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Review of the Health Services in the United Nations system (expanded report)

Report of the Joint Inspection Unit

Prepared by Victor Moraru

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English only

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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
IFAD	International Fund for Agricultural Development
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	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. The United Nations, in fulfilling its organizational mandates, aims to provide a healthy, safe and respectful working environment that promotes greater accountability, efficiency and commitment in its workforce.[1] Improving the capacity of the United Nations system to protect, manage and monitor the health of its personnel remains a system-wide preoccupation.

2. The present review was initiated in response to requests from several Joint Inspection Unit (JIU) participating organizations, which suggested that JIU assess the current status of United Nations Health Services. The proposals from the proponent organizations also envisaged this undertaking as follow-up to the JIU review issued in 2011[2] and placed it in the broader context of the coronavirus disease (COVID-19) pandemic, during which the Health Services played a critical role in many aspects. Issues related to the United Nations workforce's health and well-being have been referred to in more recent JIU reviews on staff-management relations (JIU/REP/2011/10), management of sick leave (JIU/REP/2012/2), business continuity (JIU/REP/2021/6), mental health and well-being policies and practices (JIU/REP/2023/4), flexible working arrangements (JIU/REP/2023/6) and the review of health insurance schemes in the United Nations system organizations (JIU/REP/2023/9).

3. The mandate and function of a Health Service is to promote and protect the health, safety and well-being of the organization's 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.

4. 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,[3] signified a move away from limited medical-administrative functions to a more holistic, preventative and modern health and healthcare approach for the United Nations workforce. In some participating organizations, the Health Services introduced improvements aimed at streamlining their work and focusing more on occupational health and safety (OHS)-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

5. The main objective of the present review is to provide an assessment and comparative analysis of Health Services in the United Nations system and the related policy guidance and practices, with a view to identifying areas for further improvement and opportunities for enhancing coherence system-wide. The specific objectives of the review are to:

[1] See HLCM OSH Vision Statement, Bonn, 2019.
[2] Review of the Medical Service in the United Nations system (JIU/REP/2011/1).
[3] See CEB/2010/HLCM/11.

(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.

6. The review was carried out on a system-wide basis and included all JIU participating organizations.[4] 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 at aspects related to inter-agency cooperation, including in the OHS area and the work of the United Nations Medical Directors Network (UNMD). It did not cover mental health aspects and health insurance schemes because those topics were covered by two recent JIU reviews.[5]

C. Methodology

7. In accordance with JIU internal standards and working procedures, a range of qualitative and quantitative data collection methods from different sources were used to ensure the consistency, validity and reliability of the findings. Although information provided by participating organizations, as well as insights obtained through interviews with relevant stakeholders, could not always be independently verified, the team reviewed and triangulated the data to ensure internal consistency and plausibility, and systematically sought additional details or clarifications when needed.

8. The data and evidence used in preparing this report were collected at various periods from June 2024 to May 2025 using the following tools and methods:

- A pre-scoping exercise aimed at identifying the review's key areas and issues and defining the scope of the review, including possible limitations. This involved interviews with officials from selected organizations (FAO, IFAD, WFP), including chief medical officers, human resources officers, representatives of staff unions and the Chair and secretary of UNMD.
- A comprehensive review and an in-depth analysis of relevant health-related documentation, including, among other sources, governing and/or legislative body resolutions, strategies, policies, reports, manuals, guidance notes, terms of reference, memorandums of understanding, service-level agreements tools, procedures and notes, including those submitted by the participating organizations or produced by the United Nations inter-agency mechanisms and networks. Relevant documents produced by other international organizations or the private and public sectors pertaining to health-related issues were also studied.
- Organizational questionnaires requesting qualitative and quantitative information and supporting documentation, sent to all 28 JIU participating organizations. Three different sets of questionnaires were developed, tailored to the different groups of organizations and their set-up and model of Health Services:

[4] UNCTAD did not fully participate in this review. It communicated that its personnel benefits from the health services of the United Nations Office at Geneva Medical Service and that all United Nations Secretariat's health-related policies are applicable.

[5] See JIU/REP/2023/4 and JIU/REP/2023/9.

the United Nations Secretariat; participating organizations with their own health services; and participating organizations that benefit from the health services of third parties, such as another United Nations organization's Health Services, regional United Nations Joint Medical Services (UNJMS) or private service providers. An ad hoc questionnaire for regional UNJMS was also developed. The questionnaires' annexes included questions to assess progress in the implementation of the recommendations of the High-level Committee on Management (HLCM) Task Forces on Duty of Care and Occupational Health and Safety.

- Drawing on the responses to the organizational questionnaire, between June 2024 and November 2024, the Inspector conducted 65 interviews, mostly virtually, with 138 officials from 27 JIU participating organizations[6] and one non-participating organization.[7] Interviews with the former and current Chairs and Secretary of UNMD, were also held.

9. For quality assurance purposes, in accordance with article 11.2 of the JIU statute, the draft report underwent an internal peer review process to test the recommendations against the collective wisdom of the Unit. The revised report was then shared with participating organizations for factual verification and to solicit comments on the findings, conclusions and recommendations. All feedback received was duly considered in finalizing the report; however, the author bears sole responsibility for its content.

10. The review was conducted in accordance with the JIU statute and its internal procedures. Due consideration was given to protecting the confidentiality of stakeholders who responded to questionnaires, queries and surveys, as well as to those who participated in interviews. In fulfilling its professional and ethical obligations, the team maintained its independence, fairness, neutrality and professional integrity during the planning, execution and drafting phases of this review.

11. The Inspector notes some limitations to this review, which 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, 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.

12. To help the reader, the definitions and explanations for some terms and concepts are provided in the footnotes of corresponding pages. In general, the definitions and terminology used in this report follow those provided in the United Nations Secretariat, WHO and ILO guidelines. While the names "Medical Service" and "Health Service" are used as generic terms in a few cases in the present report according to context, these terms are not synonymous. The term "Health Service" refers to a more evolved entity that integrates the Medical Service or Medical Unit along with other health-related sub-functions/units.

13. The Inspector expresses his appreciation to everyone who assisted in the preparation of the report, in particular those who provided valuable responses to the questionnaires and participated in the interviews and so willingly shared their knowledge and expertise.

[6] Except UNCTAD.
[7] IFAD.

D. About the report

14. There are two outputs resulting from the review: (a) the present expanded version of the concise report which is available in English only; and (b) a concise report, issued under the symbol JIU/REP/2025/6, available in the six official languages of the United Nations.

15. The present report consists of six chapters. It provides an overview of the health function in United Nations system organizations and its evolution (chap. II), outlines the healthcare management and medical support in the field, including related challenges and opportunities (chap. III), and reviews the changing organizational approach to the health, safety and well-being of the United Nations workforce (chap. IV). Chapter V deals with health data management in JIU participating organizations, and chapter VI contains suggestions on further enhancing inter-agency cooperation and coordination.

16. The report includes nine formal recommendations, which are numbered and presented in bold, of which six are addressed to the executive heads of the JIU participating organizations, two to the Secretary-General of the United Nations and one to the executive heads of the JIU participating organizations in their capacity as members of CEB (see annex I to the concise report (JIU/REP/2025/6) for actions to be taken by JIU participating organizations related to these recommendations). The formal recommendations are complemented by 24 informal recommendations, which appear in bold text (see annex I to the present report for a list of all recommendations resulting from the review).

II. Health function in United Nations system organizations

A. United Nations health infrastructure at a glance

17. **United Nations health infrastructure.** Grasping the size and evolution of the United Nations health infrastructure is a prerequisite for understanding its components and their adequacy. The review found the lack of comprehensive mappings of health facilities in the United Nations system. It has not been possible to obtain full information on the size and composition of United Nations health personnel. While fragmented information on health facilities and health personnel exists, it is restricted to individual organizations and not always easily accessible. For the purpose of this report, JIU used the information collected during the desk research and the information that was provided by some participating organizations to produce a map that includes data on the types and number of health facilities, number of health personnel, operating/administering authority and locations or location areas for those facilities (see annex II). The lack of disaggregated data did not allow JIU to include in the map information pertaining to the specialty mix and age and sex distribution of the health personnel. While the map contains rather detailed information, it may not capture statistically all United Nations health facilities and all United Nations health personnel and may not be reflective of changes in numbers that occurred since May 2025.

