JIU/REP/2025/6

United Nations

Review of the Health Services in the United Nations system

Report of the Joint Inspection Unit

Prepared by Victor Moraru

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Original: English

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United Nations • New York, 2025

About the Joint Inspection Unit

The Joint Inspection Unit (JIU) is the only independent external oversight body of the United Nations system mandated to conduct evaluations and inspections system-wide. JIU works to secure efficiency and transparency and to promote greater coordination between the United Nations entities.

The Unit is a subsidiary body of the General Assembly and reports to the governing bodies and legislative organs of the organizations that have accepted the statute of the Joint Inspection Unit.

Copies of the JIU statute, its annual report to the General Assembly and its review reports are available at www.unjiu.org.

Project team

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Contents

Acronyms

FAO	Food and Agriculture Organization of the United Nations
IAEA	International Atomic Energy Agency
ICAO	International Civil Aviation Organization
ILO	International Labour Organization
IMO	International Maritime Organization
ITC	International Trade Centre
ITU	International Telecommunication Union
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UN Tourism	World Tourism Organization
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPU	Universal Postal Union
WFP	World Food Programme
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WMO	World Meteorological Organization

I. Introduction

A. Context

1. As part of its programme of work for 2023, the Joint Inspection Unit (JIU) conducted a review entitled "Review of the Health Services in the United Nations system". The present report provides an assessment of the current status of Health Services. The topic was last covered by JIU in 2011.[1]

2. The mandate and function of a Health Service is to promote and protect the health, safety and well-being of the organizations' personnel, both at headquarters and in field offices, with the highest regard for confidentiality and privacy. It provides a variety of personal healthcare and occupational health services to address and mitigate the main health risks faced by personnel to ensure that they remain productive, engaged and motivated, thus enabling the organization to achieve its objectives while controlling healthcare costs and ensuring adherence to the duty of care.

3. The implementation of a new healthcare vision in the United Nations system, as endorsed by the United Nations System Chief Executives Board for Coordination (CEB) in 2010,[2] signified a move away from limited medical-administrative functions to a more holistic, preventative and modern health and healthcare approach for United Nations system personnel. In some organizations, the Health Services introduced improvements aimed at streamlining their work and focusing more on occupational health and safety-related preventative services. The new healthcare approach has also led to a process of the gradual integration of health-related sub-functions into a more evolved Health Services with an extended mandate to provide a broader range of health services that support a holistic approach to health and well-being.

B. Objectives and scope

4. The objectives of the present review are four-fold: (a) examine strategies, policies and practices related to the Health Services; (b) analyse organizational arrangements for Health Services in United Nations system organizations and assess their adequacy and effectiveness; (c) review relevant system-wide mechanisms and inter-agency initiatives; and (d) identify lessons learned and good practices.

5. The review was carried out on a system-wide basis and included all JIU participating organizations. It focused on the Health Services in place in the United Nations system. The specific aspects of field health facilities were factored into the data collection and analysis, to the extent possible. It also looked into aspects related to inter-agency cooperation, including in the occupational health and safety area. It did not cover mental health aspects and health insurance schemes because those topics were covered by two recent JIU reviews.[3]

C. Methodology

6. The data and evidence used in preparing the present report were collected from June 2024 to May 2025 using different qualitative and quantitative data-collection methods, namely, a pre-scoping exercise, a comprehensive review of relevant health-related documentation, four sets of questionnaires tailored to the different groups of organizations and/or their set-up and model of Health Services, and 65 interviews,

[1] Review of the Medical Service in the United Nations system (JIU/REP/2011/1).
[2] See CEB/2010/HLCM/11.
[3] See JIU/REP/2023/4 and JIU/REP/2023/9, JIU/REP/2023/9/Corr.1 and JIU/REP/2023/9/Corr.2.

conducted mostly virtually, with 138 officials from 27 JIU participating organizations[4] and 1 non-participating organization.[5]

7. Limitations to this review include restricted access to several categories of information and the lack of accompanying metadata related to quantitative and qualitative information shared by some participating organizations. Where feasible, the reported data were cross-checked against alternative sources, and, in some cases, relied on proxy data to fill critical information gaps. Also, there were significant delays in responses from stakeholders at every stage of the review process, including data collection through the organizational questionnaire and interviews.

8. A draft of the present report underwent an internal peer review for quality assurance and was subsequently shared with JIU participating organizations. The Inspector affirms that independence, impartiality and professional integrity were maintained throughout the planning, execution and drafting stages.

D. About the report

9. Two JIU outputs were produced: (a) the present report, focusing on the main findings, conclusions and recommendations and available in the six official languages of the United Nations; and (b) an expanded report, issued under the symbol JIU/REP/2025/6 [Expanded report], providing a broader analysis, detailed findings and related supporting information, including annexes, available in English.

10. Nine formal recommendations, which will be tracked and reported on by JIU, have been issued as a result of the review. The annex to the present report provides a table indicating each recommendation and the corresponding required action. The review also resulted in 24 informal recommendations, shown in bold, which complement or inform the formal recommendations.

[4] Except UNCTAD.

[5] International Fund for Agricultural Development.

II. Health function in United Nations system organizations

A. United Nations health infrastructure at a glance

11. The review found a lack of comprehensive mappings of health facilities in the United Nations system. For the purpose of the present report, information on types and number of United Nations health facilities, number of health personnel, operating/administering authority and locations or location areas for those facilities were collected. The data show that, in 2024, there were more than 223 health facilities, including 11 Health Services located at Headquarters duty stations, employing more than 1,500 healthcare personnel. This represents a significant increase, more than double the number of total United Nations health facilities and health staff compared with the data presented in the 2011 JIU report. The growth is related closely to the increase in health facilities in the United Nations peacekeeping missions that mirrors, in turn, the increased number and/or scope of United Nations peacekeeping operations and special political missions.

12. Of 28 JIU participating organizations, 11 have in place their own Health Services (FAO, ICAO, ILO, IMO, ITU, UNESCO, UNHCR, United Nations Secretariat, WIPO, WFP and WHO), 9 are served by regional United Nations Joint Medical Services (IAEA, ITC, UN-Habitat, UNCTAD, UNEP, UNIDO, UNODC, UPU and WMO)[6] and 6 are served by the Health Services of other United Nations organizations (UN-Women, UNICEF, UNAIDS, UNDP, UNFPA and UNOPS).[7] Two organizations have contractual arrangements with external non-United Nations health services providers (World Tourism Organization and UNRWA[8]).

B. Paradigm shift in the provision of healthcare and its impact on health function

13. Historically, the United Nations system has responded to the growing needs of healthcare services by employing an increasing number of medical staff and by establishing medical facilities in various locations, notably in the field. The decentralized nature of the United Nations healthcare system limited organizations' capacity to monitor, support and manage it. Moreover, the capacity of organizations to discharge the duty of care to personnel was further weakened by the absence of a clinical governance framework and an occupational health and safety framework. The development and implementation of such overarching frameworks marked a paradigm shift in the provision of medical services, since emphasis was placed on prevention rather than cure.

14. Most organizations, notably those that have their own Health Services, confirmed that the implementation of new approaches related to healthcare management had resulted in the gradual transformation of the health function. Table 1 provides an illustration of the consolidation and integration of the health function.

[6] United Nations Office at Geneva Medical Service (ITC, UNCTAD, UPU and WMO); United Nations Office at Nairobi Joint Medical Service (UNEP and UN-Habitat) and Vienna International Centre Medical Service (IAEA, UNIDO and UNODC), hosted by IAEA.

[7] United Nations Secretariat (UNICEF, UNDP, UNFPA, UN-Women and UNOPS) and WHO (UNAIDS).

[8] UNRWA provides, through its health centres, primary healthcare services to Palestine refugees only.

Table 1
Transformation of the health function in participating organizations with own Health Services

Organization	*Health function consolidation*	*Integration of health-related sub-functions*				*Status of integration*
		Medical sub-function	*Psychosocial well-being sub-function*	*Occupational health and safety sub-function*	*Other*	
FAO	Yes	Yes	Yes	Yes	No	Completed
ICAO	Yes	Yes	Yes	Yes	No	Completed
ILO	Yes	Yes	Yes	Yes	No	Completed
IMO	Yes	Yes	Yes	–	No	Ongoing
ITU	Yes	Yes	Yes	Yes	No	Ongoing
UNESCO	No	No	No	No	No	Not initiated
UNHCR	Yes	Yes	Yes	Yes	No	Completed
United Nations Secretariat	Yes	Yes	Yes	Yes	No	Completed
WIPO	Yes	Yes	–	Yes	No	Ongoing
WFP	Yes	Yes	Yes	–	Yes[a]	Completed
WHO	Yes	Yes	Yes	Yes	No	Ongoing

Source: Prepared by JIU on the basis of information provided by the participating organizations with their own Health Services.
[a] Health insurance sub-function.

