Duty Station
Health Risk Assessment
&
Health Support Planning
Guide

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Introduction

Purpose

A Duty Station Health Risk Assessment (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 personal. The purpose of a HRA in a duty station is to 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 employees 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).

This is a technical guide, based on principles agreed within the UN Enterprise Risk Management (UNERM) System. It has been developed by the network of the UN Medical Directors (UNMD) to become part of the overall ERM framework. The UN Staff/Stress Counsellors Group (UNSSCG) has also partnered with the UNMD to assist with the development of psychosocial hazard identification and methodologies for the HRA.

Audience

This guide is intended for persons accredited as health and safety officers, advisors and professionals who will be involved in carrying out health risk assessments but also as an explanatory guide for managers, administrative officers, or other officials at duty stations who are designated with accountability for duty of care.

Acknowledgments

The UNMD wish to thank the UN Secretariat Enterprise Risk Management team for their support in this project and the UNSSCG for partnering with the development of psychosocial hazard and methodology. The UNMD wishes to thank the HRA working group of participating agencies funds and programs (UN Secretariat, WFP, WHO, and UNHCR).

Duty Station Health Risk Assessment Methodology

The methodology developed for the DS-HRA is based on UNERM (United Nations Enterprise Risk Management) to identify health hazards and assess health risks at a duty station. The outcomes of the assessment will build the basis for the health support plan suggesting risk mitigation measures for the duty station. The assessment of internal and external health facilities will identify gaps in the healthcare response which should be provided for UN personnel. The DS-HRA can be looked at as two parts:

I. Gathering information to identify hazards & risks at duty station:
- -Desk Top Review
- -Health questionnaires & surveys
- -Interview & Group Discussions
- -GAP Analysis/assessment of local healthcare capabilities
- -Observation

II. Assessment of the information:
- -Analysis of risks from a health perspective

-Risk Rating & Stratification
-Prioritizing hazards and risks for the Risk Treatment Plan
-Consolidation of the above for the Health Support Plan

While some of the sections in part I. may be delegated to a trained OSH focal point or other onsite personnel, part II. of the DS-HRA should involve the appropriate medical team which may consist of medical officers, nurses, and/or counsellors designated by the appropriate Medical Director.

Hazards & Risk Identification

Just as in the standard ERM methodology, the starting point for a health risk assessment (HRA) is the identification of hazards using a "hazard catalogue", described in the following section. This hazard listing should not be considered exhaustive; the inclusion of hazards that are not listed in the current iteration of the risk catalogue is encouraged, particularly when those hazards have manifested into "real risks", or present a high level of harm. Evaluation of previous risk events is particularly important in conducting a robust risk assessment, as well as in developing a thorough hazard catalogue. Previous risk events that have occurred can assist in a better understanding of the impact and severity those risks may entail.

Hazard vs Risk

Hazard is defined as an object or situation that might cause harm.

Risk is defined as the likelihood that the exposure to the hazard will cause injury, illness, or death if exposed to the hazard together with an indication of how serious the harm might be.

Risk= Severity/Impact x Likelihood

Hazard Catalogue for Health Risk Assessment

UNMD and UNSSCG have worked collaboratively to develop a hazard catalogue specific to the UN operating environment. This is not an occupational health and safety inspection (which looks at work processes and work stations) but a high-level assessment of the hazards that arise from being in a specific operational context. In view of the unique operational contexts in which UN personnel operates, certain hazards must always be assessed while others can be included/excluded based on local context.

UNMD and UNSSCG Hazard Catalogue :

- **Physical (Trauma):** Motor Vehicle Accidents, Malicious Acts/ Physical Trauma, Workplace Injuries/Illness, Unsafe physical environment, Other

- ***Infectious Disease***: Vector Borne, Water Borne and food borne, Human to human, Zoonotic

- ***Environmental Factors:*** Air Pollution, Temperature (Heat/Cold), Altitude, Envenomation, Radiation, Shelter/Accommodations, Natural Disasters

- ***Psychosocial Hazards:*** Job Content, Control, Work overload & Work Pace, Work Schedule, Environment & Equipment, Role in Organization, Organizational Culture & Function, Career Development, Interpersonal Relationships at Work, Home Work Interface, Substance Abuse & Misuse, Workplace Violence including bullying, mobbing, third party violence, Direct threat to life

- ***Context specific hazard not otherwise classified:*** Includes any additional information as described above.

The duty station assessors and a UNMD steering committee (Medical Directors and Staff Counsellors of organizations with staffing footprint in country) will choose which hazards are most relevant for the duty station, based on desk review and consultations with country team and staff representatives.

Desk Review

The DS-HRA begins with a desk review and is followed by detailed interaction with personnel (staff and managers) in the duty station. WHO country reports usually contain information about infectious diseases risks, natural disasters, motor vehicle accidents, and the state of the healthcare system. Other useful sources of information include sick leave data, medevac data, the security risk assessment, staff health risk survey and program criticality assessments: to this effect please refer to the list of potential sources of information in Appendix 7.

The UNMD will establish a steering committee (which will include at last one counsellor) to guide a DS-HRA. This steering committee will determine the membership of the assessment team and scope of the assessment.

The Steering committee and assessors will have an initial kick-off VTC to share information and determine the key deliverables for the assessment. They will be able to provide the assessors with additional information, much of which will not be available in the public domain. The Steering committee will review the draft report and health support plan submitted by the assessors.

The **time horizon** and review period for the risk identification should typically be of two years, in line with the strategic planning cycle of the organization. Beyond desk review, a number of techniques should be used for these purposes, ranging from risk questionnaires and surveys, data analysis of actual health events/problems in the duty station, workshops and interviews.

The local managers and staff should be involved in developing the duty station health risk assessment, to ensure engagement and ownership, and to increase the likelihood that they will act diligently to address and action on the results.

Risk Questionnaires and Surveys

Risk questionnaires and surveys should be used in any health risk assessment based on occupational health research. It is useful and a cost effective way of gathering information in an anonymous manner from a large number of participants in a relatively limited period of time; however their contribution to an effective assessment process is limited by several factors, among which is the risk of bias derived from self-reporting, the usually low response rate, and potentially , the fact that they may be perceived as a bureaucratic exercise failing to stimulate proper thinking and discussion on relevant risk areas. They are therefore not a substitute for interviews, but should certainly be a complement to other means of data collection. Whenever possible, the team should consider using standardized health surveys that

have strong validity and reliability in multicultural environments. Until this is possible, if the team designs a risk survey, keep it simple – remembering that data collected must be analyzed. See Appendix 1 for a sample risk survey.

Risk Interviews & Discussions

In this perspective, one-on-one risk interviews with the members of the senior management team and staff representatives are an effective and powerful tool. They stimulate important conversations about risks, contributing to the progressive creation and strengthening of a risk aware culture at all levels. The number of interviews depends on the size and governance of the duty station. They should include all the members of the senior management team and an appropriate representation of field offices or areas and sections with specific focus. As a general guidance, the UN experience shows that a number of interviews between 20 and 30 should provide a comprehensive and balanced range of responses.

One-on-one risk interviews also give the opportunity for confidentially expressing concerns to senior officials for those who may be uncomfortable in sharing sensitive information in a group setting. Senior officials could also choose to hold **small workshops** instead, inviting a small group of their closest advisors, should they prefer so. Workshops are an excellent opportunity for sharing risk information, thanks to the enriched discussions they generate. One-on-one interviews can usually be completed in around 45 minutes to an hour; small workshops could take longer, in order to give all the participants the opportunity to participate in the conversation. When a psychosocial risk assessment is conducted by a Staff/Stress Counsellor based on the methodology described in this guide, the process includes small focus groups. This a good way to incorporate additional data to the overall DS-HRA, not only the psychosocial hazards.

Risk Analysis & Rating

Each of the identified hazards shall be then evaluated according to defined risk and internal control rating criteria, using a combination of impact, likelihood and level of internal control.

(i) **Likelihood** – The probability that a given event will occur in the specific duty station

(ii) **Impact –** The potential effects on health resulting from an identified hazard. The impact score is allocated on the basis of the worst-case but still plausible scenario, of what would happen if no prevention and no mitigation was in place. Malaria for example – death is entirely plausible if not treated.

(iii) **Level of Internal Control Effectiveness (ICE)** – The perceived effectiveness of the internal controls, processes and activities in place to manage or mitigate a risk. In this context, internal controls are defined as the processes effected by an entity's governing body, management and other personnel, designed to provide reasonable assurance regarding the achievement of its set objectives.

The Organization has defined the scoring criteria for the measurement of impact, likelihood and level of control effectiveness in mitigating risk at the Secretariat entity level, as seen in Tables 1, 2 and 3. To see how the health and medical risks align with other elements in the full Enterprise Risk Management System, see Appendix 2.