18. **The number of health facilities and the size of the health workforce has grown over the years.** The map (see annex II) illustrates that health facilities are present at the headquarters of United Nations system organizations and in many regional and field offices, including hardship duty stations and in United Nations peacekeeping missions where healthcare is delivered to United Nations personnel, including uniformed personnel. Compared to the situation in 2011 when, according to JIU/REP/2011/1, there were approximately 100 medical facilities, with approximately 200 doctors, 200 nurses and a similar number of support staff in the United Nations system, 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. The healthcare personnel also includes an estimated number of 246 staff/stress counsellors.[8] This represents a significant increase, more than double the total number of United Nations health facilities and health staff compared to the data presented in the 2011 JIU report. The growth is closely related to the increase of health facilities in the United Nations peacekeeping missions after 2011 that mirrors, in turn, the increased number and/or scope of United Nations peacekeeping operations and special political missions. In 2024, there were 133 medical units[9] deployed in eight United Nations peacekeeping missions. According to the United Nations Secretariat, in 2024, there were 20 hospitals (7 level I+, 7 level II, 5 level II+ and 1 level III),[10] employing 1,115 medical personnel, deployed to provide medical support. Furthermore, there were 154 United Nations-owned health facilities, including 66 medical facilities and health centres[11] operated by the United Nations Secretariat, 56 UNDP-administered

[8] According to the United Nations Secretariat, not all staff recorded in the system as staff counsellors are employed full-time.

[9] The medical units and hospitals deployed in the United Nations peace operations are provided by the troop- and police-contributing countries.

[10] The Department of Peace Operations has adopted a four-level medical support organization, with the classification level of a unit largely determined by its treatment capability and capacity.

[11] File “UN Secretariat Medical Facilities 04_2024.elsx”. The list includes also Medical Services and Health Care Centres located at United Nations offices away from Headquarters and in the regional commissions’ headquarters duty stations.

clinics[12] and 27 WFP clinics. In addition, as of May 2023, there were 141 UNRWA health centres employing 3,126 health staff.[13] While not formally part of the United Nations healthcare workforce, 908 United Nations examining physicians[14] provide health services to United Nations system personnel.

19. **Less than half of organizations are served by their own Health Service.** Out of 28 JIU participating organizations, 11 organizations have in place their own Health Services (FAO, ICAO, ILO, IMO, ITU, UNESCO, UNHCR, United Nations Secretariat, WFP, WHO, WIPO), 9 are served by a regional UNJMS (IAEA, ITC, UNCTAD, UNEP, UN-Habitat, UNIDO, UNODC, UPU, WMO)[15] and 6 organizations by the Health Services of other United Nations organizations (UNAIDS, UNDP, UNFPA, UNICEF, UNOPS, UN-Women).[16] Two organizations have contractual arrangements with external non-United Nations health services providers (UNRWA and UN Tourism).[17]

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

20. **A medicalized health function.** 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 health system limited the organizations' capacity to monitor, support and manage it. Moreover, their capacity to discharge the duty of care[18] to personnel was further weakened by the absence of clinical governance and OHS frameworks. Against this backdrop, in 2009, UNMD advocated for a new vision for healthcare management that would integrate elements of OHS,[19] including aspects such as employee wellness/well-being. According to this approach, the "[United Nations] system medical services should primarily provide a modern occupational healthcare service based on health promotion and preventive services, with primary care elements tailored to the needs of individual duty stations".[20] The endorsement by CEB of the proposals to develop an OHS framework[21]

[12] File "UNDP CLINIC LIST January 2025_0.pdf". UNDP administers these clinics as part its common services, hiring the personnel and managing everything on the administrative side, with the Healthcare Management and Occupational Safety and Health Division (DHMOSH) of the United Nations Secretariat offering technical support.

[13] See 2023 UNRWA annual health report.

[14] United Nations examining physicians are appointed by DHMOSH, based on the recommendations made by United Nations resident coordinators and WHO representatives. They are not given any United Nations formal contract, and they charge fees for their services.

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

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

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

[18] While there is currently no United Nations system-wide duty of care definition, it is often defined as a non-waivable duty to manage foreseeable risks that may harm or injure the organization's personnel and eligible family members in the line of duty.

[19] In alignment with the relevant HLCM decision, JIU has used in this report the acronym OHS for "occupational health and safety". In 2023 the OHS Forum considered the use of the acronyms OHS and OSH and found that both acronyms have merits. While the OHS Forum would continue using OHS as decided by HLCM, the acronyms OHS or OSH could be used interchangeably.

[20] See CEB/2009/HLCM/32, p. 4.

[21] See CEB/2010/HLCM/11.

and the subsequent development and implementation of such a framework marked a paradigm shift in the provision of medical services, since emphasis was placed on prevention rather than cure.

21. **Gradual integration of the health function in the United Nations system.** The data collected during the review indicate that the new healthcare approach has led to a process of gradual consolidation of the health function (conventionally based on medical sub-function) through the integration of other health-related sub-functions such as psychosocial well-being, occupational health, occupational safety and health insurance. Most JIU participating organizations, notably those that have their own Health Services, confirmed that the implementation of new approaches related to healthcare management resulted in the gradual transformation of the health function. Table 1 provides an illustration of the consolidation and integration of the health function.

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

		Integration of health-related sub-functions				
Organization	*Health function consolidation*	*Medical sub-function*	*Psychosocial well-being sub-function*	*OHS sub-function*	*Others*	*Comments (status of integration)*
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	–		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
WFP	Yes	Yes	Yes	–	Yes[a]	Completed
WHO	Yes	Yes	Yes	Yes	No	Ongoing
WIPO	Yes	Yes	–	Yes	No	Ongoing

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

22. **Types of integration of the health function.** Two types of integration of the health function have been observed in participating organizations: vertical and horizontal. The first type of integration is based on the vertical integration of all or of some health-related sub-functions, around existing Medical Services. The second type of integration is based on the creation of a new Health and Well-being Service by merging health-related sub-functions.

23. **The level of integration of the health function.** The full integration of the health function is still an open question in some organizations. For instance, the discussions about the organizational placement of the psychosocial well-being sub-function have

been rather polarized in a few organizations.[22] Furthermore, the integration of the insurance sub-function in the health function is less common and the discussions around it tend to be localized in large-size organizations. Yet, the progress towards full integration of the health function has been noticeable[23] and this process is likely to continue.

24. **Critical benefits of an integrated health function.** An integrated health function brings together the main health-related sub-functions: medical, psychosocial well-being, and occupational health and safety. Compared with other arrangements in which health-related sub-functions are scattered among various organizational entities (human resources, safety and security, etc.), an integrated health function facilitates integrated health interventions. In this form of integration, a Health Service is well organized to manage and support health-related sub-functions to achieve the best possible health outcomes for the organization's workforce. All interviewed medical directors, and the vast majority of healthcare professionals, have confirmed the positive impacts of an integrated health function. Most health professionals recognize the imperative of full integration of the health function as 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.

25. In 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.

26. **The change process may also lead to the reduced use of the Health Services as walk-in clinics.** Customarily, the headquarters-based Medical Services operated as medical clinics or provided services as walk-in clinics. Eleven organizations (FAO, ICAO, IMO, ITU, UNESCO, UNHCR, United Nations Secretariat, WFP, WHO, WIPO) indicated that they have had in place walk-in clinics. While the notion of "walk-in clinics" is widely used in the United Nations system, no formal organizational definitions exist. The set of clinical services provided under this umbrella term may be slightly different from one organization to another. Generally, these are primary healthcare services and first referrals. While staff convenience and well-being are the reasons for offering walk-in services, there are a few matters of concern. One is linked, to some extent, to confidentiality involving some of these services, as the medical staff who provide them are employed by the organizations and often report to human resources. Moreover, the cost-effectiveness of such services may not be satisfactory for a Health Service that should function on the premise that cost management is a critical component of occupational health. Several organizations conveyed that the new organizational focus has led to the reduced use of headquarters-based Health Services as walk-in clinics (WIPO) and that there is no direct provision of a walk-in clinic except for a medical emergency response in the headquarters building (UNHCR). **In the context of integration of the health function and of**

[22] See JIU/REP/2023/4.