15. Most health professionals recognize the imperative of full integration of the health function because it allows for a more holistic approach to healthcare, ensures the coordination and integration of health and well-being considerations within the organization and facilitates integrated case management. Full integration of the health function is pending in some organizations. In the light of the benefits associated with a fully integrated function, the implementation of the following recommendation is expected to enhance the effectiveness of the health function.

Recommendation 1

By the end of 2027, the executive heads of the United Nations system organizations that have their own Health Services and who have not yet done so should review the organizational health function and ensure that it effectively integrates relevant health-related sub-functions to achieve the best health outcomes for their organizations' personnel.

16. The current change process may also lead to the reduced use of the headquarters-based Health Services as walk-in clinics. **In the context of integration of the health function and of related efforts aimed at optimization or reducing walk-in services, the Inspector suggests that organizations also explore the alternative of engaging at the headquarters level third-party private medical services providers on framework agreements, in order to improve the access and quality of healthcare services, which are fully funded by the health insurance plans/schemes.** Apart from being an effectiveness and efficiency measure, this alternative may positively

influence the healthcare access behaviours of personnel, many of whom do not have a primary healthcare provider (i.e., family doctor).

C. Changing organizational set-up and focus

17. The review found that an increasing number of organizations had streamlined the work of their Health Services by focusing them on occupational health, safety and well-being aspects. The progressive transition of Medical Services to integrated Health Services reflects a strategic realignment aimed at enhancing organizations' focus on the occupational health, safety and well-being of personnel. Table 2 illustrates the change process of the health function.

Table 2
Change process reflected in the new names and organigrams of integrated Health Services

Organization	*Name of Health Service before integration*	*Name of Health Service after integration*	*Current structure of Health Service*
FAO	Health Services	Health Services	1. Medical Unit 2. Staff Counselling Unit 3. Occupational Health and Safety Unit
ICAO	Medical Services	Medical Services	1. Occupational Health 2. Primary Health Services 3. Global Telehealth and Employee Assistance
ILO	Medical Services	Staff Health and Well-being Service	1. Medical, Counselling and Welfare Unit 2. Occupational health unit
IMO	Medical Unit	Health and Well-being Service	Not structured in units/sections
ITU	Medical Services	–	Process of integration is ongoing
UNESCO	Medical Service	Occupational Health Service	Not structured in units/sections
UNHCR	Medical Services	Staff Health and Well-being Service	1. Medical Section 2. Psychosocial and Well-being Section 3. Occupational Safety Unit
United Nations Secretariat	Medical Services Division	Healthcare Management and Occupational Safety and Health Division	1. Health Intelligence and Public Health 2. Healthcare Quality and Clinical Governance Section 3. Medical Entitlements 4. Occupational Safety and Health Section 5. Staff Counsellor's Office 6. United Nations Medical Emergency Response Team Public Health Section 7. Workforce Management Section

Organization	*Name of Health Service before integration*	*Name of Health Service after integration*	*Current structure of Health Service*
WIPO	Medical Unit	Occupational Safety and Health Service	Not structured in units/sections
WFP	Medical Service	Wellness and Culture Division	1. Medical Service 2. Counselling Service 3. Health Insurance Service 4. Culture and Values Unit
WHO	Health and Medical Services	Staff Health and Well-being Department	Not structured in units/sections

Source: Prepared by JIU on the basis of information provided by participating organizations.

18. The process of integration of the health function had, so far, little effect on the function's status in organizational structures and reporting lines. This brings to the fore the issue raised by 2011 JIU report whether the Health Services should be "independent" from other organizational units, notably human resources. There are several examples that demonstrate that the creation of integrated Health and Well-being Services with a higher standing within the organization has led to the optimization of healthcare delivery. Segregating the health function from the human resources function creates a sense of autonomy for the Health Services and the regional United Nations Joint Medical Services and empowers personnel to seek healthcare services, notably medical consultation and counselling without fear of breach of confidentiality. The varied supervisory structures, reporting lines, additional functional tasks and expectations of the headquarters-based Health Services call for a uniform approach regarding their administrative reporting chains and hierarchical status. The implementation of the following recommendation is expected to enhance the effectiveness of the health function.

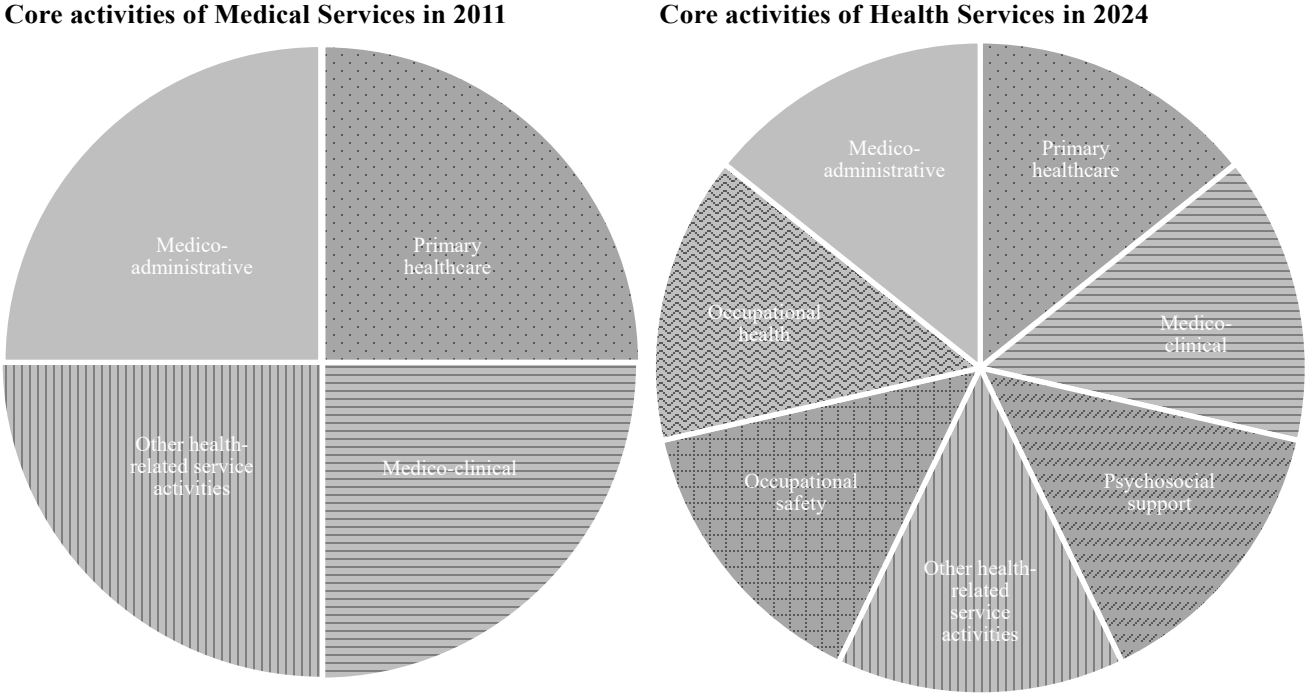
Recommendation 2

By the end of 2027, the executive heads of the United Nations system organizations that have their own Health Services and who have not yet done so should review the organizational arrangements for the function in terms of reporting lines, to assign a degree of autonomy that is required for the proper management and supervision of the function, as well as to ensure the confidentiality of medical and psychosocial well-being services.

D. Core activities, policy guidance and mandates

19. The transformation of Medical Services into integrated Health Services has also led to an increased number of core activities (see figure I).

Figure I
Evolution of core activities: Medical Services versus Health Services



Source: Prepared by JIU on the basis of information provided by participating organizations.

20. The review found that the policy guidance for the health function in participating organizations consists of a multitude of documents that include rules and regulations, manuals and policies, among others. However, stand-alone documents clearly defining the mandates of the organizations' Health Services and regional Medical Services of the United Nations Secretariat are largely absent. The Inspector considers the absence of a formal mandate a critical weakness. In line with the general practice adopted in the United Nations system, it is expected that each organization adopts a formal "mandate" for its Health Service in which its main purpose/objectives, roles or tasks are defined. A clear-cut mandate offers a realistic basis for deciding on the adequate resource levels for the Health Services, including in cases in which additional tasks and responsibilities are being added. The implementation of the following recommendations is expected to strengthen the effectiveness of the management of Health Services.

Recommendation 3

By the end of 2027, the executive heads of the United Nations system organizations that have their own Health Services and who have not yet done so should review and promulgate administrative documents that clearly set out the primary purpose, responsibilities and core activities for their organizational Health Service, including relevant aspects of occupational health and safety.