Table 1: Likelihood Rating

LIKELIHOOD			
Rating		**Certainty**	**Frequency**
1	Rare	< 10%	Every 10 years or beyond - rarely
2	Unlikely	< 30%	Approximately every 7-10 years
3	Likely	< 60%	Approximately every 3-7 years
4	Highly likely	< 90%	Approximately every 1-3 years
5	Expected	> 90%	At least yearly and/or multiple occurrences within the year

Table 2: Health Impact Ratings

HEALTH IMPACT		
Rating		Description
1	Low	Less than one month inability to work, sick leave (HR Level)
2	Moderate	Single long-term injury or illness resulting in temporary inability to work from 1 to 6 months
3	High	Significant injury or illness resulting in temporary inability to work for 1 staff member for more than 6 months, or multiple staff members (2 or more) from 1 to 6 months; No deaths or permanent injury
4	Significant	Single death, permanent inability to work (1 person), multiple hospital admissions; Temporary loss of function: ≥2 persons for ≥ 6 months
5	Critical	Multiple (2 or more) deaths, multiple permanent inability to work, MCI; Temporary loss of function: N/A

Inherent Risk Exposure (IRE)

In the work of risk management, inherent risk is the risk present before controls are put into place. Once risk rating is completed, inherent risk exposure is calculated using a simple mathematical formula:

Risk exposure = $\sqrt{(Impact\ x\ Likelihood)}$

IRE: This number represents the unmodified risk – before any controls are in place.

Internal Control Effectiveness (ICE)

Many risks in a duty station will already have some controls in place so the risk assessment is not complete until the impact of those controls is evaluated. They are scored according to perceived effectiveness from 1-5 (5 being highest indicating most effective). ICE ratings can be seen in table 3. The proper assessment of internal controls will depend on a thorough understanding of their intended purpose – i.e. how they intend to reduce the likelihood or impact of a defined risk, and their operational effectiveness.

Table 3: Internal Control Effectiveness (ICE)

INTERNAL CONTROL EFFECTIVENESS (ICE)		
Rating		**Description**
1	Highly ineffective	Controls and/or management activities are non-existent or have major deficiencies and do not operate as intended. Controls and/or management activities as designed are highly ineffective in efficiently mitigating risk or driving efficiency
2	Ineffective	Limited controls and/or management activities are in place, high level risk remains. Controls and/or management activities are designed and are somewhat ineffective in efficiently mitigating risk or driving efficiency
3	Significant improvement needed	Key controls and/or management activities in place, with significant opportunities for improvement identified
4	Limited improvement needed	Controls and/or management activities are properly designed and operating somewhat effectively, with some opportunities for improvement identified
5	Effective	Controls are properly designed and operating as intended. Management activities are effective in managing and mitigating risks

There are two directions in which a control aims to reduce the inherent risk exposure – by either reducing the likelihood or the impact. Because inherent risk exposure comes from both, reducing either the impact or the likelihood will reduce inherent risk. In reality, not all risks can be prevented, so robust risk management looks at both prevention and at mitigation.

They are not however, equal. Measures to reduce likelihood (prevention) are generally considered preferable to measures to reduce impact (mitigation). For example, it is better to have good brakes on a car and avoid the crash altogether, than to have excellent medical systems for resuscitating the critically injured.

In practice one will identify and rate the effectiveness of multiple relevant internal controls for each hazard. This will help to prioritize the risk treatments by identifying those controls not yet properly implemented at that duty station.

Controlling exposures to hazards is the purpose of a DS-HRA. When looking at the internal controls the effectiveness is assessed through the traditional hierarchy of control concept which is presented in Figure 1. The control methods at the top of the graph are more effective and protective than those at the bottom. *Elimination and substitution* are most effective at reducing hazards but are often the most difficult to implement in existing system.

Hierarchy of Controls

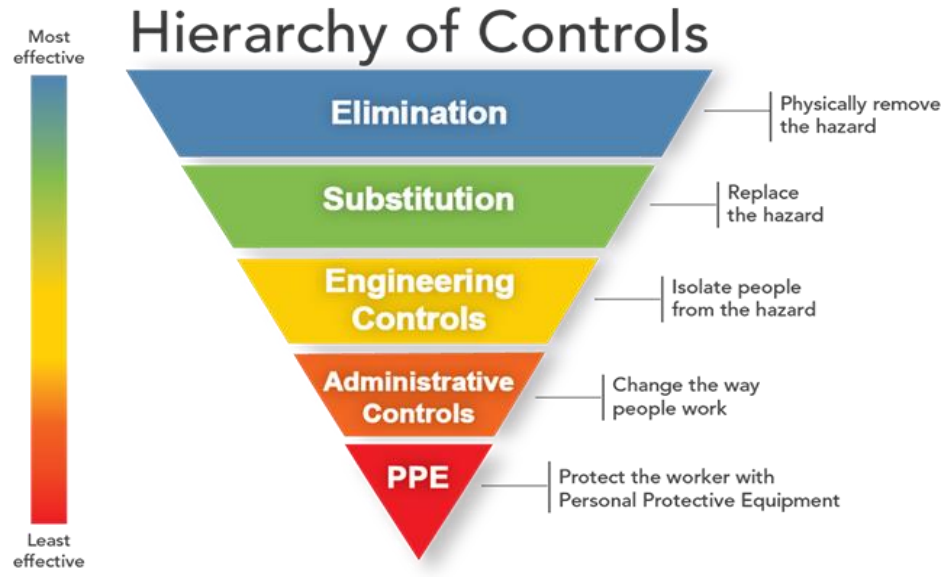

Figure 1: Hierarchy of Controls

To rate their overall combined effectiveness, the assessors need to go back and review if the controls change impact and/or likelihood of the risk. This is an estimate, based on input from the duty station about how frequently this particular risk is a "realized" risk, and the information about how completely and thoroughly controls are implemented at the duty station. The assessment will flesh out the strength of those controls.

The ICE assessment allows to analyze, for the purposes of communication and education of the risk owners, what are the gaps or incomplete implementations of their risk controls. Note – the overall or aggregated ICE is what matters from the risk rating and prioritization perspective.

Residual Risk

Residual risk is the risk remaining after management has taken action to alter the risk's likelihood or impact (internal controls), and the starting point for determining the appropriate treatment response.

Residual risk = Inherent Risk exposure – Internal Control Effectiveness

RR= IRE - *Aggregated* ICE

Example of Risk Rating

Example Malaria in South Sudan:
Malaria is endemic in the duty station where the assessment took place. The WHO country fact sheet and sick leave data was consulted by the assessors.
The **likelihood** of a Malaria infection was expected, therefore **5**.
The **health impact** of an untreated Malaria infection is critical, often resulting in death, therefore **5** as well.
The result of the present risk rating (**IRE, inherent risk exposure**) before modification was consequently also **high: 5** (square root of impact x likelihood)

Now for Malaria there are multiple controls available such as prophylaxis, bed nets and vector control. Each identified control should be rated separately, this will help to target the recommendations for mitigating the risk (the available tool will support the assessors to calculate the remaining risk after controls effectiveness are being assessed)

However, for the overall risk rating of Malaria, an aggregated ICE is needed. In the example of South Sudan, the internal controls suggested were:
- Malaria prophylaxis (ICE 3)
- Malaria nets and window screens and individual chemo prophylaxis (ICE 2)
- Malaria vector, environmental control (ICE 2)
- malaria awareness campaign among personnel (ICE 1)
-> Aggregated ICE: 2
Note: The aggregated ICE is an overall estimate, not an average, of the combined effectiveness of the risk controls.
The remaining risk (residual risk) is therefore 3, rather high.
The next step is a risk treatment plan, suggesting actions to increase the aggregated ICE and thus to lower the residual health risk.

In this example it is suggested to establish the following actions:

- Ensure Malaria prophylaxis is available and incoming personnel is being briefed
- Intensify communication and promotional campaign for prevention measures at duty station and for home environment of personnel
- Readily available guidelines and health risk mitigation plans for personnel in the appropriate languages

Risk Stratification

Risk stratification allows for classifying various levels of exposure for each duty station based on the organizational needs of that location. Based on the consideration of the level of residual risk, and most importantly judgement on contributing factors and the information gathered during the risk assessment process, risks shall be classified into three tiers by the assessment team, ranging from “very high & high”

to “medium”. These tiers should be set independently by the assessment team with management at the duty station in order to best fit their needs to prioritize the health of staff in this process. This allows the assessment team to offer a concrete assessment of the hazards with risk classifications for management to decide on acceptable vs. unacceptable risks and to prioritize actions accordingly.

While there is not a “score” that indicates a hazard as Tier 1, Tier 2 or Tier 3, the hazards that rate high in IRE and low in ICE should be strongly considered for Tier 1 (mandatory action required) especially if there are internal controls that can easily be implemented. This allows managers to act on their own organization’s risk appetite, and focus attention on the highest priority risks. For example, a manager may have identified an area with a very high residual risk, but has implemented every known control, effectively and thoroughly. Although this residual risk is high, there is simply nothing more to be done about it. The risk must be accepted, or not accepted (see example below). Allowing managers to participate in determining which of their hazards go into Tier 1 ensures their commitment to actively manage, and drive down residual risk of those risks that are modifiable. This allows a focus on achievable results, and avoids the situation where managers eventually ignore the risk management plan because it is full of elements that are outside their control.

Example of Risk Stratification

A duty station has high risk of air pollution and respiratory illnesses due to local work and lack of environmental protections at the country level. The health support plan is to offer staff health education and appropriate masks to use during the peak hazard exposure but overall, there is no further action possible aside from medically screening to assure that high risk individuals (i.e. asthma patients) are not relocated to this location. The organization (i.e. senior managers) need to decide that this location is necessary for the work and therefore, the risk is acceptable OR they decide that the hazard and risk is too high and non-essential staff are moved from the location until air quality improves.

Very High risks (*Tier 1*, mandatory action) are the most significant risks to which the department or office is exposed to, and will require priority attention. They shall be reported to the relevant Head of Office or Department, and the central Health Risk function (UNMD), so that appropriate action and/or interagency cooperation to manage systemic risks can be coordinated. Addressing Very High Risks will be a core element of the Health Support Plan, and measures to address very high risks should be mandatory.