[23] Compared to data provided in the report JIU/REP/2023/4, three more organizations integrated their counselling sub-function into an organizational Health Service (ITU, UNHCR, WIPO).

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, 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 healthcare access behaviours of personnel, many of whom do not have a primary healthcare provider (i.e. family doctor). According to the United Nations intelligence surveys and some organizational surveys, most Health Services do not provide family physician and first referral services and only a few provide such services in respect of personnel posted in hardship locations where access to medical services is not available.

C. Changing organizational set-up and focus

27. **Headquarters-based organizations and organizations with a field presence have similar but slightly different perceptions on the optimal set-up of a Health Service.** The Inspector was interested to find out which Health Service's set-up would best respond, in the opinion of participating organizations, to existing and/or emerging challenges and would support the personnel's health, safety and well-being. The organizations with a significant field footprint (FAO, ILO, UNHCR, WFP) stressed the importance of having in place integrated and well-resourced Health Services, with OHS core teams embedded in regional offices, which proactively address health and safety risks, and create and support the conditions for the workforce, at the headquarters and field offices, to function at their optimal level. The headquarters-based organizations emphasized the need to have a well-resourced core medical staffing complement and organizational arrangements with health service providers to ensure high-quality health services for their personnel (ICAO, IMO, ITU, WIPO).

28. **Few existing organizational set-ups of Health Services are deemed to be optimal.** The review found that all organizations that have their own Health Services consider that the current organizational set-up could be further improved. This includes organizations with well-developed Health Services. According to WFP, an ideal organizational set-up is a well-resourced OHS team at headquarters, with regional technical expertise that could support capacity-building and implement the OHS management system. An integrated Health Service, comprising the Medical Section, Psychosocial Well-being Section and Occupational Safety Unit, with their core teams embedded in the regional offices, is the model that, according to UNHCR, allows for an agile and focused response to the needs of the organization and the staff. A risk-based preventative health, safety and well-being service model that proactively addresses the physical, mental and emotional well-being of staff, current and anticipated, and at the headquarters and field offices, would be considered optimal by ILO, provided that, in parallel, there is an alignment of internal policies to the preventive-focused health and well-being model. While other organizations, with less developed organizational arrangements, share, in general, these views, for them, an optimal model to provide health services is a Health Service that integrates the occupational health (physical health and mental health) and occupational safety sub-functions and allows interaction with other partner functions (human resources, logistics, security, etc.) with more independence (ITU, UNESCO).

29. **Outsourcing the health services is a close-to-optimal model, notably for medium- and small-size organizations.** More than half of participating organizations outsourced their health-related services to the Health Services of sister organizations or benefit from services provided by Joint or Common Medical Services. This group

of organizations shares a common approach to outsourcing health services that is leveraging Health Services, health facilities and service providers, including private health providers, existing in the United Nations system through memorandums of understanding for the provision of health services or other outsourcing agreements and health insurance agreements. They claim that this model creates cost efficiencies and ensures consistency in the provision of health services for them and, notably, for corresponding healthcare providers. In particular, most medium- and small-size organizations consider that it would not be cost-effective to run their own Health Services and employ health personnel.

30. **The optimal model to provide health services or to benefit from them is a matter of opinion in some organizations.** Yet, there were a few cases when organizations decided to discontinue the outsourcing arrangements, and instead to re-establish their own Health Services as this was considered to be "more effective and efficient". For one medium-size organization that reconstituted its Health Service, this also meant having "added flexibility of tailoring the service offerings to the existing organizational specificities and to the needs of its personnel as opposed to a large-scale service provider context where the organization was but one small client entity". This point is implicitly acknowledged by several large-size organizations that also outsourced their health services. One such organization, with a significant field footprint, admitted that cost-sharing agreements in place do not envisage dedicated support for its specific needs and that it had to contract doctors to meet the "high volume of medical requests" of its personnel. It is evident that organizations with or without a Health Service have yet to put in place and implement more effective models to ensure health, safety and well-being at headquarters and field duty offices.

31. **An organizational focus tilted toward OHS and well-being.** The review found that an increasing number of participating organizations have streamlined the work of their Health Services by focusing on OHS and well-being aspects. According to information provided, in seven organizations (FAO, ICAO, ILO, ITU, United Nations Secretariat, WHO, WIPO), the Medical Service has been transformed into an integrated Health Service. In two organizations (UNHCR, WFP), the Medical Service has stayed unchanged but was incorporated into a newly created Occupational Health and Safety and Well-being Service along with the other health-related components/sub-functions. The transformation of the Medical Service into an integrated Health Service is still a work in progress in other two organizations (UNESCO, WIPO). The changed focus is also illustrated by the inclusion of terms like "OHS", "well-being" and "wellness" in the names of several Health Services even if the meaning of the latter two notions[24] is different, as the review found out, for different organizations.

32. **The change process of the health function is a relatively recent effort that is unfolding in some organizations that have their own Health Services.** The process of integration of the health function and the subsequent structural consolidation of respective organizational units is still ongoing in almost half of organizations that have their own Health Services. The progressive transition of Medical Services to integrated Health Services reflects, according to participating organizations, a strategic realignment aimed at enhancing the organizations' focus on the workforce's OHS, well-being and wellness, as well as optimizing operational support functions. Table 2 illustrates the change process of the health function.

[24] According to the Global Wellness Institute, the term "wellness" is defined as the process of active research of lifestyle choices that lead to a holistic health condition while the term "well-being" is defined as "good health", understood as a static condition that goes beyond mere health physics, incorporating other subdimensions, including mental health.

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	–	The 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	Division of Health Care Management and Occupational Safety and Health	1. Health Intelligence and Public Health 2. Healthcare Quality and Clinical Governance Section 3. Medical Entitlements 4. Occupational Safety and Health Section 5. Staff Counsellors Office 6. United Nations Medical Emergency Response Team Section 7. Workforce Management Section
WFP	Medical Service	Wellness and Culture Division	1. Medical Service 2. Counselling Service 3. Health Insurance Service 4. Culture and Values Unit

Organization	*Name of Health Service before integration*	*Name of Health Service after integration*	*Current structure of Health Service*
WHO	Health Medical Services	Staff Health and Well-being Department	Not structured in units/sections
WIPO	Medical Unit	Occupational Safety and Health Service	Not structured in units/sections

Source: Prepared by JIU based on information provided by participating organizations.

33. **The integration of the health function has so far had little effect on the reporting chains and on the function's status.** An integrated health function is associated, institutionally, with an integrated Health Service. Table 2 shows that an integrated Health Service means, in some cases, a larger organizational entity, with several divisional units which mirror, sometimes, the corresponding health-related sub-functions. The consolidated status of such integrated entities may put them on an equal footing with other similar organizational structures or even elevate their hierarchical level. In four organizations (UNHCR, United Nations Secretariat, WFP, WHO), the process of integration has led to the empowerment of the health function. For instance, apart from inducing integration of the health function, another major change brought about by the United Nations Secretariat's 2018 management reform was the termination of the Health Service's subordination to the Human Resources Services Division. The Healthcare Management and Occupational Safety and Health Division (DHMOSH) was made equal to the Human Resources Services Division, and its incorporation into the Department of Operational Support (DOS), together with other divisions (Logistics, Procurement, Capacity Development and Operational Training Service) has allowed for synergies to better support service delivery. In other organizations, the integration of the health function did not affect the traditional reporting chain and/or the function's subordination status. The Health Services of seven organizations (ICAO, ILO, IMO, ITU, UNHCR, UNESCO, WIPO) remain placed within the human resources function and report to it. This mirrors the situation described in the previous JIU report (JIU/REP/2011/1) when only one Medical Service had an emancipated reporting line (FAO).

34. **Dissenting views on preserving the placement of the health function within the human resources management function.** Undoubtedly, there are benefits associated with the traditional reporting line. Both functions cover areas that include employee relations, including OHS. The human resources function monitors and analyses staff sickness-related absence data, including certified and uncertified sick leave, to identify trends and allow both functions to work together to address the root causes. Furthermore, according to one organization, "the model of [the] Medical Service being part of [the] human resources division does not compromise its autonomy and … enables efficiency gains through the flexibility [of] resource cross-sharing". However, according to other organizations, notably those that upgraded the status of their Health Service, being part of the human resources function represented both "confidentiality and budgetary control issues" and "the change in status and of reporting line contributed not only to improving employees' perception regarding the protection of their medical confidentiality but also led to the optimization of budgetary resource management". There are more detached standpoints, summarized by one organization, which stressed that "the focus should not be on structure, but on ensuring a close collaboration of two functions" as well as with "other stakeholders". This has not always been the case, according to some interviewees. It appears, therefore, that other benefits related to the communication and coordination area, claimed mostly by the interviewed human resources officials, are equally achievable

through effective collaboration between two independent functions and not only within a superior-subordinate relationship.