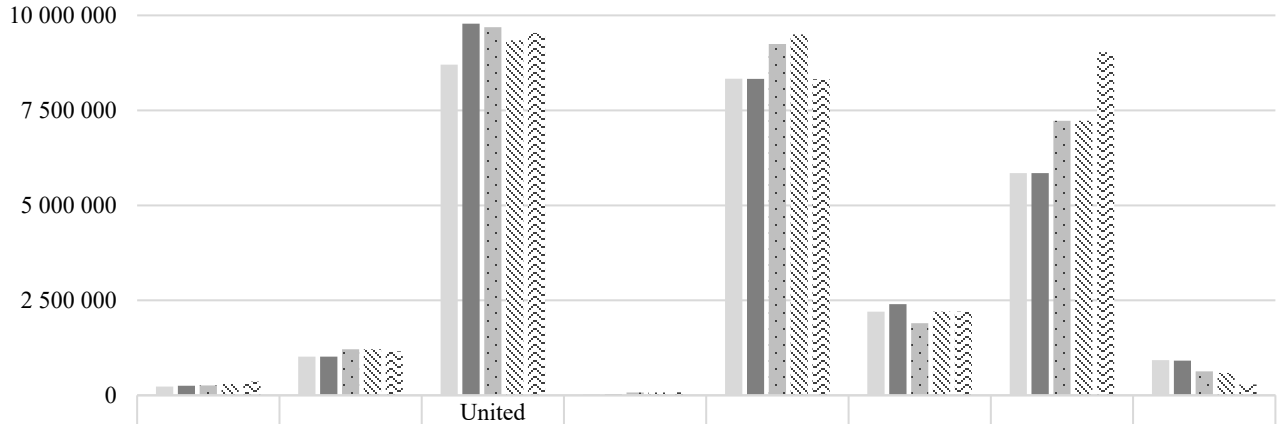
Recommendation 4

By the end of 2028, the United Nations Secretary-General should review and promulgate administrative documents for the regional Medical Services located in offices away from Headquarters and in the regional commissions that clearly set out their purpose, responsibilities and core activities, including relevant aspects of occupational health and safety.

E. Funding and procurement

21. The review found that the budgetary allocations for Health Services remained unaffected by the change process of the health function. Information provided by some organizations indicated that their budgets remained, overall, at similar levels from 2020 to 2024, except for two organizations. Figure II provides an overview of the health budgets for organizations that provided such data.

Figure II
Health budgets of selected organizations in the period 2020–2024
(United States dollars)



	ICAO	ILO	United Nations Secretariat	UNESCO	UNHCR	WFP	WHO	WIPO
2020	230 000	1 017 039	8 705 400	27 500	8 333 465	2 200 000	5 847 900	924 501
2021	250 000	1 017 039	9 783 300	27 500	8 327 918	2 400 000	5 847 900	913 170
2022	260 000	1 212 796	9 688 200	75 000	9 245 147	1 900 000	7 225 000	629 486
2023	300 000	1 212 796	9 342 200	75 000	9 499 332	2 200 000	7 225 000	590 345
2024	360 000	1 159 277	9 535 800	81 000	8 320 638	2 200 000	9 032 000	287 240

Source: Prepared by JIU on the basis of information provided by some participating organizations.

22. The review found that decision-making on funding allocation for Health Services was driven mostly by the availability of funds and was not linked closely to healthcare needs and priorities. Very few Health Services (e.g., WFP and WHO) develop and issue dedicated documents (e.g., operational plans, health strategies and others) that can support health-tailored funding. This is a good practice that could be replicated in other organizations. **Organizations that have not done so should develop operational plans for their Health Services, health strategies or similar**

documents, as appropriate, that could support the allocation of a healthcare budget that reflects evolving organizational healthcare needs.

23. In general, Health Services have little say over their funding. This is mainly a consequence of their subordinated role in the organizational structure. It is essential that input be sought from Health Services in relation to their budgets, irrespective of existing organizational arrangements and reporting lines. **Organizations that have not done so should involve the heads of Health Services in the budget process related to healthcare budgets to ensure effective budgeting and budget's alignment to the organization's changing health priorities and needs.**

24. Approaches vary with regard to the procurement of medical goods. The procurement criteria used for the procurement of medical goods follow the organization's procurement rules and regulations. In general, they include price, quality, delivery lead time and expiration date. While the price of products is always an important factor, **the Inspector encourages organizations to prioritize the value-based approaches in the procurement[9] of medical items to maximize the ultimate value of money.**

25. Centralized procurement for medical goods is the preferred option by most organizations. Notwithstanding its benefits, centralizing procurement may be less flexible for local needs and less efficient and more time-consuming because there is a requirement to secure approval from headquarters procurement services. **Allowing for required flexibility for purchasing options and payment terms for local suppliers' networks may be beneficial for field entities with urgent needs for medical supplies with a low volume.**

F. Human resources complement, credentialing and career framework

26. The human resources complement of Health Services varies significantly across organizations, given their different mandates and geographical coverage. The review found that staff allocation, including staff hiring for field health facilities, is rarely based on actual requirements and needs assessments. **Organizations should conduct periodic needs assessment of staffing requirements of their health facilities to ensure adequate and sufficient staff allocation that is aligned with the organization's healthcare priorities.**

27. The recruitment of medical professionals falls under the policy and procedures established for the appointment of staff in regular positions. This approach may be sub-optimal for the recruitment of medical personnel, notably in field health facilities. **Organizations with a significant health staff complement should pursue the standardization of the recruitment process through the issuance of technical clearance methodology, including guidelines and/or standard operating procedures.**

[9] Value-based procurement means evaluating purchases beyond price, including factors such as long-term value and other parameters, in order to provide good quality healthcare at competitive or sustainable prices.

III. Healthcare management

28. United Nations system organizations have invested considerable resources in developing a network of field health facilities. Even when health facilities are deployed in the field, there are challenges in replicating the conditions existing in the health facilities that are available for headquarters-based personnel. Appropriate standards of care and fit-for-purpose health infrastructure are key preconditions for bridging the gaps.

A. Standards of care

29. Standards of care are a core pillar of healthcare management. With standards and guidelines in place, United Nations healthcare providers can deliver consistent healthcare, which, in turn, can translate into reduced healthcare and compensation costs. The expected outcomes of implementing standards of care are summarized in box 1. Some organizations use their own standards of care. Notwithstanding the different mandates, organizational healthcare focus and priorities of Health Services operating in various organizations, **the Inspector recommends that organizations that did not do so review, adjust or adopt standards of care that are aligned to United Nations Healthcare Quality and Patient Safety Standards in order to ensure system-wide standardization and to facilitate the implementation thereof and compliance therewith.**

Box 1
Expected outcomes of implementing United Nations healthcare standards

- Reduce preventable harm and reduce comorbidity and mortality
- Provide consistency in processes and systems in all United Nations hospitals and clinics
- Create the ability to collect and measure clinical outcomes for quality improvement
- Create the ability to measure patient experience
- Meet expectations of all mission and United Nations personnel for trustworthy, consistent and dependable care

Source: United Nations international patient safety goals and standards (2019)

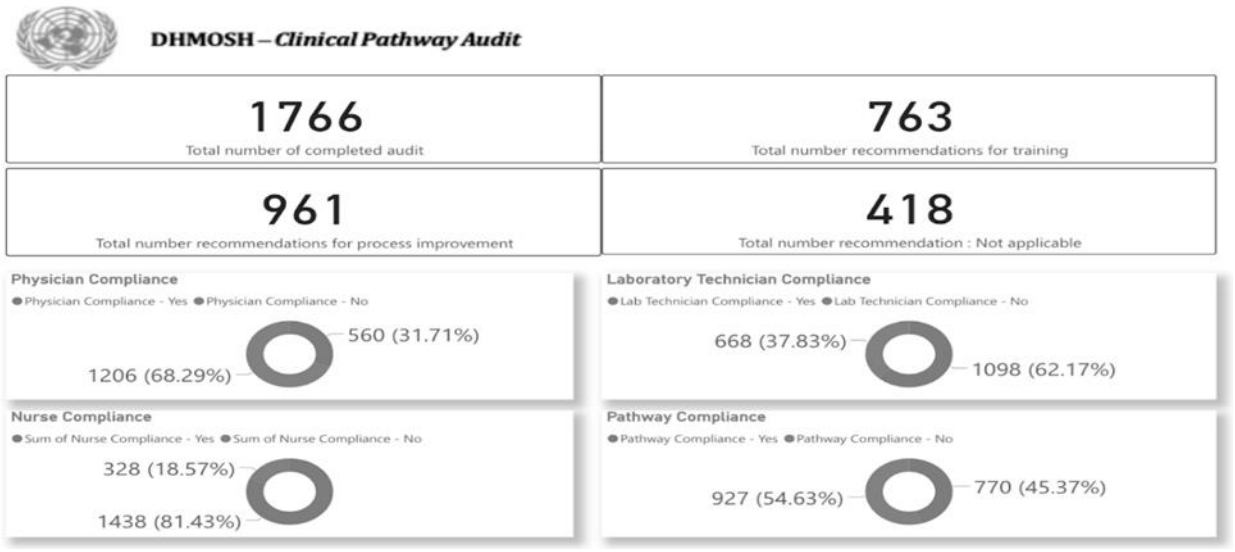
30. Only four organizations (UNHCR, United Nations Secretariat, WFP and WIPO) confirmed the existence of mechanisms for monitoring and evaluating the level of compliance with the existing standards of care, but only the United Nations Secretariat, admittedly, has capacity for effective monitoring and evaluation. No data were readily available at the time of the review to determine how many United Nations health facilities globally had in place processes compliant with healthcare quality and patient safety standards. However, according to publicly available information, between 2021 and 2023, one headquarters-based medical clinic (UNHCR) and four peacekeeping missions' hospitals successfully completed quality and patient standard assessments.[10] Feedback received from the Healthcare Management and Occupational Safety and Health Division also revealed that, as a result of 10 healthcare quality and