High risks *(Tier 2, Strongly Suggested)* includes risks from hazards that requires action to correct to reduce the risk. This action is strongly suggested.

Medium risks *(Tier 3, Optional)* will typically require specific remedial or monitoring measures under the responsibility of the specific Risk Owners and local Risk and Internal Control Focal Points, under the overall guidance of the relevant Head of Office or Department.

Risk Tiers should be allocated in partnership with the implementing team. Health risk management plan is not something that the UNMD can impose on the Regional Coordinator and country teams but should be a partnership. Any disagreements between the assessment team and the managers on the Tier 1 classification should be documented but this should be avoided through a collaborative relationship throughout the process from desk review (prior to visit/meetings through the DS-HRA report draft).

Risk Heat Map

A tool should be used to calculate the IRE & ICE map for each hazard identified. The **Risk Heat Map** is a four-quadrant chart as depicted in Figure 2 below, provides a graphic representation of the results of the risk assessment, and has in particular the function to show level of risk exposure and level of internal control effectiveness. This tool can be used to assist management in the determination of appropriate risk treatment strategies and risk mitigation measures.

Reading a Risk Heat Map

Each quadrant of the Risk Heat Map suggests different treatment of those risks. The Risk Heat Map plots each hazard assessed with the IRE on the Y axis with 5 (greatest risk based on likelihood and impact) at the top and the assessed aggregated ICE along the X axis with 1 (highly ineffective) on the left side. Based on this mapping, the top left corner shows the highest risk hazards with highly ineffective controls in place. Everything in this "risk reduction (required)" quadrant should be considered for a tier 1 or 2 health treatment plan. The assessment team can also use the map to re-evaluate the risks overall and generate discussions with team and managers. The goal is to move hazards from the "risk reduction" quadrant to the bottom right "risk optimization/acceptance" or at least the top right for hazards that are not within our control to decrease.

For example, in Figure 2, the risks characterized by a high inherent risk exposure and ineffective internal controls fall into the "Risk Reduction" quadrant. Many of the risks found in this quadrant are also found to be very high risks (Tier 1) or high (Tier 2) by the team, suggesting that these are appropriate targets for further investigation to reduce exposure to that risk (through impact or likelihood decrease) and/or improved internal controls.

Example of Risk Heat Map

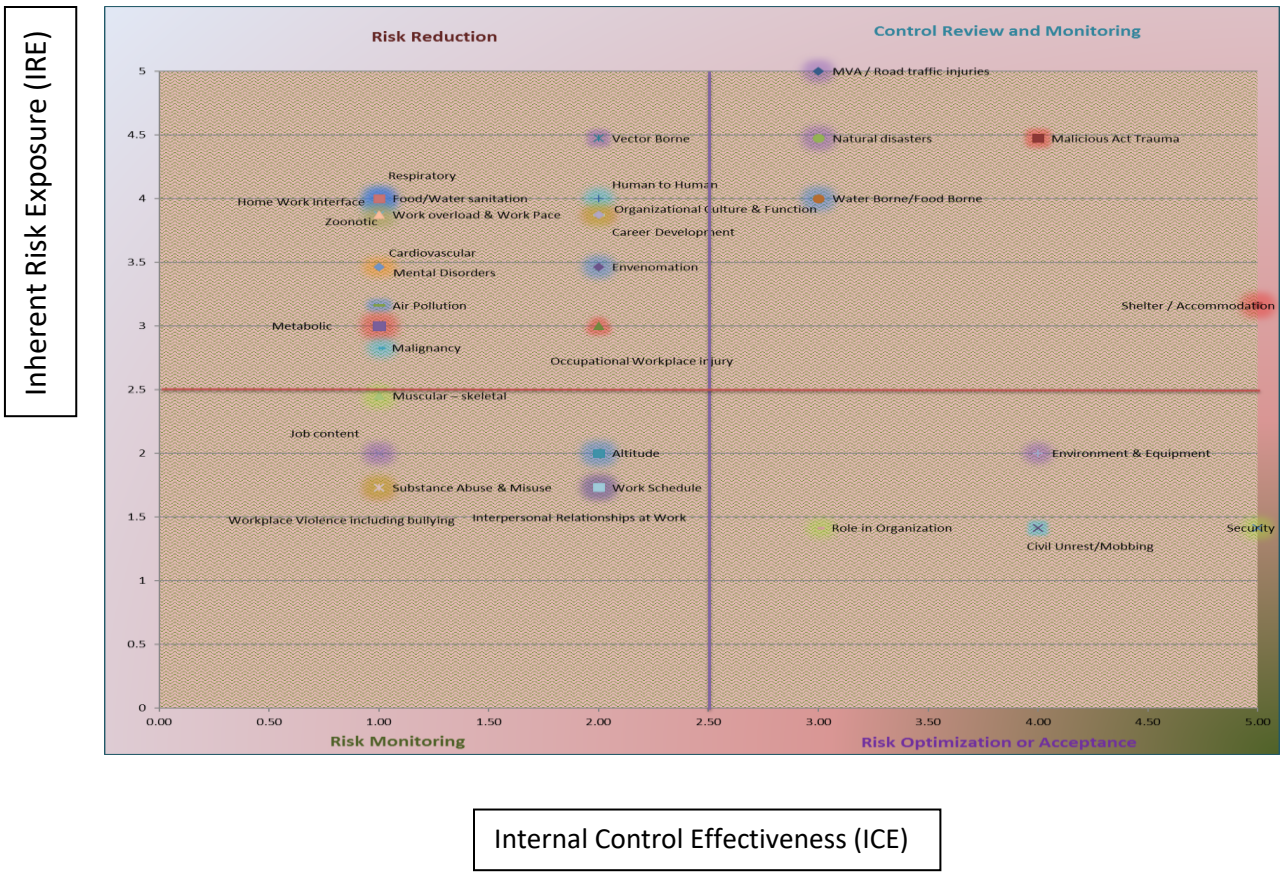

Figure 2: Example Risk Heat Map

Risks found in the "Control Review and Monitoring" quadrant may be appropriately controlled with low risk exposure although many risks that fall into this quadrant need to be frequently reassessed in order to provide assurance of the ongoing effectiveness of the internal controls.

Within the "Risk Monitoring" quadrant, these risks have inherently low risk exposure and low internal control effectiveness. Risks that fall into this quadrant, even if they do occur, would result in only modest impact and generally do not warrant further improvements to internal control effectiveness.

Finally, the "Risk Acceptance/Optimization" quadrant displays low risk exposure risks with high levels of internal control effectiveness. As such, these risks may generally be accepted, although assessments may be performed to evaluate whether these internal control activities are worth the cost of implementation given the low risk exposure.

Map Example: Respiratory is mapped as one of the highest IREs & lowest ICE plotting in the top left quadrant for the example in figure 2. In the assessment tool, the team identified the hazard related to respiratory conditions is heavy dust and pollution due to temporary road construction. Since no internal controls were in place, the ICE was 1 (highly ineffective). The assessment team identified this as a tier one recommending that the local medical officer should begin an educate campaign to all staff members on the appropriate masks and procure for all staff and family members at the duty station. Health education is also recommended. While the UNCT has no ability to control the inherent risk of road construction, there are internal controls that can easily be implemented. Doing so would move this

hazard which has a temporarily high inherent risk (one-year road construction plan) to the top right quadrants by implementing improved ICE.

Specialty Assessment: Psychosocial Health Risk Assessments (P-HRA)

Similar to the overall DS-HRA, the P-HRA ideally takes into account the overall healthcare facilities available to staff members at the duty station when assessing the identified Psychosocial Hazards (PH). As agreed upon by the UNSSCG Psychosocial Health Risk Assessment Working Group (P-HRA WG) and UN MSD PM, the PRIMA-EF was used as a guiding resource for the P-HRA.

P-HRA Methodology

Based on the existing literature and the methodology piloted by the P-HRA Project Manager for MSD, and in order to maximize the accuracy of the assessment and to facilitate a comparative process across different UN bodies and duty stations, it is suggested conducting P-HRAs in line with the guidelines by the P-HRA WG outlined in Appendix 4 and as shown in Figure 3 below.