35. **Increased OHS roles of the integrated Health Services should be factored into analysis.** While the views mentioned above may be valid within the organizational culture prevailing in each organization, a system-wide perspective cannot exclude the focus on existing organizational arrangements. This brings to the fore the issue raised in the previous JIU report as to whether the Medical Service should be "independent" from other organizational units. While the point was made in 2011 that "OHS Services should remain independent from other administrative/organizational units and report either directly to the head of the organization or to his/her appointed representative", this approach may not be optimal for all organizations given their size, business model and internal structuring. The same goes for organizations that have in place small health teams that are primarily focused on medico-administrative activities. Yet, the evolved or integrated Health Services should be considered in terms of their current tasks and added responsibilities, notably in the area of OHS. The significant implementing roles assigned to integrated Health Services, including reporting roles to organizational OHS committees, put them on equal footing with other implementing entities, including human resources. The same is true for the regional UNJMS. Their beneficiaries are not only the United Nations Secretariat's entities but also many organizations that operate in the various regions. As has been the case of organizational Health Services, the adoption or expected adoption of OHS policies impacted their mandate orientation and new OHS-related tasks were assigned. Though they are large health providers, comparable to the Health Services of some United Nations organizations, they have had little say in their governance. Their reporting line has invariably been through the human resources directors of United Nations offices away from Headquarters and of the United Nations regional commissions, linked to the budget and programme. Most interviewees from regional medical services stressed, inter alia, that one of the consequences of not being autonomous in decision-making and budget matters was the lack of flexibility in terms of human resources allocation and medical equipment acquisition for the areas of emerging need.

36. **Empowering Health Services.** While the integration of the health function has been influenced by the acknowledgement at the system-wide level, in 2010, of a new vision for healthcare management and, more recently, by the need to implement OHS principles and standards, many organizations admitted in their responses to the JIU questionnaire that the "tone at the top" remains a key factor in finalizing this process. The lack of buy-in at the executive management level is best illustrated by one comment on this subject: "The name of the organizational unit (i.e. Medical Service) was changed to Occupational Health Service, but no other change was implemented". Moreover, contrary to existing formal commitments "the Staff Welfare sub-function was transferred to another structural unit". In light of benefits associated with a consolidated organizational health function, there is a need to pursue the process of effective integration of the health function. There are several examples which demonstrate that the creation of Health and Well-being Services with a higher standing within the organization have 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 UNJMS[25] and empowers the personnel to seek health services, notably medical consultation and counselling, without fear of a breach of non-confidentiality. This enhances confidence and trust in the Health Services and leads to a specialized focus on expertise, improving the quality of services offered. While the changing reporting lines and resulting

[25] The regional UNJMS have dual reporting lines: technical reporting lines to DHMOSH and administrative reporting lines to the human resources units of offices away from Headquarters.

segregation may lead initially, in some cases, to some communication gaps and to slightly increased administrative costs, the potential challenges could be minimized by establishing parallel reporting lines for these entities to the same executive management function. From the Inspector's point of view, 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.

37. 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.

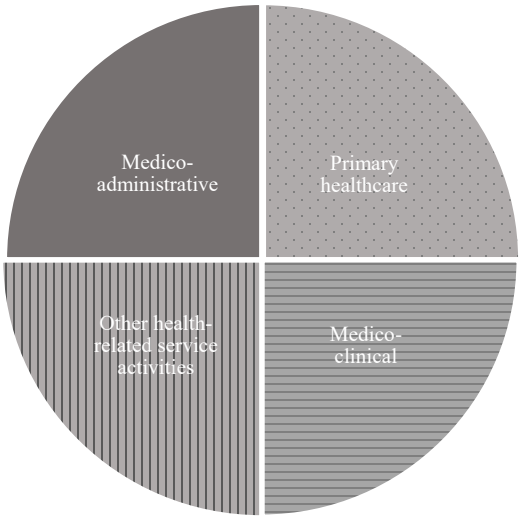
D. Core activities, policy guidance and mandates

38. The number of core activities and corresponding categories has increased. In order to understand the evolution of core activities, for comparative purposes, the list of healthcare services provided by Medical Services, according to the 2011 JIU report (JIU/2011/1), was used as the baseline.[26] Information collected from participating organizations indicates that the number of core activities has increased, notably in the area of OHS. The transformation of Medical Services into integrated Health Services has also led to the addition of a distinct category of psychosocial support activities (see figure I).

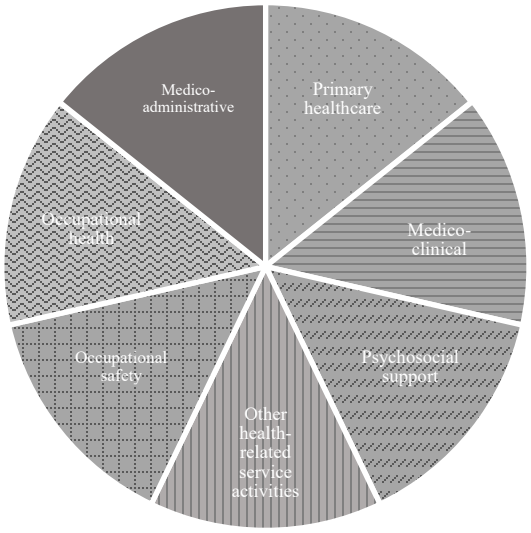
[26] Information provided in JIU/REP/2011/1, figure 3 and annex I.

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

Core activities of Medical Services in 2011



Core activities of Health Services in 2024



Source: Prepared by JIU based on information provided by participating organizations.

39. **Lack of uniformity in core activities assignment to applicable categories.** Information collected from organizations also indicates that while several categories and terms (medico-administrative, primary and preventive healthcare, medico-clinical, occupational health and occupational safety) appear in various internal documents, the core service activities are not rigorously assigned to or grouped under corresponding categories. The significant discrepancies in the way the organizations assigned, in their responses, identical or similar core activities to different categories of core services reveals the lack of rigour and, to some extent, the lack of understanding of the scheme of classification applicable in such contexts. There is a clear need for a common approach in assigning core activities to applicable categories. UNMD should consider and agree upon, at the earliest opportunity, the use of a harmonized taxonomy pertaining to the assignment of core activities to applicable categories, and promote the inclusion and utilization thereof in the policy guidance of the participating organizations. This would also allow the possibility of comparing the sets of core health activities across health facilities in the United Nations system and/or promoting system-wide harmonization.

40. **An abundant but incoherent policy guidance for health function.** 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, strategies, policies and administrative issuances, standard operating procedures and guidelines (see annex III). Yet very few organizations were able to provide structured information, in order of descending priority, regarding the main governing documents for their Health Services. In some cases, the hierarchical apex of the policy framework was “guidelines on sick leave entitlements”, “policy on flexible working arrangements” or “policy framework on occupational safety and health”. At the same time, 10 of the 11 organizations that have their own Health Services indicated that

some of their governing documents need to be revised or are being reviewed (FAO, ICAO, ILO, IMO, ITU, UNESCO, United Nations Secretariat, WFP, WHO, WIPO).

41. **Insufficiently transparent and structured policy guidance.** Furthermore, except for UNHCR, no organization confirmed the existence of a compendium of documents or of a dedicated digital repository where all the latest versions of such documents are included. In the view of the Inspector, these governing documents are intended to be widely shared and available to medical teams, especially in the field, to provide transparency and to communicate mandates. A streamlined documentation process directly translates into faster, more accurate service delivery. Participating organizations which have their own Health Services, and which have not yet done so, should consider establishing a dedicated digital repository of documents related to healthcare management and/or compiling and maintaining a compendium of such documents to ensure centralized access, version control and prioritization across all documents.