[10] A4+first progress report.

patient safety standards hospital assessments conducted by mid-2024, 3 hospitals had failed the assessment.[11]

31. The Healthcare Management and Occupational Safety and Health Division developed a Clinical Pathway Compliance Dashboard, which serves as a real-time tool to monitor several metrics (see figure III). It shows that 418 clinical audits found full compliance with the four tracked categories (recommended numbers of medical personnel; pathway compliance or non-compliance and per health facility).

Figure III
Status of compliance with healthcare quality and patient safety standards between July 2023 and May 2024



Source: Healthcare Management and Occupational Safety and Health Division.

B. Health infrastructure

32. United Nations health infrastructure in the field is often reported to be insufficient or inadequate. No specific data were made available by organizations to ascertain the proportion of inadequate health facilities in terms of capacity gaps and other related metrics.

33. To comprehend the situation, the responses provided during the interviews and the data included in non-classified Office of Internal Oversight Services audit reports were analysed. Box 2 presents data disaggregated by audited peacekeeping mission and number of audits and recommendations. Analysis of the data revealed gaps in terms of compliance with United Nations requirements related to the capacity and capabilities of peacekeeping missions' health facilities, as follows: (a) gaps related to the adequacy of field health facilities; (b) gaps related to the adequacy of maintenance programmes for medical equipment and drug inventory management systems; (c) gaps related to the adequacy of casualty evacuation mechanisms; (d) gaps related to the adequacy of cost-recovery arrangements for provided services; (e) gaps related to support planning; and (f) gaps related to deployment and distribution per location of health facilities.

[11] As at 9 July 2024, eight healthcare quality and patient safety standards assessments were pending.

Box 2
Number of audits (and recommendations)

- MINUSCA – 2 (14)
- MINUSMA – 1 (11)
- MONUSCO – 2 (8)
- UNAMI – 1 (2)
- UNFICYP – 1 (8)
- UNIFIL – 2 (6)
- UNMISS – 3 (15)
- UNSOS/UNSOM – 1 (5)
- UNAMID – 1 (7)

34. Very few organizations shared data on the capacity and capabilities of non-peacekeeping clinics, notably regarding the UNDP and WFP clinics. The lack of specific data prevented an assessment of their adequacy in terms of capacity/capabilities, their utilization rates and their cost efficiency and effectiveness.

35. The review found an inadequate mandatory health support in the field, as well as weak risk-based healthcare management. According to one organization, 50 per cent of 612 United Nations duty stations do not meet all mandatory health support elements.

36. The practice of closing or opening by individual organizations of field clinics without reference to a system-wide Health Support Plan and to the United Nations country team's collective needs should be avoided. Box 3 contains a summary of the practices that undermine the adoption of risk-based healthcare management in the field.

Box 3
Poor practices undermining the adoption of risk-based healthcare management in the field

- Continued support for health facilities that are not fit-for-purpose
- Reliance on medical evacuations as a first line of defence, whereas it should be the last line
- Duplication of efforts by different United Nations entities leading to the creation of similar clinics, sometimes in close proximity, within the same duty station
- Failure to consider sustainability and scalability when setting up local solutions; low recognition of novel approaches that could offer lower risk solutions in challenging environments

Source: responses to the JIU questionnaire.

37. Health Risk Assessment methodologies are in place to evaluate access to healthcare in the field duty stations, in order to ensure an objective assessment of existing gaps and to recommend optimal solutions. However, these methodologies are not applied broadly owing to the persistence of outdated practices and/or a lack of

funding to implement them. Weak implementation of the risk management model in managing field health facilities undermines duty of care and health system efficiency. Developing comprehensive medical/health support plans based on the health risks of the duty stations is crucial for the deployment of fit-for-purpose health facilities and the optimal distribution of health facilities in the area of operations. The implementation of the following recommendation is expected to improve the access of United Nations personnel to healthcare and enhance the efficiency and effectiveness of United Nations healthcare facilities.

Recommendation 5

By the end of 2027, executive heads of United Nations system organizations who have not yet done so should assess and identify gaps or areas to improve access to healthcare of their personnel, prioritizing and using the Health Risk Assessment methodologies prepared by the United Nations Medical Directors Network and endorsed by the High-level Committee on Management of the United Nations System Chief Executives Board for Coordination.

C. Medical arrangements for emergency preparedness and emergency medical support

38. The United Nations Medical Emergency Response Team (UNMERT), casualty evacuation (CASEVAC) and medical evacuation (MEDEVAC) are the main medical arrangements for emergency preparedness and emergency medical support. While UNMERT is designed to deal with preparedness and response during crises involving mass casualties, CASEVAC and MEDEVAC are designed to ensure timely care for the critically ill or injured in any setting or environment, including during mass casualty incidents.

39. The review found that UNMERT, in its current form and capacity, is partially operational and can play only a limited role in supporting medical emergency preparedness and response. The Inspector notes that a working group of senior medical officers revisited and refined the UNMERT scope, terms of reference and incident command system. The proposed "UNMERT 2.0" concept (see figure IV) is designed to address the shortcomings of the existing emergency coordination support mechanism. **Executive heads of United Nations system organizations should take individual or collective action, in consultation with the executive heads of other organizations as CEB member organizations, to consider, within the framework of High-level Committee on Management inter-agency mechanisms, the endorsement of a revised UNMERT concept, as proposed by United Nations Medical Directors Network. They are also advised to explore the possibility of inter-agency funding for UNMERT in order to support its system-wide mandate in the area of medical emergency coordination support.**

Figure IV
United Nations Medical Emergency Response Team (UNMERT) 2.0 concept

Source: United Nations Medical Emergency Response Team (June 2024).

40. The proposed revamping of UNMERT and the desired enhancement of emergency medical coordination support, which also cover CASEVAC and MEDEVAC, shows that improving the speed and quality of medical care for United Nations workforce in the field remains an important objective. The Inspector notes that, as a result of full-scale casualty evacuation stress tests conducted in several peacekeeping missions, weaknesses were identified in the medical chain of care and rectified, including through updating, in 2020, the casualty evacuation policy.[12]

41. By contrast, the 2000 administrative instruction on medical evacuation (ST/AI/2000/10) awaits updating. This policy should be aligned closely to the updated casualty evacuation policy to allow for an integrated and effective interplay of the two mechanisms. It should also address certain operational challenges highlighted during the unique circumstances of the coronavirus disease (COVID-19) pandemic. While the medical evacuation mechanisms functioned effectively in large part, the experience underscored opportunities for improvement in areas such as preparedness for rapid response, streamlining procedures for medical evacuations and ensuring consistent and reliable transfer protocols for ill personnel.

42. On the basis of the above, **the Inspector suggests that the Secretary-General update the 2000 administrative instruction on medical evacuation.** The COVID-19 MEDEVAC mechanism, established to meet requests for medical evacuations at the United Nations system-wide level between 2020 and 2022, illustrated an efficient and effective inter-agency approach, based on cost-sharing arrangements. This is a good practice, and its legacy should be maintained and built upon. Therefore, **the Inspector suggests that organizations use lessons learned from the COVID-19 MEDEVAC mechanism to enhance the efficient use of resources for improved medical emergency coordination support mechanisms.**

[12] See United Nations, "Casualty evacuation in the field" (1 March 2020).