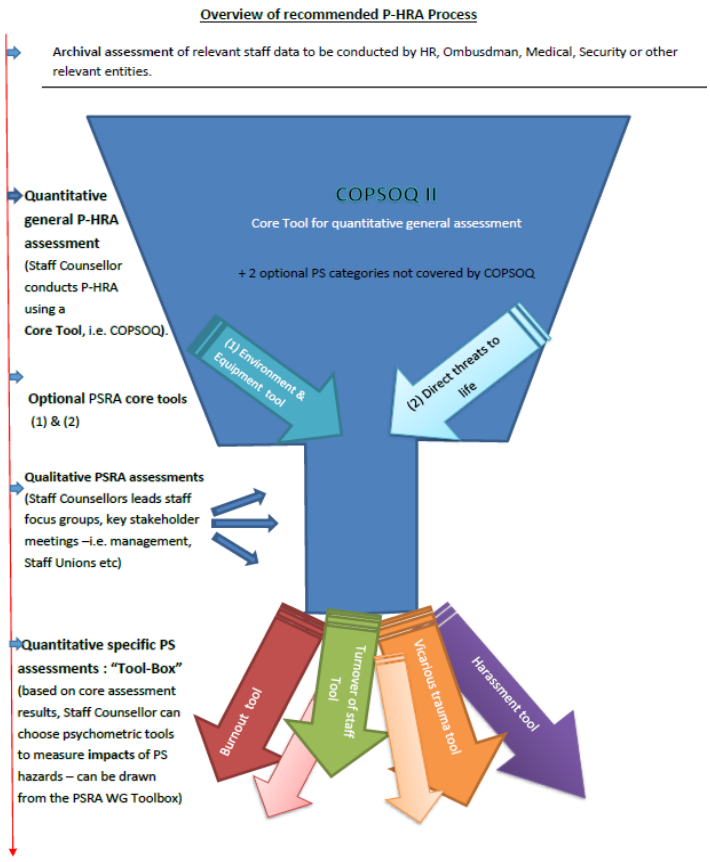

Figure 3: Recommended P-HRA Process

The assessment of psychosocial hazards is complex and requires that the assessment is done by a mental health professional who is trained on the UN P-HRA methodology and specific psychosocial risk hazards (PRH)[1].
As suggested for the medical component of the DS-HRA, if possible, the local counsellor should not facilitate or provide the assessment to decrease the risk of bias or conflict of interest. In general, the conflict of interest would sit in the assessment of control and an additional Counsellor's involvement in leading the focus group discussions (onsite or remotely) should be considered especially in small duty stations where the Counsellor's lead may influence outcomes. The use of technology can also be considered for future assessment which may help to decrease any potential conflict of interests. Decisions on the appropriate Counsellor or mental health professional for an assessment should fall to the UN SSCG for consultation. However, the local counsellor should be interviewed for the overall DS-HRA/P-HRA.

The P-HRA assessment requires a multimethod approach encompassing the following:

- Individual meetings with staff members, senior management team, medical officer, nurse, and stress/stress counsellor, etc.
- Meetings with external providers (Ministry of Health, medical and mental health providers)
- Group Meetings (town hall, staff association meetings, etc.)
- Group discussions on Psychosocial Risk Hazard
- Data review of the internal and external resources
- Validated & Reliable survey on PRH (see recommendation of tool by P-HRA WG)
- 1-2-week mission observations by assessment team
- Visits to local healthcare providers who treat (or will potentially treat) UN Staff.

Psychosocial Risk Survey

The P-HRA Working Group provided recommendations of the use of a core tool and a protocol for conducting psychosocial health risk assessments (see Appendix 4).
The Copenhagen Psychosocial Questionnaire, second version (COPSOQ II) is recommended by the P-HRA WG to be used as the core tool in Psychosocial Risk Assessment, for the following reasons:

1. It is a reliable and valid instrument for use at different levels and it has been specifically developed constructed with the goal of making international comparisons and improving the quality of interventions in the working environment. Therefore, the COPSOQ can be used to assess risk and the decision-making process about preventative measures, but also as a risk management tool to determine the efficacy and effectiveness of controls put in place after the risk assessment. The COPSOQ II successfully integrates key elements of Job-Strain, Demand-Control-Support and Effort-Reward Imbalance, which are critical components of a psychosocial risk assessment in the UN. In addition, the COPSOQ II contains scales to assess meaning of work, commitment to the organization and organizational justice.

2. The COPSOQ II has three versions: 128, 87 and 40 items respectively. Since the 128-item version is more for research purposes the P-HRA WG recommends to use the medium 87-items version of COPSOQ II for the assessments. The short and medium versions of COPSOQ II are readily

[1] Methodology & PRH list developed by the P-HRA Project Manager/Chief Staff Counsellor UN MSD and the UNSSCG P-HRA Working Group (P-HRA WG).

available at no cost: http://www.arbejdsmiljoforskning.dk/en/publikationer/spoergeskemaer/psykisk-arbejdsmiljoe.

3. Issues that are flagged in the results could be further investigated using additional assessment tools (see Section III).

4. As the COPSOQ II does not include a question to assess the categories "Direct threats to life" or "Substance Abuse", the questions will be added to allow for subjective experience of exposure to such threats.

5. The scoring system is simple and allows the use of the COPSOQ II in all types of workplaces. Minimal technical resources are required to calculate results in small duty stations or missions.

Psychosocial Risk Hazards Groups

In accordance with the recommendations and following the methodology the P-HRA assessment should include the following PRHs:

- Job Content
- Control
- Work Overload & Work pace
- Work Schedule
- Environment & Equipment
- Role in Organization
- Organizational Culture & Function
- Career Development
- Home Work Interface
- Interpersonal Relationships at Work
- Substance Abuse & Misuse
- Workplace Violence (bullying, mobbing, or third-party violence)
- Direct threat to life

In locations where there may be a lack of ongoing stress management training, it is advised to offer training workshops on the topic of "Stress Management" combining individual stress management with organizational Psychosocial Risk Hazards training and focus group discussions. Below are suggested training methods on group work.

Group Work Part I (Stress Management Training)

The initial part of the training workshop is designed as a basic stress management workshop for individual stress (1-1.5 hours based on group size). The Stress management training should be provided by a Staff/Stress Counsellor through, for example, a dialectic workshop with PowerPoint presentation and group exercises. The announcement of the training should include all staff with encouragement to attend the workshops covering the following topics:

- Define different kinds of stress
- Signs/symptoms of stress
- Challenges of workplace stress for UN staff & managers
- Understanding workplace stress as a psychosocial & health hazard

- Exercise: Complete your Personal Stress Profile
- Self-care
- Exercise: Organizational Psychosocial Hazards

This introduction session allows the group to look at their own individual stressors and coping skills and to get the discussion started using a common language and understanding of stress and stressors (or hazards).

Group Work Part II (Organizational Psychosocial Hazards Focus Groups)

The second part of the training requires approximately 1.5-2 hours (depending on the group size) and can be conducted as a stand-alone interactive focus group via a PowerPoint slide presentation. It will describe each of the psychosocial risk hazards (PRH) in detail prior to breaking the participants into smaller focus groups (ideally 3-5 persons in each group). The focus groups are provided with large white sheets/flip charts, a set of pre-printed cards with each describing a different PRH, and a marker. The groups are instructed to complete the following tasks:

> *(1) Use the PRH cards to do a card-sorting exercise as they discuss each hazard as it relates to their current duty station and UN staff (not UN system but the local duty station). Using the cards to guide the discussion, the group should place the cards in order from the most significant and impactful in this location being #1. They will then be asked to list them in order on the white sheet which will be displayed for the larger group discussion. They only need to list those they find to be hazardous in the duty station.*
>
> *(2) Brainstorm and list what they see the duty station or organization is trying to do to help them with the identified hazards.*
>
> *(3) Brainstorm and make a wish list of what they think the organization should/can (realistically) do to help staff deal with the identified hazards.*

The smaller groups will then split into different location/areas but the Staff/Stress Counsellor should check in for questions and clarifications and to monitor time for regrouping. It generally takes approximately 45 minutes for this exercise (longer for larger groups).

Following the small groups work, the participants come back together and each group presents its outcomes allowing for discussion. The Staff/Stress Counsellor guides the discussion, asking for clarification as needed. The Staff/Stress Counsellor also marks the sheets with star (*) for repeated PRH noting the themes from the different groups. The sheets are kept by the trainer for assessment after the mission in identifying themes.

Variation: When the visiting Medical Officer is also onsite, he/she can join the discussion if possible. For example, when on HRA mission the Staff/Stress Counsellor is leading the training and group discussions and the Medical Officer assessing the mission joins for the end of the session to hear the participants discussion on PRH specific to the location.

Resources: All UN Counsellors should be trained in the P-HRA methodology for consistency in P-HRAs globally. Psychosocial Health Risk Assessments should not be conducted by practitioners who are not Mental Health Professionals and who are not familiar with the UN System and the UN DS-HRA/P-HRA methodology.

Mandatory Health Support Elements

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 are:

- Primary Care[2]
- Hospital Care[3]
- Mental Health Services[4]
- Mass Casualty Incident Plan[5]
- Medical Emergency Response[6]
- Access to pharmaceuticals (including PEP)

The mandatory health support elements should, where possible be provided by external providers. Assessment of local healthcare facilities will allow a determination of their suitability for use by UN personnel in the overall duty station Health Support Plan.

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. For this reason, the desktop review and as much of the DS-HRA (with hazard identification) should be completed prior to the start of the assessment of Mandatory Health Support Elements. A full review of the healthcare facilities should be completed by a healthcare professional.

Local Healthcare Capability Assessment

Following the analysis of the Local Healthcare Capability Assessment, identify which parts of risk control and mandatory health support elements can be safely outsourced to reputable local providers.

In assessing suitability of external healthcare facilities and services, a structured assessment, reflecting international consensus on the elements of healthcare quality should be undertaken. Evaluation may include the following quality domains:

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[2] Primary care is 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 gynecological 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 providers, and they are trained to deliver it. The health support plan must have express reference to women's' health emergencies.

[3] 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

[4] Access to Mental health professionals either in person or via telehealth

[5] The Mass Casualty Incident Plan (MCIP), 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.

[6] IFAK, ETB, Ambulance providers, Emergency Departments, casevac and medevac.