42. **Stand-alone documents defining the mandates for Health Services and regional UNJMS are largely absent.** Only two organizations (UNESCO,[27] United Nations Secretariat) and one Joint Medical Service (Vienna International Centre Medical Service)[28] have in place a document that formally sets out the mandate and, to some extent, the core service activities. However, in the case of the United Nations Secretariat, the formal mandate of DHMOSH is contained in the latest edition of the Medical Support Manual for United Nations Field Missions (2024),[29] which also comprehensively covers medical support aspects across all United Nations missions globally.[30]

43. **The absence of a formal mandate and core activities is considered a critical weakness.** The absence of a formal document describing the mandate and core activities of health facilities generates implementation issues in terms of what tasks should be performed and what resources are required to do so. The review found that most headquarters-based Health Services as well as the United Nations Secretariat-administered regional UNJMS perform tasks without a well-defined regulatory basis. Furthermore, the additional responsibilities which have been assigned to the regional UNJMS in conjunction with the decentralization are not reflected in their mandates. For instance, performing additional tasks related, for example, to the provision of travel and medical clearance of United Nations personnel located in the respective regions and/or tasks generated by the operationalization of OHS frameworks is considered to be a concerning trend that cannot be sustainable in the short or medium term. Some interviewees noted that “we do more and more and not sure that the existing document(s) include all the activities that we are doing now”. The lack of sufficient resources to perform such additional tasks was also stressed in this context by most interviewees (see sect. F below).

44. **The issuance of a formal document clearly setting out the mandate and core activities is warranted.** In line with the general practice adopted in the United Nations system, it is expected that each organization promulgates internally a formal “mandate” for its Health Service where its main purpose/objectives, roles or tasks are defined. An effective mandate is one that clarifies why the unit exists, what its domain is, and its authority or decision rights. Its absence dilutes accountability. A clear-cut mandate and core activities offer a realistic basis for deciding on the adequate

[27] UNESCO Human Resources Manual, item 7.2, para. 10, 2009.

[28] AM.II/18. The Vienna International Centre Medical Service provides services to other entities which have concluded an agreement with the IAEA.

[29] Medical Support Manual for United Nations Field Missions (fourth edition).

[30] See also ST/SGB/2011/4, which outlines the roles and responsibilities of the medical services division.

resource levels for the Health Services, including in cases where additional tasks and responsibilities are being added.

45. 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.

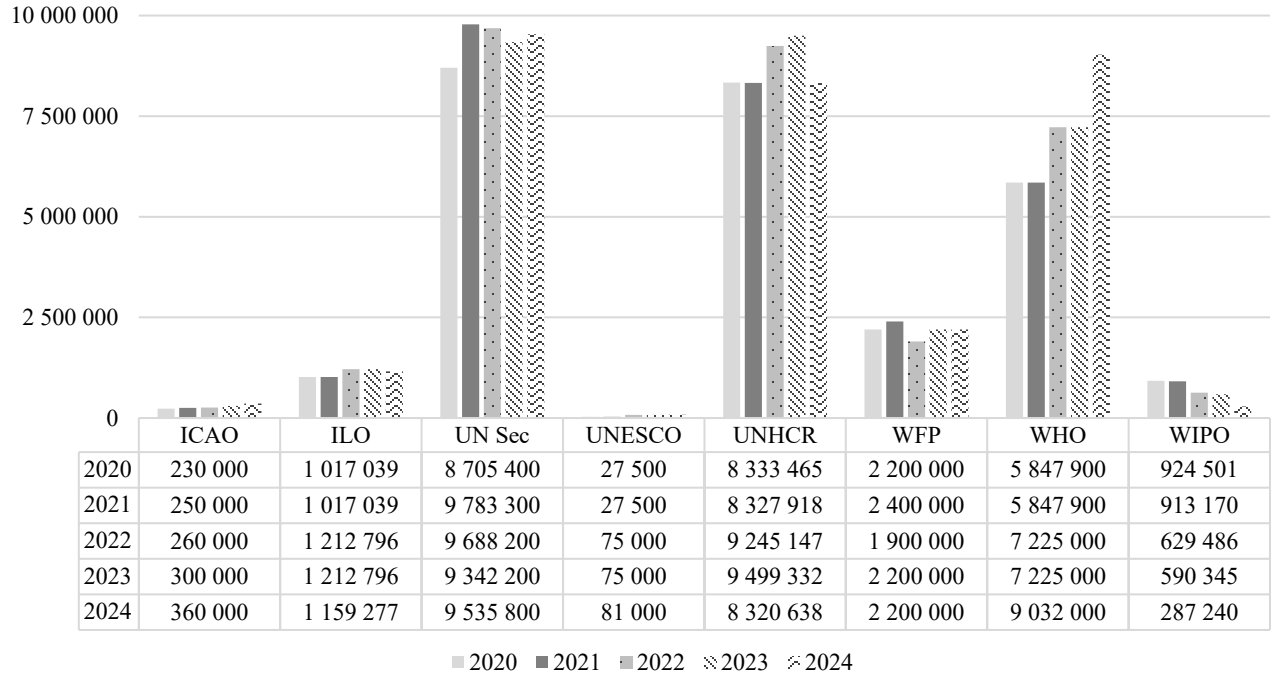
Recommendation 4

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

46. **The budgetary allocations for Health Services remained unaffected by the change process of the health function.** The information provided by some organizations indicates that the budgets for their Health Services remained overall at levels similar to the period from 2020 to 2024, except for two organizations. It seems that the integration of the health function did not affect the health budgets, except for WHO where the budget increased. Figure II below 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	UN Sec	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 based on information provided by some participating organizations.

47. **Comparing budgets of Health Services.** The review compared the healthcare budgets, including parameters such as the percentage of the Health Service budget compared to the total organization budget and the ratio of the Health Service budget in relation to the number of personnel serviced. Organizations spent about 0.23 per cent of their total organizational budget for the Health Service in average across participating organizations in 2024, ranging from 0.08 per cent (WIPO) to 0.42 per cent (ICAO). In terms of the ratio of the Health Service budget in relation to the number of personnel serviced, it was on average approximately $400 per employee annually in 2024. The budgetary data shared by the organizations were limited and no firm conclusions can be drawn on these aspects. Furthermore, there is no one-size-fits-all approach, given the differences of the size, structure, mandates and business models of organizations. Yet, the data included in table 3 below allow for comparison and this may help organizations to identify an equivalent, personnel-adjusted level of funding for healthcare.

Table 3
Healthcare expenditure statistics in selected United Nations organizations, 2020–2024

	Healthcare budget share of total organization budget (percentage)					*Healthcare budget per employee annually (United States dollars*				
Organization	*2020*	*2021*	*2022*	*2023*	*2024*	*2020*	*2021*	*2022*	*2023*	*2024*
ICAO	0.28	0.30	0.31	0.34	0.42	200	217	226	261	313
ILO	0.29	0.25	0.31	0.26	0.26	300	286	336	345	329
UNHCR	0.17	0.17	0.16	0.18	0.20	467	442	448	456	415
WFP	0.51	0.54	0.23	0.23	0.22	109	113	81	91	96
WHO	0.16	0.16	0.15	0.15	0.18	545	525	619	587	788
WIPO	0.29	0.26	0.17	0.18	0.08	785	778	539	509	245
Average	0.24	0.23	0.22	0.22	0.23	459	449	433	431	418

Source: Prepared by JIU based on information provided by some participating organizations.

48. **Funding may be insufficient to support some Health Services' core activities.** Five organizations (ICAO, ILO, ITU, UNESCO, United Nations Secretariat) considered the allocated financial resources to be sufficient for providing the core health services at the headquarters level, while five other organizations (FAO, UNHCR, WFP, WHO, WIPO) considered them insufficient. When it comes to the funding allocated for health facilities in the field, organizations with a larger field footprint admitted that they are faced with financial challenges in view of increased costs and workload and the need for additional resources, mainly human resources. This is particularly true for the medical services of the United Nations Secretariat's regional commissions and offices away from Headquarters (except for the United Nations at Geneva Medical Service), as well as for regional medical teams of UNHCR and WHO. Organizations noted that the allocation of funding has not been commensurate with the increased OHS-related needs, including in the area of coordination and implementation. Moreover, very limited financial resources are available to ensure a timely emergency response when new emergencies arise, notably in remote areas where there is limited health capacity.