D. Some issues related to healthcare workforce management and coordination

43. The different ownerships and lines of authority of health facilities have traditionally raised a number of coordination issues in terms of accountability, health workforce planning and medical support in the field. There is no central United Nations authority for these matters. The Healthcare Management and Occupational Safety and Health Division is the only entity entrusted to support effective coordination of medical support in the field, including through strategic planning and management of medical personnel. However, the Division does not hold direct line authority over health facilities administered by other organizations (e.g., UNDP) or their health workforce. Its role remains largely advisory, limited to entities and locations under its responsibility. As observed by one interviewee, "the command and control of Medical Services is not currently built on an effective hierarchy nor even on matrixed reporting. It relies on guidance, not authority". In the absence of delegated technical authority, Division guidance, no matter how rigorous, will remain advisory, which can dilute accountability for clinic governance, workforce planning and compliance with minimum standards. There is an increasing need to establish clear roles and responsibilities for technical supervision that enables delegated medical authority. The implementation of the following recommendation is expected to formalize technical supervision and to enhance accountability.

Recommendation 6

By the end of 2027, the United Nations Secretary-General should promulgate an administrative instruction on medical technical supervision in order to establish effective roles and clear responsibilities.

E. Ensuring access to healthcare in the field through common/support Medical Services

44. Organizations can subscribe to healthcare services for their field personnel offered by the United Nations Joint Medical Services operated in United Nations regional hubs and by United Nations clinics and other health facilities deployed in field locations. Memorandums of understanding and service-level agreements set out the terms and conditions of the services to be provided, the cost-sharing mechanisms, billing arrangements and other relevant details. They may also include obligations of the signatories, the handling of disputes and provisions on performance metrics, termination, among others. Typically, the delivery of and quality of subscription healthcare services is supervised by oversight/management committees on common services, or equivalent, which include the representatives of signatory entities. According to the United Nations Booking Hub,[13] powered by WFP and that offers shared services to 18 United Nations organizations, as of mid-June 2025 more than 90 United Nations clinics and more than 40 counsellors were registered in its medical-related section as providers of such services.

45. In general, the costing method is based on fees per capita for certain services and/or a fee for service whereby fees are charged against actual utilization for other services. Exploring and clarifying which healthcare services could be charged as reimbursable under the existing medical insurance schemes may also prove beneficial. Very few organizations have explored this model. While cognizant of limitations associated with this approach (e.g., staff may have separate insurance, limiting unified billing), **the Inspector suggests that organizations consider applying the model of cost recovery through insurance in order to enhance the financial sustainability of cost-shared/common Medical Services.**

[13] See https://unbooking.org/.

46. The financial sustainability of cost-shared/common Medical Services could be further optimized through more responsive and balanced costing methodologies. The periodic reviews of memorandums of understanding and service-level agreements may offer such opportunities. Yet, as the review found, such reviews are not always prioritized, even when the field realities and requirements are changed. **The Inspector recommends that organizations periodically review the cost-sharing agreements and costing methodologies of the cost-shared/common Medical Services that provide services upon subscription to ensure that they meet the interests of both the service providers and the service users.**

47. The organizations and health providers agree that cost-shared/common Medical Services foster inter-agency cooperation in the field and generate efficiencies of scale. However, the sustainability of this advantageous model is often jeopardized by opt-out practices. Opt-out decisions are often taken arbitrarily by field managers, sometimes on the basis of financial biases, without considering the possible negative implications for the level of healthcare support that field personnel are entitled to receive. This is particularly important for those duty stations where the subsequent downgrading of or even cessation of some specialized health services, as a result of opt-out decisions, cannot be remediated by the local health providers.

48. Therefore, **the Inspector suggests that the heads of field United Nations structures that entered into medical cost-sharing arrangements should consult the senior medical officers of their organization on the proposals for opting out to ensure that the healthcare needs of field personnel are fully taken into account, in line with the duty of care requirements.**

49. While it is the prerogative of all individual signatory entities to opt out from the cost-shared/common Medical Services, such decisions should be also considered in terms of potential negative consequences on burden-sharing. The Inspector was informed that some opt-out decisions had been taken and implemented without prior notice. This is an indication that not all memorandums of understanding and service-level agreements (as appropriate) contain effective or specific termination and withdrawal clauses, including provisions for the situations when the remaining service users are unable to absorb the financial obligations of the withdrawing service user(s). Including such clauses and other relevant provisions, as also recommended in the United Nations Sustainable Development Group standard template for the memorandum of understanding concerning common services,[14] may enhance the financial sustainability of cost-shared/common Medical Services and, by doing so, build a stronger disincentive to arbitrarily opting out. The following recommendation is intended to address the gaps related to arbitrary opt-out practices and to enhance control and compliance by establishing and maintaining rigour around the review and effectiveness of contractual provisions to support the sustainability of joint healthcare delivery in the field.

Recommendation 7

Executive heads of United Nations system organizations who have not yet done so should periodically review, preferably through the existing ad hoc management/supervisory bodies, the memorandums of understanding and/or service-level agreements, as appropriate, and further enhance their provisions, notably those related to amendments, termination and withdrawal, in order to ensure that the Joint/Common Medical Services remain sustainable and effective.

[14] See https://unsdg.un.org/resources/memorandum-understanding-concerning-provision-and-use-common-services.

IV. Supporting the fulfilment of obligations in the area of occupational health and safety

50. Health Services have played a key part in the adoption and implementation of occupational health and safety policies and standards at the system-wide level and in their own organizations. Such policies and standards introduce a structured approach to managing occupational health and safety. The United Nations occupational safety and health framework initiated by the United Nations Medical Directors Network and endorsed in 2015 by the High-level Committee on Management[15] provides a clear structure and an implementation guide for use within all United Nations organizations to protecting the health, safety and well-being of United Nations system personnel. As illustrated in box 4, an organizational occupational health and safety management system addresses the core elements of establishing a policy, allocating responsibilities at higher levels, building capacity across all levels, implementing compliance and continuous improvement processes.

Box 4
Elements for phased introduction under an occupational health and safety framework/system

- A safety and health oversight body led by senior management
- An organizational occupational health and safety policy
- Mapping of organizational workplace safety and health risks, a rating of and prioritization of these risks and the development of risk management plans for the highest risks
- Implementation of an occupational health and safety incident reporting system
- Development of further occupational health and safety standards and guidance and the development of a compliance mechanism for these standards
- Capacity development across the organization through training and awareness

51. The review found that a few organizational Health Services have been required to act as the owners of the organizational occupational health and safety management system. In one case, the establishment and implementation of the organizational occupational health and safety management system was incorporated into the mandate of the Health Service concerned as a main function. Such demands are unwarranted. The occupational health and safety framework purposefully underscores that "[occupational health and safety] is a line management responsibility and cannot be addressed by a Health Service operating in isolation from management action". On the basis of the above, **the Inspector suggests that the executive heads of participating organizations ensure that the role and responsibilities of their Health Service under the organizational occupational health and safety management system are aligned closely to the principles stipulated in the occupational health and safety framework.**

52. As part of the JIU questionnaire, the organizations provided information on the status of implementation of selected Duty of Care Task Force recommendations and of the occupational health and safety framework, using a matrix that included key questions from the occupational health and safety forum surveys, to assess the

[15] CEB/2015/HLCM/7/Rev.2 (31 March 2015).

progress of selected components.[16] In general, approximately half of the organizations have made progress in or are in the process of implementing Duty of Care Task Force recommendations.[17] The review found that the implementation of the occupational health and safety framework's components is ongoing and at various stages of completion in participating organizations. Although high-level commitments were captured in system-wide documents, conversion from documents to managerial action, notably at the field level, was lacking.

53. Table 3 shows that only six organizations adopted an ad hoc occupational health and safety policy, eight created an occupational health and safety oversight body and four established a mechanism for the promulgation of occupational health and safety standards and used such standards. While 12 organizations confirmed the existence of incident reporting capabilities (IRS) and 6 of occupational health and safety risk registers, few organizations had begun to identify data sources and risk mapping, which are critical for proactive risk-based hazard management and incident prevention. Occupational health and safety capacity remains sub-optimal, given that only nine organizations reported the establishment of occupational health and safety committees at the headquarters level and six at the regional or country levels.