- Accessibility (wait-time for appointments/admission and acceptance of UN health insurance) and the level of qualifications of key medical personnel who are providing services at the facility.
- Safe: Avoiding harm to patients from the care that is intended to help them, and ensuring that procedures are in place to give assurances that only qualified personnel are delivering services.
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Sample of Mandatory Health Support Elements (MHSE)

MHSE Gap Analysis & Risk Controls										
	Element Description	Residual Risk Score	Recommended risk controls (joint recommendations from	Local Provider available and accessible as	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
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	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	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

Table 4: Mandatory Health Support Elements (MHSE) as shown in the tool

Consideration of variety of models of care

A model of care is a method for delivering healthcare. This can be traditional (e.g. a doctor's clinic), or innovative – (e.g., telehealth). Both mode of delivery and responsible personnel can be flexibly considered when making recommendations to deliver the lowest cost, most effective care.

Some examples of models of care to deliver the requirement for Primary Care include:

1. Use local external providers exclusively.
2. Use local external providers, but also have a nurse internally, who knows local providers and can assist staff to navigate system
3. Use local external providers, but also have a doctor internally
4. Have a UN Clinic that delivers all primary care except women's health, and outsource women's health
5. Have a UN clinic that delivers all primary care.

A decision to resource healthcare internally (e.g. through a UN clinic, and occupational health nurse, or by the WHO Office) should only be taken after consideration of the risk profile and the mandatory health support elements, how effectively the local external resources mitigate that risk (gap analysis), and whether adding an internal UN health resource would have a significant impact on key risks.

Risk Treatment & Health Support Plans

The Risk Treatment & Health Support Plans are built from the merging of the prior steps of the DS-HRA, for the purpose of health planning for the UN Personnel. This requires that Hazard/Risk and individual control assessment and the assessment of local healthcare capabilities are completed prior to starting this stage. These items feed into the Risk treatment recommendations and the Mandatory Health Support Elements. The following section describes the process to merge these and formulate a cohesive Health Support Plan.

The Risk Treatment Plan

The Risk Treatment plan is developed based on the hazard & risk assessment done through the desktop review, interviews, surveys, site assessment and local healthcare facility assessment. The purpose is to make recommendations on controls to introduce, to continue, to substitute and/or to cease. To be effective in reducing residual risk, controls must either reduce the inherent risk, or increase the internal control effectiveness (or both). The recommended risk treatment should be expressed ***as actions***, (for example, implementation of vector control program) ***not resources*** (e.g. environmental health officer/function). Resourcing the controls is a second step that can be more appropriately done when the entirety of the risk treatment plan is understood.

It is necessary to introduce a risk control when a risk has a low internal control effectiveness (i.e., the management interventions to date are not effective), or when despite some controls, the residual risk is still high. Such risk controls can be in addition to an existing control, or can be substituted for an existing control that is either ineffective, or more resource intensive. If there is a risk that is over-controlled (i.e., low inherent risk exposure, and high internal control effectiveness), then consideration

should be given to transferring resources away from controlling that risk, and onto another, higher priority risk.

The assessment team and appropriate healthcare professionals (from medical, nursing, and counselling) will decide on the most appropriate risks to address in the treatment plan. While they may opt to address only the high-risk areas using the heat map as a guide, all hazards can be addressed if assessment team should opt for this option. The Steering committee can help guide this evaluation.

Risks that are mapped in the upper left quadrant (Risk Reduction) of the risk heat map are the highest priority in the health support plan. This will mostly comprise Tier 1 and Tier 2 risks. The goal is to "move" risks into either the upper right or lower left quadrant, by introducing treatments that lower either likelihood, impact or both.

Prioritization of risk treatments, using the Risk Heat Map and Residual Risk Scores

While the heat map is a good guide for identifying which risks to address, the RR is another area for consideration. In this Risk Treatment Plan, the assessment team will consider which actions are recommended as risk treatment (e.g. new or improved internal controls) for the individual hazard and what the new projected RR will be if fully implemented.

Evaluate the likely impact of proposed risk treatments. This can be expressed as a "Projected Residual Risk", and doing so will allow managers to see the potential benefit of proposed risk treatments. The risk treatment plan will include recommendations.

Selection of Risk Treatments

Based on the projections of impact and consideration of effort, some risk treatments will stand out as very worthwhile, and others will be less attractive. A risk treatment plan might include some elements that will make a smaller difference, but with immediate effect, whilst planning for "major project" type reforms as a second wave. Because treatments are expressed as actions, not resources, the end result of this activity is a "to do list" for the management team.

Give consideration to whether the mandatory health support elements will adequately address the risks, or whether additional risk controls are necessary. Where necessary, propose risk controls that are additional to clinical service delivery.

Assignment of Responsibility to the Actions

Once the necessary risk control actions are mapped, it is time to think about who will be responsible for the necessary actions. Some risk controls will be able to be very appropriately mapped to existing personnel or external resources. However, some risk controls will require the introduction of new resources, or the reshaping of existing controls. In the initial phase, the risk treatment plan might have multiple internal and/or external resources listed against specific actions pending evaluation of suitability of external resources, and cost-benefit analysis of the options.

Finalizing the Health Support Plan

The final health support plan will list the Mandatory Health Support Elements, and the recommended method for delivery of these. It will then list the Health 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 HRA.

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.

Engagement with the Duty Station and Country Team

The UNMD established a SOP, see Appendix 8, for the process of a duty station health risk assessment and the communication with the country team, after finalizing the report and its recommendations. The final report will be provided to the Country Team via the Resident Coordinator. The UNMD will engage periodically with the Country Team to support implementation of agreed measures.

Appendix 1: Health Risk Assessment Survey (sample)

Introduction

This short survey is part of a Health Risk Assessment for your duty station. Your responses will contribute to the planning of health support services. Thank you for taking the time to share your knowledge with the Risk Assessment Team

Risk Ratings

The following questions list risks from the Health Risk Cataloge. Please rate how likely you think it is that the following things could happen to you or a colleague at some time during the next 2 years.

1. How likely is it that you will be affected by....

	Extremely Unlikely	Unlikely	Possible	Very likely	Almost certain
Motor Vehicle Accidents	○	○	○	○	○
Malicious Acts	○	○	○	○	○
Workplace	○	○	○	○	○
Others	○	○	○	○	○

Other (please specify)

2. How likely is it that you will be affected by....

	Extremely Unlikely	Unlikely	Possible	Very likely	Almost certain
Malaria	○	○	○	○	○
Other insect-transmitted diseases	○	○	○	○	○
Typhoid, Cholera or Hepatitis A	○	○	○	○	○
Influenza	○	○	○	○	○
HIV	○	○	○	○	○
Hepatitis B or C	○	○	○	○	○

Other (please specify)

3. How likely is it that you will be affected by....

	Extremely Unlikely	Unlikely	Possible	Very likely	Almost certain
Air Pollution,	○	○	○	○	○
Heat/Cold	○	○	○	○	○
Altitude	○	○	○	○	○
Snake, spider or scorpion envenomation	○	○	○	○	○
Radiation	○	○	○	○	○
Contaminated Water supply	○	○	○	○	○
Petty crime	○	○	○	○	○
Problems with obtaining or keeping accommodation	○	○	○	○	○
excessive noise	○	○	○	○	○
vibration	○	○	○	○	○
inadequate lighting	○	○	○	○	○

Other (please specify)

4. How likely is it that you will be affected by....

	Extremely Unlikely	Unlikely	Possible	Very likely	Almost certain
Excess alcohol consumption	○	○	○	○	○
Recreational drug use	○	○	○	○	○
Work-related Stress	○	○	○	○	○
Working in excess of 60 hours per week for more than 4 weeks	○	○	○	○	○
Difficult relationships with supervisors	○	○	○	○	○
Witnessing deaths or dead bodies	○	○	○	○	○
Having your own life at risk	○	○	○	○	○

Other (please specify)

Appendix 2: Enterprise Risk Management System

Impact									
Score	**Rating**	**Description of impact**							**Recovery**
		Health and Medical	**Safety and security**	**Duration**	**Organizational and operational scope**	**Reputational impact**	**Impact on operations**	**Financial impact (measured in terms of budget)**	**Required action to recover**
5	Critical	Deaths: ≥2 persons Permanent loss of function: ≥2 persons Temporary loss of function: N/A	Loss of life (staff, partners, general population)	Potentially irrecoverable impact	**Organization-wide:** inability to continue normal business operations across the Organization	Reports in key international media for more than one week	In ability to perform mission or operations for more than one month	> 5 per cent >$500 million	Requires significant attention and intervention from General Assembly and Member States
4	Significant	Deaths: 1 person Permanent loss of function: 1 person Temporary loss of function: ≥2 persons for ≥ 6 months	Loss of life due to accidents/non-hostile activities	Recoverable in the long term (i.e., 24-36 months)	**Two (2) or more departments/offices or locations:** significant, ongoing interruptions to business operations within 2 or more departments/offices or locations	Comments in international media/forum	Disruption in operations for one week or longer	3-5 per cent $300 million-$500 million	Requires attention from senior management
3	High	Deaths: N/A Permanent loss of function: N/A Temporary loss of function: 1 person ≥6 months or ≥2 persons for ≥ 1 month to < 6 months	Injury to United Nations staff, partners and general population	Recoverable in the short term (i.e. 12-24 months)	**One (1) or more departments/offices or locations:** moderate impact within one of more departments/offices or locations	Several external comments within a country	Disruption in operations for less than one week	<2-3 per cent $200 million-$300 million	Requires intervention from middle management
2	Moderate	Deaths: N/A Permanent loss of function: N/A Temporary loss of function: 1 person ≥1 month to < 6 months	Loss of infrastructure equipment or other assets	Temporary (i.e., less than 12 months)	**One (1) department/office or location:** limited impact within department/office or location	Isolated external comments within a country	Moderate disruption to operations	<1-2 per cent $100 million-$200 million	Issues delegated to junior management and staff to resolve
1	Low	Deaths: N/A Permanent loss of function: N/A Injuries with ≥1 month or no loss of function	Damage to infrastructure equipment or other assets	Not applicable or limited impact				<1 per cent <$100 million	Not applicable or limited impact

Appendix 3: Risk matrix

A common tool to graphically display risk is the **Risk Matrix**. Matrices have been used to show the intersection of likelihood of an event and the impact such an event might have. It allows for a gradient of risk assessment. However, such tools have largely been replaced by more detailed representations, such as Risk Dashboards and Residual Risk Heat Maps. Risk Matrices can still be converted to show quantitative metrics of Risk Exposure and that data can be transposed to Residual Risk Heat Maps. Figure 4 provides a useful tool in converting Risk Matrixes to Risk Exposure values used for building Residual Risk Heat Maps.