49. **Healthcare needs and priorities should guide the decision-making on funding allocation.** The review found that the decision-making on funding allocation for the Health Services is mostly driven by the availability of funds and not tightly linked to healthcare needs and priorities. The COVID-19 pandemic has not altered the organizational healthcare budgets, and this is reflective of existing budgeting approaches. Very few Health Services (WFP, WHO, etc.) develop and issue dedicated documents (e.g. operational plans, health strategies, etc.) which can support health-tailored funding. For instance, the WHO Staff Health and Well-being Services strategy for 2018–2023 sets out the priorities, key performance indicators and targets for each key objective. It serves as the conceptual framework for developing a coordinated and harmonized approach to annual workplans and measuring success, and as the strategic basis for biannual budgets and resource mobilization. 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.**

50. **Limited involvement of the Health Services in the budget discussions.** Generally, the Health Services have little say over their funding. This is mainly a consequence of their subordinated role to other functions. The Health Services with

an upgraded status and with a reporting line to executive management (ex. United Nations Secretariat, WFP, WHO), which have more opportunities to effectively participate in the discussions on the allocation of healthcare budgets. It is essential to seek inputs from the 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.**

51. **Approaches vary in procurement of medical goods.** The review found that various approaches are employed for the procurement of medical supplies and equipment, and this is reflected in the degree of centralization and the criteria used by organizations with their own Health Services. The trend is towards centralization at the headquarters level in most of the organizations (FAO, ICAO, ILO, ITU, UNESCO, United Nations Secretariat, WHO, WIPO) except for some organizations with larger field footprints (e.g. UNHCR, WFP) where the procurement is primarily decentralized. The latter group and some other organizations, including WHO, often employ a combination of centralized and decentralized procurement approaches, where bulk purchases are often made centrally and the acquisition of particular medical goods, notably for specific emergencies, is done locally. The criteria used for the procurement of medical goods follow the organization's relevant rules and regulations, and generally they include price, quality, value for money, matching of technical specifications, delivery lead time and expiration date. The criteria used by WFP – quality, pricing volume, maintenance needs and geographical coverage – seem to indicate a more comprehensive approach that is close to the core idea of value-based procurement.[31] While the price of products is always an important factor, **the Inspector encourages organizations to prioritize the value-based approaches in the procurement of medical items to maximize the ultimate value of money.**

52. **Health Services are involved in the procurement process.** Organizations acknowledge the essential role of the Health Services in ensuring an effective procurement process. Without their involvement it would be difficult to procure "the right product or service of the right quality and right price, and the right quantity, at the right place and time", which is a basic tenet of procurement, recognized also in the WHO procurement process resource guides.[32] The Health Services' role in the procurement of medical goods includes: preparing procurement plans for medical goods and services, defining the terms of reference and specifications of all medical goods to be procured, providing technical support during the evaluation of bids related to medical supplies and equipment; verifying conformity with the specifications provided on receipt; and consulting and liaising with other organizational units and procurement committees involved in the procurement process, etc. Annex IV provides an overview of the procurement process and practices for medical goods.

53. **Challenges and opportunities related to procurement process.** More than 10 years ago, the organizations agreed with, but did not follow up on, a view advocated in a previous JIU report (JIU/REP/2011/1) that there was "a need for a [United Nations] centralized, properly structured and funded procurement system for medical supplies, which would increase efficiencies of bulk purchasing, reduce unnecessary and duplicated administration, and minimize such delays".[33] Indeed, the United Nations system could achieve significant efficiency gains, particularly with respect to

[31] Value-based procurement, also known as "best value" procurement, means evaluating purchases beyond price. It means going beyond "lowest responsible bidder" criteria to weigh in factors such as long-term value, evolving technologies and other parameters in order to provide good-quality healthcare at competitive or sustainable prices.

[32] See, for example, WHO procurement process resource guide, 2011.

[33] See A/66/327/Add.1, para. 11.

numerous field offices. The same is true for acquisitions through individual, centralized procurement systems. Responding to the current review's questionnaire, several organizations indicated that a centralized procurement system for medical goods would allow for taking advantage of volume discounts and bulk purchasing, consolidate orders and thereby reduce redundant orders and speed up the overall process. There are opportunities to further increase efficiencies in the bulk purchasing of medical goods by using long-term procurement agreements and by standardizing the medical equipment. Product standardization reduces a variety of item purchases, simplifies orders and takes advantage of bulk discounts. Joint procurement contracting of certain medical goods and services could be also envisaged. For instance, to improve efficiencies and to benefit from a joint economy of scale, WFP, FAO and IFAD jointly contracted evacuation services, which is a good practice, in the Inspector's view. Despite its benefits, centralizing procurement for medical goods may be less flexible for local needs, less efficient and more time consuming as there is a requirement to secure approvals from headquarters procurement services. In some situations, it may be cheaper to acquire some medical goods locally, as this may incur lower transportation costs and ensure faster delivery (or even lower prices). Therefore, **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.** However, controlled flexibility for local procurement should be explicitly enabled – especially in duty stations where customs bottlenecks, fragile delivery networks, security restrictions or macroeconomic volatility routinely delay the timely acquisition and last-mile delivery of medical goods. For instance, UNHCR regional offices manage their own procurement processes, except for situations when the allowed amount for a five-year window is being exceeded. Similarly, the United Nations Secretariat-administered regional UNJMS have delegated authority for certain procurement processes.

54. **Procurement and preparedness for health emergencies.** Past health emergencies, notably the COVID-19 pandemic, revealed vulnerabilities in the United Nations procurement system for critical medical items while also driving innovation and inter-agency cooperation. In particular, it highlighted the importance of pooled funding and collaborative procurement frameworks (ex. the COVID-19 Vaccine Global Access Facility and the WHO Access to COVID-19 Tools Accelerator) and pre-positioned emergency medical stockpiles. Several organizations shared their experiences in this area. For instance, the United Nations Secretariat indicated that procurement for COVID-19-related items, such as protective equipment, vaccinations, masks and gel, etc., which were purchased globally through centralized procurement, was considered a good practice, and may be done for other emergencies. WIPO had put in place a pilot bulk procurement initiative with other United Nations organizations for orders during the pandemic. Such practices could be used to optimize the procurement mechanisms to make them fit-for-purpose for both health emergencies and the non-emergency settings. The Inspector advises participating organizations to utilize pandemic-related lessons learned and good practices and put in place a United Nations procurement arrangement to ensure preparedness and response for large-scale health emergencies.

F. Human resources complement, credentialing and career framework

55. The review looked at the various human resources aspects related to Health Services, including staff composition, credentialing and career framework. The human resources complement of the Health Services varies significantly across organizations, given their different mandates and geographical coverage (see annex V).

56. **Fewer than half of the organizations consider the human resources complement of their Health Services to be satisfactory.** While three organizations indicated in their responses to the organizational questionnaire that, in general, the human resources complement of their Health Services is satisfactory (ILO, WFP, WIPO), all organizations that have their own Health Services acknowledged that, in an environment of continuously increasing workload, there are challenges as to the sufficiency of providing adequate services, including in field duty stations, notably in the "deep field". According to them, additional human resources, particularly in key areas such as OHS and counselling services, would strengthen mandate delivery. Furthermore, technical expertise shortages need to be addressed by hiring specialized staff (e.g. OHS professionals, health administrators, data analysts, communication experts, etc.).

57. **Staffing structure could be further optimized.** A number of common challenges as to the adequacy of the human resources complement were raised by organizations, including from those entities that considered it satisfactory. Many organizations noted that the current staffing structure of their Health Services is suboptimal not only in terms of numbers but also of types of contracts, many of which are consultant or temporary contracts. While hiring temporary staff for emergent needs (epidemics, vaccination campaigns, staff recruitment surges, etc.) is justifiable, a staffing structure based on permanent contracts would ensure the sustainable management of the Health Services, long-term planning, retention of experienced staff and attracting of talent. The shortage of full-time medical professionals and healthcare personnel in field health facilities also hinders the delivery of effective care at the field level and in remote areas. This leads to increased workload and burn-out, and compromises the quality of care provided.