Table 3
Status of occupational health and safety framework implementation in areas of particular relevance, as at 30 September 2024

Occupational health and safety framework and system				*Occupational health and safety capacity-building at the regional or country levels*					
Occupational health and safety policy	*Occupational health and safety oversight body*	*Headquarters occupational health and safety committee*	*Headquarters occupational health and safety focal points*	*Occupational health and safety committees*	*Occupational health and safety focal points*	*Sufficient resources to implement occupational health and safety management system*	*Incident reporting system*	*Occupational health and safety risk register*	*Occupational health and safety standards and mechanism for promulgation*
FAO	FAO	FAO	IAEA	ILO	ILO	ILO	FAO	ILO	FAO
IAEA	ICAO	IAEA	ICAO	UNAIDS	ITU	UNAIDS	ILO	IMO	UNHCR
ILO	ILO	ICAO	ILO	UNHCR	UNDP	UNHCR	ITU	UNDP	UNICEF
UNHCR	UNHCR	ILO	IMO	UNS	UNHCR		IMO	UNHCR	WFP
UNOPS	UNICEF	UNAIDS	ITU	WFP	UNICEF		UNDP	UNOPS	
WFP	United Nations Secretariat	UNHCR	UNAIDS	WHO	UNOPS		UNHCR	WFP	
	UN-Women	United Nations Secretariat	UNHCR		WFP		United Nations Secretariat		
	WFP	WFP	United Nations Secretariat		WHO		UNOPS		
		WHO	UNOPS				UNRWA		
			WFP				UN-Women		
			WHO				WFP		
							WHO		

Source: Prepared by JIU on the basis of organizations' responses to annex 2 of the organizational questionnaire.

54. An incident reporting system is an important element of an organizational occupational health and safety management system. Organizations need to record and manage workplace health incidents (accidents, injuries and illnesses). Through the organizational questionnaire, organizations provided information on occupational health and safety incidents during the period 2020–2023, including category of incidents and the number of claims for compensation (see table 4). Of 12 organizations

[16] In line with annexes 1 and 2 of the JIU organizational questionnaire.
[17] Annex 1 of the JIU questionnaire did not include areas related to medical insurance and mental health.

that reported having an occupational health and safety incident reporting system, 5 provided data for the entire four-year period and 5 for some years only. Seven other organizations that do not have an incident reporting system provided data for the entire period (ICAO, UNIDO and WIPO) or for some years only (IAEA, UNESCO, UNFPA and UPU).

Table 4
Personnel affected by occupational safety incidents, 2020–2023

	Occupational safety incidents and claims for compensations															
	Headquarter duty stations								*Field duty stations*							
	Occupational safety incidents				*Claims for compensations*				*Occupational safety incidents*				*Claims for compensations*			
	2020	*2021*	*2022*	*2023*	*2020*	*2021*	*2022*	*2023*	*2020*	*2021*	*2022*	*2023*	*2020*	*2021*	*2022*	*2023*
FAO	X	X	X	X	X	X	X	X	X	X	X	48	X	X	X	X
IAEA	X	X	X	X	14	26	17	7	X	X	X	X	X	X	X	X
ICAO	2	1	–	1	1	(1)	–	1	–	–	–	–	–	–	–	–
ILO	4	2	7	11	4	2	7	11	1	–	–	1	1	–	–	1
IMO	–	–	–	–	–	–	–	–	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ITC	X	X	X	X	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ITU	X	X	X	X	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
UNAIDS	X	X	X	X	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
UNDP	X	X	1	3	X	X	1	3	X	X	–	2	X	N/A	–	2
UNESCO	X	1 (1)	22	27	X	3 (1)	2	4	X	X	6	3	X	X	X	X
UNFPA	–	–	–	4 (1)	–	–	–	4	N/A	N/A	N/A	N/A	11	15 (1)	33	24
UNHCR	–	–	7	–	4	1	2	3	4	12	28	31	11	14	33	24
UNICEF	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
UNIDO	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
UNOPS	–	–	–	3	–	–	–	3	316	113	122	200	316	113	122	200
UNRWA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
UN-Women	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
UPU	–	–	–	–	–	–	–	–	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WFP	14	9	8	23	19	14 (1)	28	38	3	13	20	48	3	13	20	48
WHO	X	X	X	X	18	12	21	33	X	X	X	X	27 (1)	12 (1)	6 (2)	24
WIPO	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
WMO	X	X	X	X	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: Prepared by JIU on the basis of information provided by participating organizations.
Note: X represents no records available; figures in parentheses represent number of deaths.
Abbreviation: N/A, not applicable.

55. The review found that the incident data-collection system was less than optimal, resulting in poor recording and low visibility by management regarding actual trends. Notwithstanding the reported availability of incident reporting systems by almost half of the participating organizations, very few had in place formal or fully operational systems before 2022. As shown in table 4, the number of reported incidents during the period 2020–2023 was very small or close to zero, which may also indicate that, in some cases, notably in the field, the numbers may be inaccurate. This may not be true for fatal occupational accidents, which are almost invariably recorded. Incident underreporting by personnel can also lead to data inaccuracy or lack of data. **The Inspector recommends that organizations ensure that personnel are regularly trained on incident reporting and have access to a system for reporting workplace incidents. Line managers should take increasing responsibility for the submission of incidents and for increased self-reporting.**

56. While low potential risks relating to workplace conditions are typically handled at the field or country level, significant risks with a potential to cause serious harm or loss of life should be captured and addressed in an enterprise risk management framework. According to the responses to the JIU organizational questionnaire, 10 organizations had included occupational health and safety risks in their corporate registers and risk management processes. In some of those organizations, major health risks (related mainly to medical emergencies) were assessed and reflected in the corporate risk registers. However, this appears to be done on an ad hoc basis rather than a systematic process. The implementation of the following recommendation is expected to enhance accountability and mitigate the occupational health and safety risks in participating organizations.

Recommendation 8

By the end of 2027, executive heads of United Nations system organizations who have not yet done so should incorporate health and occupational risks into their enterprise risk management processes to identify and mitigate such risks at various operational levels.

57. The review found that 90 per cent of organizations lack sufficient resources to implement the occupational health and safety framework. This may explain the limited progress made in implementation within the United Nations system in the past decade. However, occupational health and safety incidents constitute the absolute highest risk for United Nations personnel. While the data for non-uniformed personnel, as illustrated in table 4, are rather inconclusive, occupational health and safety-related accidents and illnesses of uniformed personnel are significantly higher. The incident data from the United Nations Secretariat show that, from 2012 to 2017, occupational health and safety injuries and illness outnumbered security injuries by approximately 10 to 1.[18] Similarly, from 2022 to 2024, the ratio between occupational health and safety and non-occupational health and safety causes to fatalities increased more than three times and reached 10 to 1.[19] **To meet the obligations under the duty of care in the area of occupational health and safety, participating organizations are strongly advised to prioritize investment in occupational health and safety capacity to ensure that the United Nations occupational health and safety management system receives the same support as the United Nations security management system.**

[18] See, for example, "Guidance on the UNSMS role in occupational health and safety", page 3.

[19] Data extracted from the notification of casualties system (NOTICAS) confidential reporting tool (as at 11 November 2024).

58. Apart from their impact on the health and well-being of personnel, fatalities, injuries and illnesses arguably come with significant costs for organizations in terms of payments for sick leave, compensation and healthcare. A lack of data prevented an assessment of the costs arising from weak occupational health and safety delivery capacity and insufficient occupational health and safety practices in participating organizations.

59. It is estimated that the financial losses due to preventable peacekeeping accidents, incidents and events related to occupational safety and health hazards can be as high as $250 million per year (A/74/533, para. 71). Against this backdrop, it would be beneficial to base the optimization and efficiency-driven proposals on a cost-benefit analysis. The review found that no research in that area had been conducted at the individual organization level or at a system-wide level. Therefore, **the Inspector suggests that organizations conduct or commission research to assess the financial impact and risk analysis of weak occupational health and safety delivery capacity and insufficient occupational health and safety practices in order to enhance efficiency and cost-effectiveness in the area of occupational health and safety.**

V. Improving health workforce data and evidence

A. Assessing workforce health status and leveraging health-related data

60. The participating organizations were requested to share information on the overall health status of their workforce in 2023, both at the headquarters and field levels. Less than half of organizations were able to provide an estimate in that regard. Those estimates (see table 5) may not provide a full picture of the workforce health situation in the respective organizations. The evidence base of most estimates appears to be rather weak because the reference was often made to a single data point, with no corroborating evidence from other relevant sources.

Table 5
Workforce health status in participating organizations

Headquarters					*Field*				
Very good	*Good*	*Fair*	*Poor*	*Very poor*	*Very good*	*Good*	*Fair*	*Poor*	*Very poor*
UNOPS	FAO[a] ICAO ILO IMO UNHCR UPU United Nations Secretariat WFP WMO	UNRWA WIPO WHO	–	–	–	FAO[a] ICAO ILO UNHCR United Nations Secretariat WFP[a]	FAO[a] UNOPS UNRWA WFP[a] WIPO WHO	–	–

Source: Prepared by JIU on the basis of information provided by participating organizations.
[a] Both FAO and WFP noted that the workforce health status of personnel in their field offices varies across field offices depending on the conditions present at the duty stations.