Risk Matrix to Risk Exposure Conversion Table

Impact						
Likelihood		**1**	**2**	**3**	**4**	**5**
	1	1.00	1.41	1.73	2.00	2.24
	2	1.41	2.00	2.45	2.83	3.16
	3	1.73	2.45	3.00	3.46	3.87
	4	2.00	2.83	3.46	4.00	4.47
	5	2.24	3.16	3.87	4.47	5.00

Figure 4: Risk Matrix

Appendix 4: UNSSCG P-HRA Recommendation, Protocol and Toolbox

1. Recommendation for a Core Tool for Psychosocial Risk Assessment

In a previous communication addressed by the UNSSCG to UN Medical Directors Group, November 2017, the "Psychosocial Risk Assessment Working Group" committed to provide recommendations of a core tool and a protocol for conducting Psychosocial Risk Assessments as a component of the overall Health Risk assessment framework (conf. UNSSCG document from Nov, 17, 2017)

Consequent to a comparative review of specialized literature and on the basis of on-going consultations between the "Psychosocial Risk Assessment Working Group" and the OHR- PM for MSD, three valid and reliable assessment tools were pre-selected:

1. ASSET (Faragher, Cooper and Cartwright, 2003)
2. COPSOQ – Copenhagen Psychosocial Questionnaire (National Research Centre for the Working Environment, Denmark – 1998 first version)
3. OrgFit (Jimenez & Dunkl, 2017)

The PRA WG acknowledges that all three instruments are valid and reliable tools for assessing psychosocial risk and all of them are acceptable measures of at least some of the categories that constitute the PRIMA Framework.

Taking into consideration not only statistical properties and consistency with the PRIMA framework, but also flexibility for use in different working environments/duty stations and costs and concerns about data ownership and storage, the **PRA WG recommends The Copenhagen Psychosocial Questionnaire, second version (COPSOQ II) as the core tool to be used in Psychosocial Risk Assessment**, for the following reasons:

4. It is a valid instrument for use at different levels and it has been constructed with the idea of making international comparisons and improving the quality of interventions in the working environment. This implies that the COPSOQ can be used to assess risk and the decision making process about preventative measures, but also as a risk management tool to determine the efficacy and effectiveness of controls put in place after the risk assessment. The COPSOQ II successfully integrates key elements of Job-Strain, Demand-Control-Support and Effort-Reward Imbalance, which we believe are very important components of PRA in the UN. In addition, the COPSOQ II contains scales to assess meaning of work, commitment to the organization and organizational justice.
5. The COPSOQ II has three versions: 128, 87 and 40 items respectively. The 128 item version is for research and for a thorough assessment, the WG recommends that the 87-items version of COPSOQ II is used whenever feasible. The short and medium versions of COPSOQ II are freely

available at no cost: http://www.arbejdsmiljoforskning.dk/en/publikationer/spoergeskemaer/psykisk-arbejdsmiljoe.

6. Issues that are flagged in the results could be further investigated through the use of additional tools (see Section III).

7. As the COPSOQ II does not include a question to assess the PRIMA category "Direct threats to life", items will be added to allow for subjective experience of exposure to such threats.

8. The scoring system is simple and allows the use of the short version of COPSOQ II in all types of workplaces. Minimal technical capabilities are required to calculate results in small duty stations or missions.

2. Proposed PRA methodology

Based on the existing literature and the methodology piloted by the P-HRA Project Manager for MSD, and in order to maximize the accuracy of the assessment and to facilitate a comparative process across different UN bodies and duty stations, the WG also suggests conducting PRA in line with the guidelines outlined below:

Before conducting the Psychosocial Risk Assessment, it is necessary:

i. To insert confidentiality & data protection elements as part of the introduction to the tool.

ii. To inform staff of the purpose of such an assessment and clarify that participation is voluntary

During the Psychosocial Risk Assessment

1. A review of available and relevant archival data, and previous staff surveys that have been conducted.

2. Quantitative Assessment: the COPSOQ II, 87-item versions, is administered by the HRA team prior to the mission and decisions are made whether to use the supplementary measures either prior to visiting the mission or during the visit.

3. Qualitative Assessment: **meetings with key informants**, such as Medical and HR personnel, Ombudsman and Conduct and Discipline Officers, Staff Union representatives and senior managers are necessary to collect qualitative data. The PRA WG recommends liaising and consulting with Occupational Safety and Health professionals whenever possible in order to ensure harmonization with policies and procedures in force in the organization/agency. Similarly, Risk Assessment professionals should be consulted with a view of including the psychosocial risks categories in already existing risk assessment registers or tools.

4. Additionally, in order to ensure participation and ownership, focus groups including staff members with different grades and positions or targeted sessions (following the methodology used in the MSD pilot missions) should be organized. This step will help the assessor in collecting

information on psychosocial hazards and internal controls already in place, and on the perceived effectiveness of the controls.

Outside of the formal HRA process, obtaining senior management buy-in for a PRA is paramount. The WG does not recommend starting a PRA unless there is a clear intention to take action with regard to corrective and preventative measures required as indicated by the results of the assessment. When a PRA is conducted, it should be repeated every 1-2 years in order to verify if improvements have been made.

It should also be noted that the PRA is a participatory process. Staff members at all levels should be involved and able to see the results of the assessment.

While acknowledging that it is the responsibility of the employer to ensure the conditions for a sound and reliable Psychosocial Risk Assessment, the PRA WG recommends that the UN Staff/Stress Counsellors are involved in the process of identifying the risks and consulted with in regards to corrective and preventative measures considered.

3. Additional tools to complement the Core Tool:

3.1. **Tools suggested to complement the COPSOQ II**

As it was not possible to identify one unique PS core tool that could cover the all PS dimensions, three additional questionnaires can be used to further complete the initial assessment, targeting specifically the three dimensions not directly represented in the COPSOQ II:

- Environment and equipment: OrgFit (Jiménez, Dunkl & Bramberger, 2014), a 54 items questionnaire assessing work activities and tasks, organizational climate, work environment and Work flow and work organization
- Workplace Harassment: Negative Acts Questionnaire- Revised (NAQ-R)
- Direct threat to life: Life Events Checklist for DSM-5 (LEC-5) : https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

3.2. **Additional tools to assess psychological impact resulting from exposure to psychosocial hazards in the workplace -**

After the initial assessment is completed according to the protocol, additional tools can be needed to measure specific PS impacts, such as PTSD, burnout and vicarious trauma, etc. A non-exhaustive list of validated tools that can be used to assess the most common impact resulting from exposure to psychosocial hazards at work can be found below. This list of risks/measures will be further developed while piloting this project:

- PTSD :
  PTSD CheckList – Civilian Version (PCL-C),

(Blanchard, Jones-Alexander, Buckley, & Forneris, 1996)
https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

- Burnout :
  Copenhagen Burnout Inventory (CBI), (Kristensen et al, 2005)
  http://www.arbejdsmiljoforskning.dk/en/publikationer/spoergeskemaer/udbraendthed
  Maslach Burnout Inventory (Maslach et all, 1996)
  http://www.mindgarden.com/117-maslach-burnout-inventory

- Vicarious Trauma :
  ProQOL, http://www.proqol.org/

- Effort-Reward Imbalance (ERI), Siegrist, 2004
  http://www.uniklinik-duesseldorf.de/unternehmen/institute/institut-fuer-medizinische-soziologie/forschung/the-eri-model-stress-and-health/eri-questionnaires/

- Harassment:
  1) Found on internet through different research sources/references, but could not be accessed:
  Work Place Bullying Assessment Checklist
  http://www.ccfqld.com/wp-content/uploads/2013/08/201308-Template-Workplace-Bullying-Assessment-Checklist-June-2013.doc

  2) Found on internet through different research sources/references, but could not be accessed:
  Bullying Risk Assessment Tool (BRAT)
  https://www.research.manchester.ac.uk/portal/en/publications/development-and-assessment-of-the-bullying-risk-assessment-tool-brat(19f1ff22-30e4-4fa9-b778-d297db46744e).html

  3) Workplace Bullying Assessment Checklist (available via internet, indirect measure, to be completed by the SC or other staff support service)

Reference:

WHO, Health Impact of psychosocial Hazards at Work: an overview, 2010

ILO, Workplace Stress, a collective challenge, 2016

Overview of recommended P-HRA Process

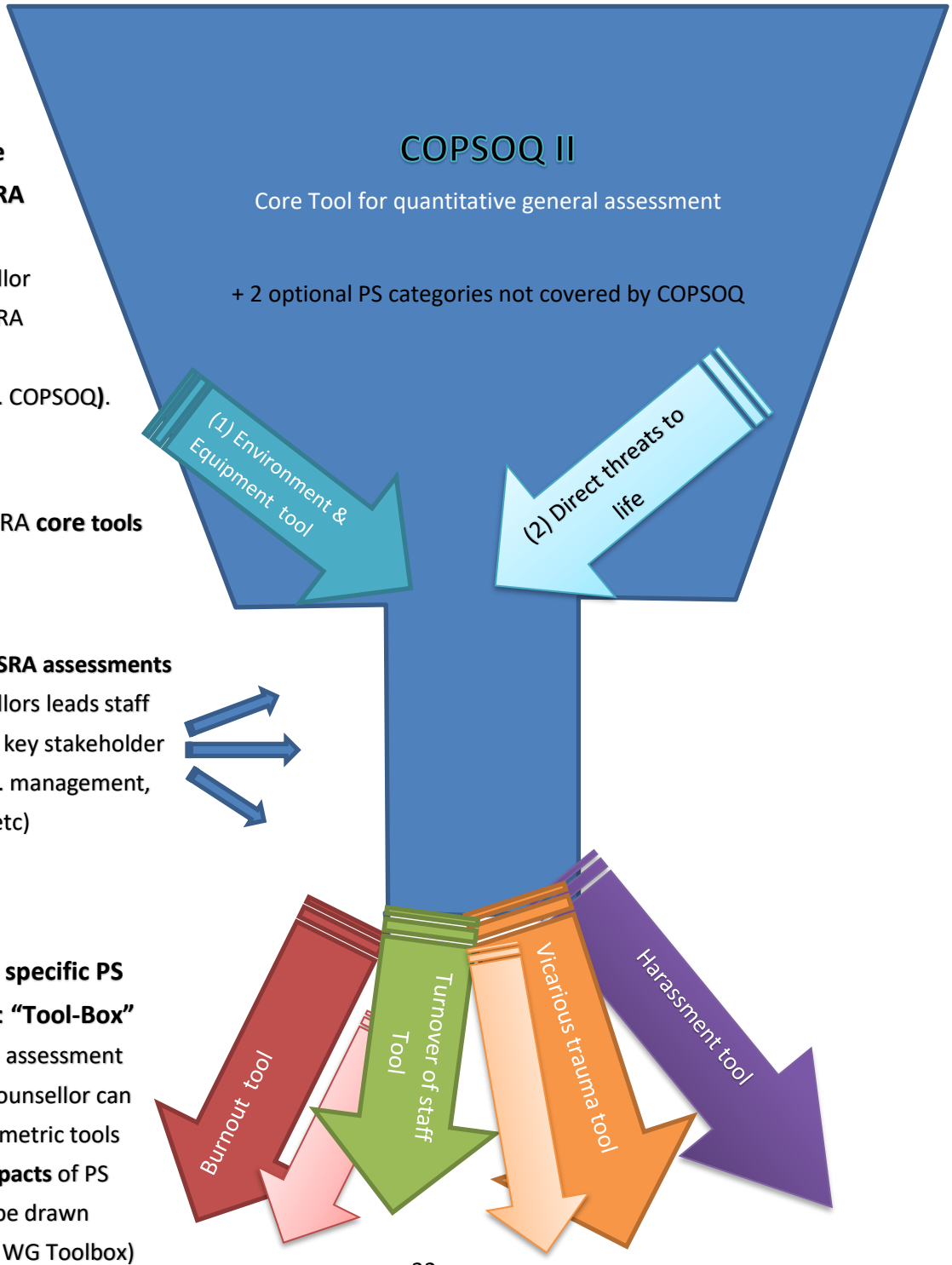
Archival assessment of relevant staff data to be conducted by HR, Ombusdman, Medical, Security or other relevant entities.

Quantitative general P-HRA assessment (Staff Counsellor conducts P-HRA using a **Core Tool**, i.e. COPSOQ).

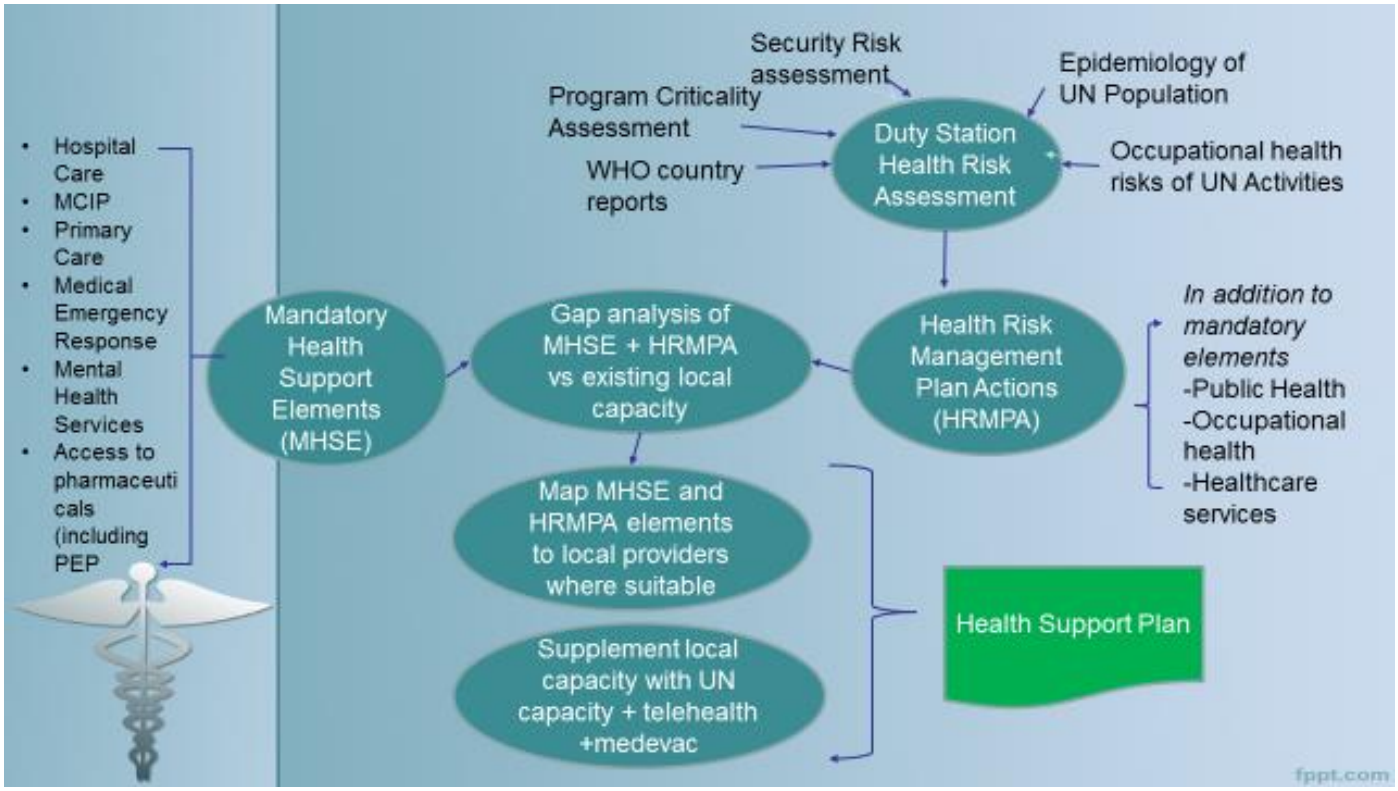
Optional PSRA **core tools** (1) & (2)

Qualitative PSRA assessments (Staff Counsellors leads staff focus groups, key stakeholder meetings –i.e. management, Staff Unions etc)

Quantitative specific PS assessments : **"Tool-Box"** (based on core assessment results, Staff Counsellor can choose psychometric tools to measure **impacts** of PS hazards – can be drawn from the PSRA WG Toolbox)