58. **Health staff allocation should be strategic.** The number and skill set of the staff allocated to Health Services should meet the operational and evolving healthcare needs. The review found that staff allocation, including staff hiring for field health facilities, is often based more on funds availability and non-medical considerations than healthcare needs. The Health Services have limited say in the staff allocation. There is little evidence that organizations conducted comprehensive needs assessments to ensure aligning health staff allocation with the organization's healthcare priorities. Furthermore, benchmarks are not used to compare the Health Services' staffing versus the size of the population served. **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.** In particular, as part of these reviews, organizations should identify critical positions of a continuous nature for the possible establishment of health staff positions, funds permitting.

59. **Benchmarks for health staff allocation.** More than half of the organizations with their own Health Services indicated that their human resources complement is inadequate. However, no specific benchmarks, internal or external, were referenced that would conclusively support such assessments. Having those may help to make the case for the desired health staff allocation. The Inspector notes that the availability of benchmarks for health staff allocation (for example, the ratio of health staff versus the size of the population served) would support and better inform the staff needs assessments. Given the limitations of external benchmarking per capita and the lack of comparable data at the United Nations system organizations level, organizations should encourage and support UNMD to continue efforts to improve and/or review its methodology to create benchmarks for health staff allocation, based on data collected from organizations with comparable mandates, including for headquarters versus field mandates.

60. **Lack of standard operating procedures for recruitment and credentialing of health personnel.** The recruitment of medical and healthcare professionals falls under the policy and procedures established by organizational human resources units for the appointment of staff in regular positions. Generally, organizations use terms of reference developed by their organization and/or generic terms of reference from UNMD that are adapted to the entities' needs. The interviewees noted that recruitment and the related credentialling of health personnel is a challenge in view of the large diversity of health-related personnel and educational backgrounds. Accordingly, additional technical guidance for recruitment and credentialing of such personnel would be welcomed. The United Nations Secretariat is the only entity that issued a standard operating procedure that applies to the recruitment of medical personnel in UNDP-administered clinics.[34] Moreover, it issued a dedicated guideline that establishes standards for the professional qualifications of medical personnel that are accepted by the United Nations and outlines the technical clearance process, including the review of qualifications of all medical personnel, to ensure that prescribed or desired qualification requirements are always met in all duty stations.[35] In the Inspector's view, this is a best practice across the United Nation system. **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.**

61. **Career framework: opportunities and challenges.** Entering the United Nations system with a clinical background is fundamental. As health personnel are technical, to ensure that they are consistently fit for purpose, organizations should help them to maintain and acquire additional skills, including of managerial nature. The review found that five organizations with their own Health Services (ILO, ITU, UNHCR,[36] United Nations Secretariat, WFP) have set formalized systems for skills maintenance and continued professional development and six others did not do so (FAO, ICAO, IMO, UNESCO, WHO, WIPO). In the latter group, health professionals are responsible for their professional development and recertification, with financial support from the employer (e.g. WIPO) or without such dedicated support. Ensuring compliance with changing regulatory requirements and accreditation standards on the credentialing of health professionals remains a challenge across the system. In most organizations, career development is limited for health staff, especially from small-sized Health Services, as the levels that can be achieved are quite low compared to non-United Nations health professionals working in national healthcare systems. Similarly, nurses seem to be unfavourably graded. It was suggested by some interviewees that it would be beneficial to provide facilitated career management for these functions across the United Nations system. Other challenges to the existing career framework include the lack of standards for continuing medical education, the lack of generic job profiles for physicians, nurses and occupational health professionals, the lack of terms of reference for occupational health and well-being senior management posts, low attention to the benefits of staff rotations through organizations and the lack of preferential selection criteria for health professionals who benefited from such rotation.

62. **Leveraging the expertise of UNMD.** UNMD is best positioned to consider the aforementioned subject matters in a holistic way. Organizations should encourage and support UNMD to examine the credentialing of health personnel, assess the grading

[34] Standard operating procedure on recruitment of medical personnel in UNDP-administered clinics (2023).

[35] United Nations guideline on technical clearance review of medical personnel for deployment to United Nations field duty stations (2023).

[36] For instance, UNHCR has in place an internal medical standard operating procedure on continuous professional development.

of medical posts and the aspects related to professional background, required skills and inter-organizational staff rotations, and provide recommendations and guidance which would foster common approaches in these areas.

63. **Assuring a competent workforce for health delivery.** The review found that most organizations offer training programmes and courses for health personnel, in person and online. They cover core activities as well as healthcare quality and patient safety, management systems (e.g. Earthmed, Cority) and telemedicine. These programmes and courses are part of continuing medical education and crucial for maintaining competence, meeting licensing requirements and staying abreast of new developments in medicine. Several organizations brought up the lack of resources and/or capacity for specialized training and indicated interest in participating in joint trainings and knowledge exchange across the United Nations system. Some organizations have offered joint training courses. For instance, WFP has offered in-house training to United Nations agencies, such that they can establish their own ergonomic programmes. DHMOSH has offered to all United Nations system organizations weekly medical workforce online trainings and global webinars, with about 40 trainings per year on various health topics: infection management, occupational disease management, mental health, health promotion programme, ergonomics, outbreaks and emergency management. WHO initiated training programmes pertaining to Medical Emergency Response Teams to bolster the effectiveness of field operations and to ensure deployment at short notice. Similarly, the sharing of training materials and related information is facilitated by DHMOSH through knowledge hubs, such as the casualty evacuation (CASEVAC) hub and the telemedicine hub. Joint trainings and inter-agency sharing of training materials are considered good practices. Organizations are encouraged to discuss cost-sharing and promote joint training activities and the sharing of training material across the United Nations system, as they are practical and cost-effective modalities that also foster system-wide coordination and coherence.

III. Healthcare management

64. A developed network of health facilities in the field. United Nations system organizations have invested considerable resources in developing a network of health facilities in the field. The field health network comprises a variety of healthcare providers, including United Nations-owned equipment and contingent-owned equipment healthcare facilities (204), UNDP-administered clinics (56), WFP-owned clinics (27), deployable medical facilities in emergency environments, specialized teams used during strategic evacuations and United Nations examining physicians (more than 900). As illustrated in table 4, most field health facilities are deployed in the United Nations peacekeeping and special political missions. The table is also reflective of existing United Nations medical support system in the field that encompasses health facilities designed to offer different levels of care, including capabilities for CASEVAC.

Table 4

Hospitals and medical units deployed in United Nations peacekeeping and special political missions

	Hospitals (levels)				*Medical Units (levels)*							
Mission	*Hospital level 1*	*Hospital level 2*	*Hospital level 2+*	*Hospital level 3*	*Police-contributing country level 1*	*Troop-contributing country level 1*	*Troop-contributing country level 1+*	*Troop-contributing country level 2*	*Troop-contributing country level 2+*	*Troop-contributing country level 3*	*Aeromedical evacuation team*[37]	*Light mobile surgical module*[38]
MINURSO	1	–	–	–	–	–	1	–	–	–	–	–
MINUSCA	–	1	3	–	16	38	–	3	1	–	4	–
MONUSCO	1	2	–	1	9	36	–	1	–	1	4	1
UNDOF	1	–	–	–	3	–	1	–	–	–	–	–
UNFIL	2	–	–	–	–	–	–	–	–	–	–	–
UNFYCYP	–	–	–	–	–	1	–	–	–	–	–	–
UNIFIL	–	–	–	–	–	13	1	–	–	–	1	–
UNISFA	–	–	1	–	7	–	–	–	1	–	1	–
UNMISS	1	4	1	–	4	26	–	–	5	–	5	–
UNSMIL	–	–	–	–	–	–	1	–	–	–	–	–
Total	**6**	**7**	**5**	**1**	**39**	**114**	**4**	**4**	**7**	**1**	**15**	**1**

Source: Prepared by JIU based on information provided by DHMOSH (July 2024).

[37] The aeromedical evacuation team is a medical team responsible for providing in-flight medical care during aeromedical evacuations (MEDEVAC) of United Nations personnel. It is used in level 2 and level 3 facilities and during strategic evacuations from remote or high-risk field missions.

[38] The light mobile surgical module is a deployable, self-contained medical facility that provides tertiary-level care (level 3) in peacekeeping or emergency mission environments.

65. **United Nations medical care model.** Principles of medical support aim to ensure the health and well-being of field personnel (see figure III). This is achieved through effective planning, coordination, monitoring and professional supervision of medical services in the field. The medical care model (see table 5) is intended to meet the requirements of United Nations civilian and uniformed personnel in field locations where access to healthcare providers is limited or unavailable.