61. Box 5 provides a summary of the data shared by these organizations regarding the most prevalent health problems affecting their workforces. Notwithstanding the relative availability of health-related data, they are rarely used to drive efficiency and improve health outcomes. Only two organizations (ICAO and ILO) were in a position to determine the level of corresponding financial implications for identified prevalent health problems and another five (ICAO, ILO, UNHCR, WFP and WHO) were able to indicate the percentage ratio attributable to work-related conditions.

Box 5
Most prevalent health problems of the UN workforce

- Mental health disorders
- Musculoskeletal conditions (non-traumatic) and injuries
- Cardiovascular diseases
- Oncologic problems
- Respiratory diseases

Source: Responses to the JIU questionnaire.

62. Data on the health workforce are a prerequisite for evidence-informed policy. Regularly reporting could increase the attention given by executive heads, legislative organs and governing bodies to critical health-related issues that have an impact on the personnel's health and well-being. Therefore, **the Inspector recommends that organizations continuously improve health data collection and fully leverage the collected health-related data, including through data consolidation, effective cross-functional data-sharing and expanded reporting, in order to support the periodic assessment of workforce health status and, more strategically, to ensure a data-driven and risk-based approach to healthcare and workforce health management.**

B. Enhancing data collection through health surveys at the organizational and system-wide levels

63. Health surveys are data sources that can help to evaluate workforce health status and produce, among others, disease prevalence estimates. Organizations confirmed that they had used a variety of internal and external surveys to collect health-related data. However, the collected data from personnel may be insufficient for evidence-based health interventions because these tools are not used systematically, given existing capacity and resource constrains, and may have methodological limitations. The standardization of health surveys across the United Nations system may reduce the cost of many distinct surveys, diminish survey fatigue and ensure data comparability. **Organizations are advised to standardize their health survey process and/or utilize the relevant system-wide surveys, rather than produce a variety of smaller surveys that may not have comparable metrics and that target different subsets of respondents that may not be comparable to one other.**

64. The Inspector considers that organizations' participation in system-wide health surveys should be prioritized for the benefit of the entire United Nations workforce. Ideally, there would be one survey format across the United Nations system organizations, launched simultaneously, to have the same data to benchmark. The precursor of such an instrument is the United Nations health intelligence survey.[20] The survey is a system-wide and cost-effective instrument, that, complemented by a United Nations centralized data-collection and management framework, could foster inter-agency information-sharing and cooperation and support an evidence-based and data-driven approach to workforce health management in the United Nations system.

65. After more than a decade of implementation, the United Nations health intelligence survey needs revalidation and upgrading of its questionnaire. The survey has, to date, been supported on a voluntary basis, and there is an increasing concern that, with no sustainable funding, it may cease to operate. **The executive heads of United Nations system organizations should take individual or collective action, in consultations with the executive heads of other organizations as CEB member organizations, to consider, within the framework of High-level Committee on Management inter-agency mechanisms, the endorsement of an appropriate cost-sharing funding solution for the United Nations health intelligence survey in order to ensure its sustainability and resourcing.**

C. Snapshot of sick leave statistics and costs of absence due to sickness

66. The review found that most organizations collect statistics on sick leave absences, and less so with regard to data on sick leave costs. A total of 22 organizations submitted information on certified sick leave during the period 2019–2023, and

[20] Also known as the United Nations-wide staff health and wellness survey.

only 5 shared complete information for the same period on the total cost borne on account of missing workdays due to sickness. Table 6 presents general statistics about the incidence of certified sick leave and corresponding expenditure.

Table 6
Overview of data on sick leave and sick leave-related expenditure

Organization	*Total number of certified sick leave days (2019–2023)*	*Total number of long-term sick leave days (2021–2023)*	*Average number of certified sick leave days per staff member each year*					*Average number of certified sick leave days per staff member (2019–2023)*	*Total expenditure due to sickness (2019–2023) (United States dollars)*
			2019	*2020*	*2021*	*2022*	*2023*		
FAO	89 637.5	–	6.72	5.63	3.98	6.73	6.14	5.63	–
IAEA	79 860	–	7.13	7.67	6.48	10.92	8.26	7.67	–
ICAO	17 787	–	5.35	4.78	3.71	4.68	4.95	4.78	8 358 038[a]
ILO	93 218	–	5.43	5.17	4.67	5.67	5.69	5.17	–
IMO	13 959	6[b]	17.06	10.64	9.68	8.53	7.95	10.64	–
ITC	10 761	–	6.27	5.05	3.51	5.28	6.27	5.05	5 038 645[c]
ITU	25 800	–	6.12	4.81	4.16	5.45	4.31	4.81	5 471 022[d]
UNAIDS	–	–	–	–	–	–	–	–	–
UNCTAD	15 781	–	8.94	6.18	4.37	5.17	6.64	6.18	11 467 382
UNDP	111 032.5	–	3.28	4.41	4.03	3.78	3.90	3.88	19 500 718
UNESCO	69 505	–	5.83	5.0	5.19	6.60	3.35	5.0	–
UNFPA	17 399	–	8.0	7.0	7.0	6.0	5.0	7.0	1 012 192
UNHCR	305 592	2 924	4.33	3.83	4.65	4.05	3.21	3.83	–
UNICEF	190 711	–	2.47	2.34	2.3	2.61	2.36	2.34	–
UNIDO	–	–	–	–	–	–	–	–	–
UNODC	17 134	–	3.4	4.30	3.82	5.20	6.32	4.61	–
UNOPS	52 610	–	2.11	1.84	2.02	2.63	0.46	1.84	–
UNRWA	–	–	–	–	–	–	–	–	–
UN-Women	8 305	–	1.44	1.49	1.08	1.69	2.06	1.49	–
UPU	6 313	38[e]	7.04	5.96	2.62	5.43	7.49	5.96	–
United Nations Secretariat	969 630[f]	–	5.83	5.23	4.97	5.96	5.45	5.23	–
WFP	214 671	1 853	1.72	1.80	2.21	2.17	2.39	2.05	–
WHO	172 720	–	3.89	3.64	3.67	3.61	3.37	3.64	–
WIPO	63 937	–	11.85	10.9	8.42	11.83	10.98	10.9	–
WMO[g]	3 965	–	–	3.14	4.94	3.17	2.22	3.14	–

Source: Prepared by JIU on the basis of information provided by participating organizations.
Note: A dash indicates that no data were provided.
[a] Amount is in Canadian dollars. For the years 2019, 2020 and 2023 only.
[b] 2023 only.
[c] Amount is in Swiss francs.
[d] Amount is in Swiss francs. For 2023 only.
[e] Number of cases.
[f] The total number of certified sick leave days provided by the United Nations Secretariat includes all entities administered in Umoja and covers UNCTAD, UNEP, UN-Habitat and UNODC.
[g] WMO provided data for four years (2020–2023).

67. The review found that organizations do not regularly calculate the average number of sickness-related absences per year across their workforce and do not use this as a benchmark for comparison internally, across organizational units and/or externally with sister organizations. Not surprisingly, there is no system-wide benchmark for organizational annual average certified sick leave per staff or a clear understanding of what the desired range should be for the certified sick leave annual average within an organization. **Organizations are strongly advised to determine and use organizational benchmarks on sickness-related absences to understand variations and trends and to make decisions on remedial action, if necessary.**

68. The analysis of table 6 shows that, during the period 2019–2023, the average figures for organizational certified sick leave remained quite stable for all organizations but one. On the basis of organizational averages, it was possible to calculate the system-wide organizational average of the number of sickness-related absences for the aforementioned period, which is 5.05 days per staff member. To the Inspector's knowledge, no study was conducted within the United Nations system to authoritatively determining the system-wide certified sick leave benchmark and range. **The participating organizations should encourage the United Nations Medical Directors Network to consider benchmarking sickness-related absence and recommend an organizational certified sick leave average number and a specific range of organizational certified sick leave averages, which could support the effective management of sick leave.**

69. Understanding the financial implications to organizations resulting from sick leave is of paramount importance. Through the JIU organizational questionnaire, organizations were requested to provide information on total sick and disability pay. The lack of responses may be indicative of the lack of methodologies to compute such costs. The insufficiency of data did not allow for the determination of the total certified sick leave-related direct costs for all participating organizations.

70. Two of six organizations that shared data on their annual expenditure due to sickness did so partially. Total expenditure for those organizations during the period 2019–2023 amounted to approximately $51 million. While partial, these data alone confirm that working days lost through sick leave can have a significant financial impact on United Nations system organizations.