Appendix 5: Schematic Example of Health Support Plan Process



Appendix 6: List of Acronyms

DS-HRA: Duty Station Health Risk Assessment

HRA: Health Risk Assessment

HRMPA: Health Risk Management Plan of Actions

ICE: Internal Control Effectiveness

ICU: Intensive Care Unit

IRE: Inherent Risk Exposure

MCIP: Mass Casualty Incident Plan

MHSE: Mandatory Health Support Elements

OSH: Occupational Safety and Health

P-HRA: Psychosocial Health Risk Assessment

P-HRA WG: Psychosocial Health Risk Assessment Working Group

PRA: Psychosocial Risk Assessment

PRH: Psychosocial Risk Hazards

PPE: Personal Protective Equipment

RR: Residual Risk

UNERM: UN Enterprise Risk Management

UNISPG: UN Manual for Health Care Quality and Patient safety

UNMD: UN Medical Directors Network

UNSSCG: UN Staff & Stress Counsellors Group

WHO: World Health Organization

Appendix 7: Suggested resources for the Desk Review

Risk Category	References
Trauma (physical)	
Motor Vehicle Accidents/Road Traffic Injuries	*Data:* http://www.who.int/violence_injury_prevention/road_safety_status/2013/en/
Malicious Act Trauma	*WHO Malicious Acts Insurance Policy:* sas.undp.org/documents/MAIP_Guildelines_2003.doc
Workplace Injury	*Data:* http://www.who.int/occupational_health/who_workers_health_web.pdf?ua=1 *Definitions - Information* http://www.who.int/occupational_health/activities/occupational_work_diseases/en http://apps.who.int/gho/data/node.main.145?lang=en
Psychosocial Hazards	
Psychosocial Hazards (Prima-ef)	http://www.prima-ef.org.
Substance Abuse/Misuse	*Data*: http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_2.pdf?ua=1
Stress in the workplace	http://www.who.int/occupational_health/topics/stressatwp/en/
Infectious Disease > (will need 2nd level of taxonomy)	
Vector Borne	*Malaria Fact sheet:* http://www.who.int/mediacentre/factsheets/fs094/en/ *Dengue Fact sheet:* http://www.who.int/mediacentre/factsheets/fs117/en/ *Zika Fact sheet:* http://www.who.int/mediacentre/factsheets/zika/en/
Water Borne	*Data on Improved Drinking Water Sources:* http://www.who.int/gho/mdg/environmental_sustainability/water/en/
Food Borne	*Data:* http://www.who.int/foodsafety/publications/foodborne_disease/fergreport/en/
Human to Human	*Data*: http://apps.who.int/gho/data/node.main.617?lang=en *Infectious Diseases:* http://apps.who.int/gho/data/node.main.170?lang=en
Zoonotic	*Rabies Data:* http://apps.who.int/gho/data/node.main.NTDRABIES?lang=en
Environmental Factors *Data on environmental health:* http://www.who.int/quantifying_ehimpacts/en/ *WHO environmental burden of disease country profile:* http://www.who.int/quantifying_ehimpacts/national/countryprofile/centralafricanrepublic.pdf?ua=1	
Air Pollution	*Fact sheet on air quality and air:* http://www.who.int/mediacentre/factsheets/fs313/en/ *Data:* http://www.who.int/gho/phe/outdoor_air_pollution/en/

Temperature (Heat/Cold)	*Climate and health country profiles:* http://www.who.int/globalchange/resources/countries/en
Altitude	*Environmental health risks- altitude:* http://www.who.int/ith/ITH2009Chapter3.pdf
Envenomation	*Fact sheet on animal bites:* http://www.who.int/mediacentre/factsheets/fs373/en/ *Data:* http://apps.who.int/bloodproducts/snakeantivenoms/database/
Radiation CB	*Fact sheet on ionizing radiation, health effects and protective measures:* http://www.who.int/mediacentre/factsheets/fs371/en/
Food/ Water/ Sanitation	*Water:* http://apps.who.int/gho/data/node.main.46?lang=en
Security	*ISOS Country Reports:* https://www.internationalsos.com/countryguide/default.aspx?languageid=ENG
Shelter, Accommodation	*Housing and health fact sheet:* http://www.who.int/hia/housing/en/
Non-Communicable Diseases *>Risks can occur only if the facilities to manage patients are not available in the country* *Global Status report on non communicable diseases:* http://www.who.int/nmh/publications/ncd-status-report-2014/en/	
Metabolic	*Global Status report on no communicable diseases:* http://www.who.int/nmh/publications/ncd-status-report-2014/en/
Malignancy	*Data:* http://apps.who.int/gho/data/node.main.A859?lang=en
Mental	*Fact sheet on Mental disorders:* http://www.who.int/mediacentre/factsheets/fs396/en/ *Data*: http://www.who.int/mental_health/evidence/atlas/profiles/en/
Cardiovascular	*Fact sheet on cardiovascular disease:* http://www.who.int/mediacentre/factsheets/fs317/en/ *Data:* http://www.who.int/gho/ncd/mortality_morbidity/cvd/en/
Respiratory	*Global Status report on no communicable diseases:* http://www.who.int/nmh/publications/ncd-status-report-2014/en/
Muscular-skeletal	*Country profiles:* http://www.who.int/gho/countries/en/
OSH Management System	
Essentials of OSH Management System in place (yes/no) or Possible List of Categories of OSH Framework	*ILO Country Profiles:* https://www.ilo.org/ilostatcp/CPDesktop/

United Nations

UNMD SOP
Ref. UNMD/SOP/01/2018

Standing Operating Procedure

Duty Station Health Risk Assessment

(DS-HRA)

Approved by: UNMD

Effective date: 16 February 2018

Contact: ***UNMD Secretariat (unmd@un.org)***

Review date: 28/2/2020

Standing Operating Procedure (SOP)

Duty Station Health Risk Assessment (DS – HRA)

Contents:

A. Purpose

1. This SOP sets out the steps and requirements for a UNMD Duty Station Health Risk assessment to be conducted by and on behalf of the UNMD,

2. The purpose of a DS-HRA is to provide system recommendations for health risk management and health support in a specific duty station.

B. Scope and Applicability

3. This SOP applies to all DS-HRAs conducted on an inter-agency basis on behalf of the UNMD.

4. This SOP is to be read in conjunction with the DS-HRA Guide published by the UNMD.

C. Methodology

5. The methodology to be applied for the DS-HRA is to be consistent with the DS-HRA guide and the UN Enterprise Risk Management System**.**

D. Roles and Responsibilities

6. UNMD – The UN Medical Directors' network:

    a. Identifies the need for a DS-HRA
    b. defines the relevant tools, templates and methods for conducting the DS-HRA, and delivers training for assessors.
    c. Determines the Team composition for conducting a DS-HRA
    d. Determines the composition of a UNMD representative Steering committee to oversee the conduct of the assessment and the production of the report.
    e. Individual medical directors liaise with their own country representatives to inform the DS-HRA and to support its implementation.

7. DS-HRA Steering Committee:

    a. Supervises the conduct of assessment and validates the finalization of the report
    b. Engages with the country team regarding the findings and recommendations
    c. Communicates with other members of the UNMD regarding progress and findings of the DS-HRA.

8. Assessors:

    a. Liaise with the UNMD appointed Steering committee.
    b. Undertake desk review and information gathering
    c. Travel to duty station as required
    d. Engage with personnel in the duty station, including staff representatives and managers.
    e. Complete the Risk Assessment tools in accordance with the Guide
    f. Compile a report in accordance with the approved template.
    g. Submit the report for quality review to the Steering Committee
    h. Undertake edits and revisions as requested by the Steering Committee

i. The assessors shall not pre-empt the final recommendations of the UNMD, which will represent the inter-agency consensus rather than the view of individuals.

E. Procedures

9. Determining the need for a DS-HRA:

    a. A Steering Committee comprising representatives of the Medical Directors of those organizations with the largest footprint (or anticipated footprint) and including at least one staff counsellor will consider requests/recommendations for DS-HRA

    b. Such a Steering Committee will be convened in the following circumstances:

        i. If a country team request a duty station assessment,
        ii. If a country team requests advice on operation (opening/closing/continuing) a UN clinic,
        iii. The Medical Director of an individual entity may request the UNMD to consider a DS-HRA.

10. Once it is determined to proceed, the Steering Committee will identify suitable assessors amongst the combined workforce of the relevant entities, and, subject to the approval of their Director, will appoint them to the DS-HRA team. Wherever possible a counsellor should be included in the assessor team.

11. The Steering Committee will convene a VTC with the Assessors for an initial briefing and scoping of assessment. The Country team can be invited to participate in this initial briefing.

12. The Assessors will complete the assessment in accordance with the DS-HRA guide and the P-HRA guide respectively.

13. The Steering Committee will provide support to the Assessors in the technical aspects of the DS-HRA and P-HRA to ensure consistent quality of assessments, and inter-rater reliability.

14. Once the risk assessment tool and the report are completed, it will be circulated to the Steering Committee for preliminary endorsement.

15. Once preliminary endorsement is received, a VTC to discuss with the Country team will be convened. The risk assessment and report should be provided to the country team at least one week before the VTC.

16. On receipt of feedback from the country team, the Steering Committee and Assessors will finalize a report, and circulate it for endorsement and for signature to the UNMD members with staffing footprint in the duty station.

17. Once endorsed, the final report will be provided to the Country Team via the Resident Co-Ordinator.
18. The UNMD will engage periodically with the Country Team to support implementation of agreed measures.

F. Health and Safety Warnings

19. Supervisors of assessors should ensure that assessors are provided with sufficient time and resource to complete this activity.
20. Planning for the safety, security and wellbeing of assessors should be incorporated into mobilizing the DS-HRA, including liaison with local security personnel.

G. Cautions and interferences.

21. If an assessment team is comprised only of individuals from a single agency, this may result in an uni - organizational focus, rather than the holistic system-level approach required by DS-HRA. Good engagement of the Steering Committee will control this risk.

H. References

22. DS-HRA Guide 2018
23. P-HRA Methodology- 2018

I. Monitoring and Evaluation

24. This SOP is maintained by UNMD. The UNMD secretariat is responsible for reporting on all aspects of (SOP/Procedure).

J. Contact

25. The contact for this SOP is the UNMD secretariat – UNMD@un.org

K. History

26. This SOP is the first issue and has not been amended. This SOP is to be implemented upon approval of the UN Medical Directors Network (UNMD) with signature of its chair, Dr. Farmer.
27. This SOP will be reviewed no later than 28 Feb 2020

APPROVAL SIGNATURE:

UNMD Chair: Dr Jillann Farmer, MSD New York
Date: 9. March 2018

Signature: _____