Duty of Care Core Draft Principles 1) Risk awareness and transparency 2) Safe and healthy living and working environment 3) Inclusion and respect for dignity 4) Caring for consequences of risk 5) Accountability at all levels
	Draft Duty of Care Framework for Affiliate workforce This Framework is based on Duty of Care Core Principles and details what all organizations must adopt when contracting affiliate workforce personnel. Prior to deployment, the roles and responsibilities of the parties (i.e. the UN organization and the individual) would have to be codified in an appropriate agreement.

¹⁵ Not to be used or disseminated until further notice. Please contact UNICEF for more information.

<p>Task Force requests the HLCM to <u>review</u>:</p>	<p>Draft Duty of Care risk management framework UN organizations, with the assistance of OSH committees, should ensure that risks associated with Duty of Care are integrated into their Enterprise Risk Management frameworks and addressed through the accountability and escalation framework. While it is noted that organizations use different terminologies and methodologies for their respective risk management frameworks, Duty of Care risks can be easily integrated into organizations' risk registers.</p> <p>The Task Force will propose additional guidance and tools for the Draft Duty of Care risk management framework at the Fall 2019 session of the HLCM. This work will be conducted in close consultation with the HLCM Cross-Functional Task Force on Risk Management and other relevant stakeholders.</p> <p>Implementation status of Duty of Care action points in UN organizations Following the first request made in August 2018, the Task Force Secretariat continues to monitor the progress on the implementation of the Duty of Care action points in UN organizations (Duty of Care M&E survey).</p> <p>The Task Force Secretariat notes that organizations are at various stages of implementation and also notes progress made towards expanding Duty of Care in all environments and to all personnel. The HLCM member organizations are requested to continue to advocate for the need to discharge Duty of Care towards their personnel.</p>
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Annexes

- Annex 1. Duty of Care Core Draft Principles and Objectives
- Annex 2. Voluntary Guidelines: An example of how to operationalize the Draft Duty of Care Framework for Affiliate workforce
- Annex 3. Monitoring and Evaluation: Implementation status in UN organizations
- Annex 4. Road to Change diagram