71. **The Inspector recommends that organizations that have not done so to consolidate their sick leave management through the adoption of effective methodologies for the determination of the costs associated with certified sick leave in order to inform decision-making and make cost data accessible for all stakeholders.**

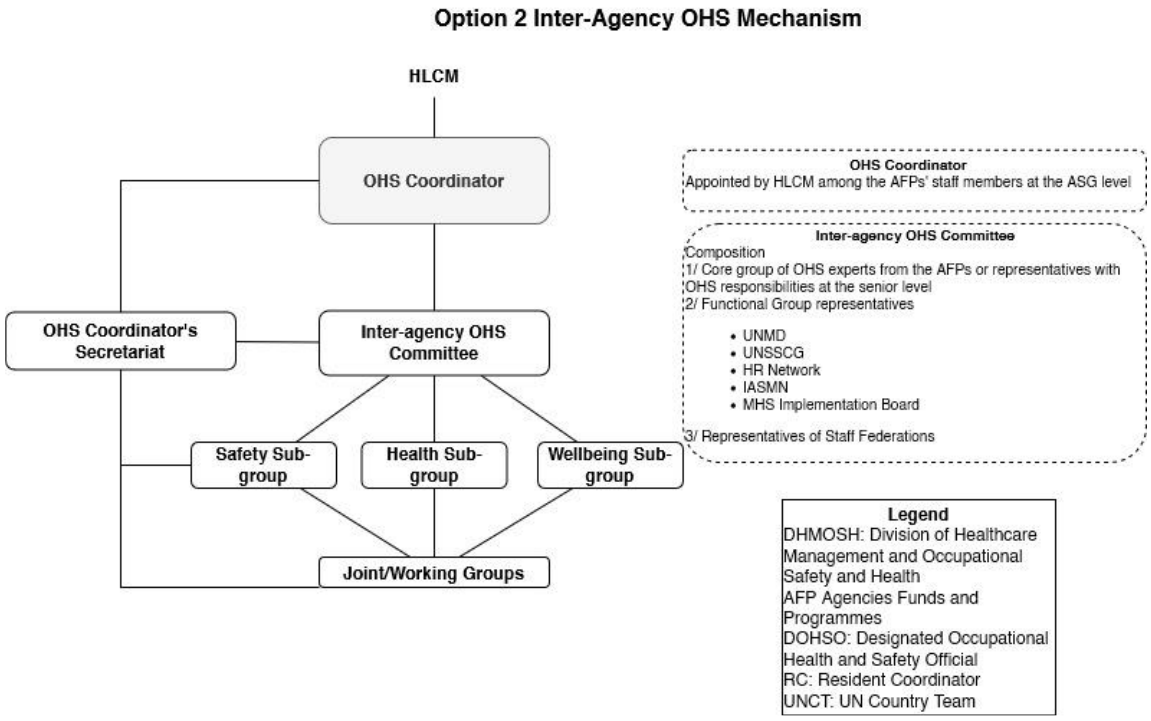
VI. Key structures to support inter-agency cooperation

72. Various inter-agency structures relevant to health, safety and well-being have operated under the High-level Committee on Management of the United Nations System Chief Executives Board for Coordination. In contrast to other strategic management areas (human resources, security, procurement, among others), no dedicated health technical network exists for the promotion of cooperation and collaboration on health and well-being matters and to provide strategic advice on system-wide health management to CEB. The complex relationships and functions involved in the current ad hoc model of inter-agency cooperation, in particular those relevant to mental health and well-being, are partially illustrated in JIU/REP/2023/4.

A. United Nations Occupational Health and Safety Coordination Mechanism

73. The evolving landscape of inter-agency cooperation in the health, safety and well-being area has resulted in new structures and roles, the most important being the United Nations Occupational Health and Safety Coordination Mechanism. Its governance structure is presented in figure V. It is expected that the mechanism will work mainly on the harmonized preparedness of occupational health and safety risks, on strengthening occupational health and safety risk assessment and on occupational health and safety policies and practices, and that its coordination role, involving some decision-making, will be activated in the case of occupational health and safety hazards affecting United Nations personnel globally or regionally.[21] The Mechanism, by virtue of its specific mandate and parameters, cannot fulfil the role of a High-level Committee on Management health technical network.

Figure V
United Nations Occupational Health and Safety Coordination Mechanism structure



Source: Occupational Health and Safety Forum, sixth activity report.

[21] CEB/2023/HLCM/17, page 6.

B. United Nations Medical Directors Network

74. At its forty-seventh session, the High-level Committee on Management briefly debated the need for the recognition of the United Nations Medical Directors Network as an official technical network,[22] but a decision was delayed, allowing for further consultation and alignment with existing structures.[23] The lack of traction for this matter reveals a certain misconception that surrounds the cross-functional collaboration approach and the concept of leadership, as applied to management of healthcare in the United Nations system. Historically, this domain has been managed from a human resources perspective. However, with the evolution of a risk-based approach to managing the health and well-being of personnel, there is now a recognized need to have fit-for-purpose leadership at the system-wide level.

75. It was the United Nations Medical Directors Network, a self-funded structure, functioning on a fully voluntary basis, that has provided, since the 1980s, expert input and guidance to the High-level Committee on Management on most health-related matters. Its current role does not allow for it to provide strategic advice and leadership on healthcare management matters such as clinical governance, workforce planning, data standards (e.g., EarthMed), change control (e.g., field clinics' openings/closures/restructures). This limitation contributes to fragmented accountability and the uneven adoption of common health-related standards in the United Nations system. There is also a deep concern pertaining to the long-term sustainability of this structure and its contribution to inter-agency cooperation. The ongoing generational change may bring new perspectives on the validity of the volunteering concept that underpins the Network model and the current form of interaction with the Committee.[24] The implementation of the following recommendation is expected to enhance inter-agency cooperation and coordination in the area of health, safety and well-being.

Recommendation 9

Starting in 2027, the executive heads of United Nations system organizations should take individual or collective action, in consultation with the executive heads of other CEB member organizations, preferably within the framework of the CEB inter-agency coordination mechanisms, to explore, biannually, conditions that allow for the establishment of a health technical network of the High-level Committee on Management that builds on an earlier request of United Nations Medical Directors Network, in order to provide strategic advice on health developments and inter-agency leadership on health-related management issues.

[22] Through a letter addressed to the CEB Chair in October 2021, the Chair of the United Nations Medical Directors Network requested the formal recognition of the Network as an official CEB technical network.

[23] CEB/2024/3, page 13.

[24] According to existing arrangements, the United Nations Medical Directors Network has reporting lines to the High-level Committee on Management Human Resources Network and should coordinate and align with the Human Resources Network in advance of each Committee session.

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Annex

Overview of actions to be taken by participating organizations on the recommendations of the Joint Inspection Unit

			Participating organizations of the Joint Inspection Unit																														
		Intended impact	*United Nations*[a]	*UNAIDS*	*UNCTAD*	*ITC*	*UNDP*	*UNEP*	*UNFPA*	*UN-Habitat*	*UNHCR*	*UNICEF*	*UNODC*	*UNOPS*	*UNRWA*	*UN-Women*	*WFP*	*FAO*	*IAEA*	*ICAO*	*ILO*	*IMO*	*ITU*	*UNESCO*	*UNIDO*	*UN Tourism*	*UPU*	*WHO*	*WIPO*	*WMO*
Report	**For action**		☒	☐	☒	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	For information		☐	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recommendation 1		**f**																**E**		**E**		**E**	**E**	**E**					**E**				
Recommendation 2		**f**																**E**		**E**	**E**	**E**	**E**	**E**					**E**				
Recommendation 3		**f**									**E**						**E**	**E**		**E**	**E**	**E**	**E**						**E**	**E**			
Recommendation 4		**f**	**E**																														
Recommendation 5		**f**	**E**				**E**		**E**		**E**	**E**		**E**		**E**	**E**	**E**		**E**	**E**								**E**				
Recommendation 6		**a**	**E**																														
Recommendation 7		**e**	**E**				**E**		**E**		**E**	**E**		**E**		**E**	**E**	**E**		**E**	**E**								**E**				
Recommendation 8		**a**					**E**	**E**	**E**	**E**		**E**	**E**	**E**	**E**	**E**		**E**		**E**		**E**	**E**		**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**
Recommendation 9		**c**	**E**		**E**		**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**	**E**

Legend:

L: Recommendation for decision by legislative organ

E: Recommendation for action by executive head

☐: Recommendation does not require action by this organization

Intended impact:

a: enhanced transparency and accountability; **b**: dissemination of good/best practices; **c**: enhanced coordination and cooperation; **d**: strengthened coherence and harmonization; **e**: enhanced control and compliance; **f**: enhanced effectiveness; **g**: significant financial savings; **h**: enhanced efficiency; **i**: other.

[a] As listed in ST/SGB/2015/3.