Figure III
Principles of medical support

Source: Medical Support Manual for United Nations Field Missions (2024).

Table 5
United Nations medical care model

Continuity of care			
Within mission area			*Outside mission area*
Point of incident/injury	*Police- or troop-contributing country clinic United Nations-owned equipment clinic level 1+, 2, 2+ and 3*	*Troop-contributing country or national hospital level 3 and 4*	*Regional hospital*
Buddy first aid	Advanced life support		Primary and specialized surgery
Field medical first Communal first aid	Reanimation and stabilization Damage control resuscitation	Damage control surgery	Definitive care
First 10 minutes	1 hour	2 hours	4–8 hours

Source: Medical Support Manual for United Nations Field Missions (2024).

66. **Ensuring fundamentals for qualitative health services.** Even when health facilities are deployed in the field, there are challenges in replicating the conditions existing in the health facilities 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

67. **The criticality of standards of care.** Standards of care are a core pillar of United Nations healthcare management. In their absence, the quality of care[39] becomes unpredictable. WHO statistics on the commonality of medical errors show that up to 80 per cent of harm is preventable. The most significant errors are related to diagnosis, prescription and the use and delivery of medicine.[40] This highlights the crucial importance of standards of care.[41] 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.

68. **United Nations framework of healthcare standards.** The lack of clear United Nations guiding principles for the standards of health services has been an area of concern in the past. As standards of care have been gradually introduced over the years, the situation improved. The review found that an evolved United Nations framework of healthcare quality and patient safety standards (HQPS) is in place. Between 2019 and 2022, DHMOSH created substantive United Nations policy guidance in this area, focusing in particular on improving medical care and support in the field. The United Nations policy guidance includes policies, standard operating procedures, guidelines, manuals, handbooks, etc., which provide instructions or direction on how to implement specific tasks, processes or activities. For instance, the 2020 HQPS introduced standards aimed at standardizing performance, improving the safety and quality of the treatment provided in all United Nations level 1+, 2 and 3 healthcare facilities (whether United Nations-owned, contracted or troop-contributing country).[42] The United Nations HQPS standards are contained in three manuals: the United Nations Manual for Health Care Quality and Patient Safety for Hospitals, the United Nations Manual for Health Care Quality and Patient Safety for United Nations Clinics, and the United Nations Manual for Health Care Quality and Patient Safety for United Nations Referral Hospitals. The HQPS standards are applicable to all United Nations healthcare facilities. The expected outcomes of implementing standards of care are summarized in box 1.

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).

[39] Quality of care is defined by WHO as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes".
[40] See www.who.int/news-room/fact-sheets/detail/patient-safety.
[41] WHO defines "standard of care" as "a statement of a defined level of quality in the delivery of services that is required to meet the needs of intended beneficiaries". See Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey 2023, p. 12.
[42] Policy on Healthcare Quality and Patient Safety, January 2020.

69. **Grouping HQPS standards for improved applicability.** The most critical standards (core standards) are differentiated in three groups: international patient safety goals, clinical-focused standards and administration-focused standards.[43] These standards are expected to be implemented by every level 1+ and above United Nations health facilities immediately upon deploying. The remaining standards are supplementary and are a next-level priority during the implementation process. The Inspector acknowledges that the differentiation and grouping of HQPS standards greatly reduced ambiguity regarding which standards are applicable in certain settings. He concurs with the views expressed by interviewed United Nations health practitioners that existing standards are realistic and achievable and is of the opinion that the current framework is adequate to guide the HQPS assessments in the United Nations health facilities.

70. **Further alignment with HQPS standards is encouraged.** The Inspector was interested to find out what standards of care are used by United Nations organizations with their own Health Services, other than the United Nations Secretariat. The review found that organizations use their own standards of care (FAO, ICAO, ILO, UNHCR, WHO, WIPO), although not all of them are strictly related to quality of care and patient safety. Three organizations (ICAO, UNHCR, WFP) indicated that their standards of care are aligned to and/or follow the United Nations HQPS standards, and one organization (ILO) follows the WHO standard guidelines. At the same time, three organizations (IMO, ITU, UNESCO) did not confirm the availability or the use of any "standards of care". While acknowledging the different mandates, organizational healthcare focus and priorities of Health Services operating in United Nations 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.**

71. **Continuous HQPS policy guidance improvement.** While acknowledging that some specific standards may require reassessment, all organizations with their own Health Services confirmed that those in use are, generally, fit for purpose. Yet, according to medical research studies, standards and guidelines in this area are rapidly outmoded due to new and changing research and practice and this can occur in as little time as just six years.[44] The Inspector encourages participating organizations to support the standard-setting and refinement efforts of Health Services and UNMD to regularly review the United Nations HQPS standards and relevant guidelines to maintain their effectiveness and relevance, according to principles advocated by WHO pertaining to continuous quality improvement.

72. **Limited clinical oversight.** Only four organizations (UNHCR, United Nations Secretariat, WFP, 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. Organizations noted the lack of resources to establish the required clinical oversight structures.

73. **United Nations clinical governance.** DHMOSH clinical governance[45] covers a multitude of health facilities, most of which are in the field, including peacekeeping medical capabilities and UNDP-administered clinics. The Clinical Governance

[43] See United Nations International Patient Safety Goals and Standards First Edition, 2019.

[44] See Paul Shekelle and others, "When should clinical guidelines be updated?", *British Medical Journal*, vol. 323, No. 7305 (2001), pp. 155–157.

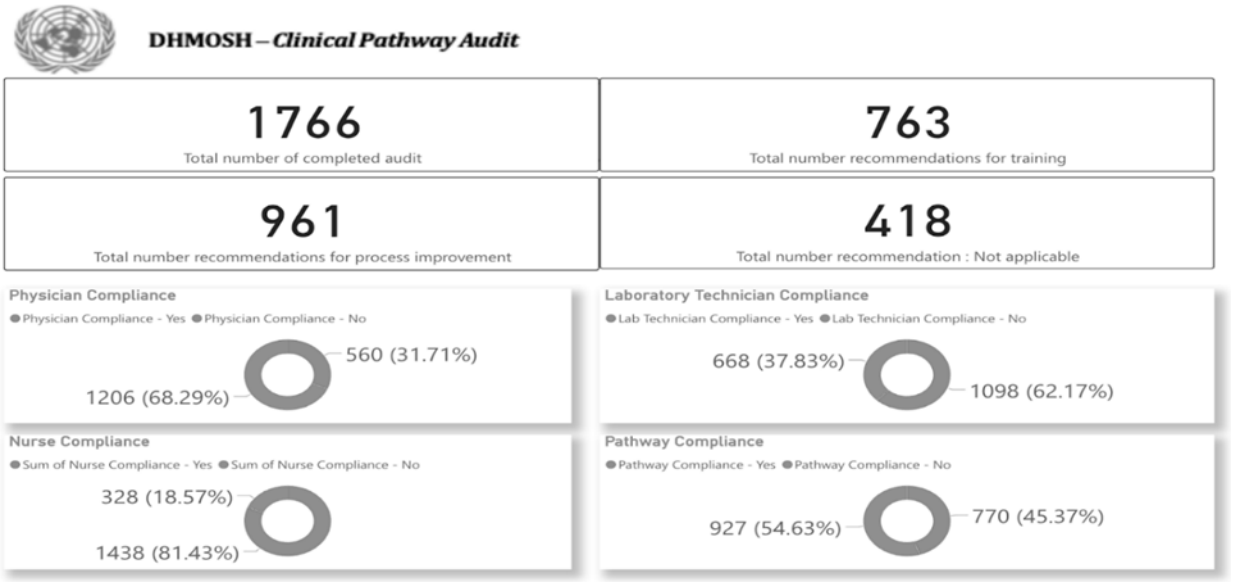
[45] Clinical governance ensures that structures, systems and standards are in place to deliver safe and high-quality healthcare and continuously improve services through monitoring and oversight.

Section of DHMOSH provides overall governance, oversight and advice on the standards and the hospital assessment process, including advice during the assessment and advisory visits, pre-deployment visits and on-site hospital assessment visits.

74. **Clinical accountability.** Clinical accountability, a subset of clinical governance, involves, inter alia, the monitoring and oversight of clinical activities. In order to ensure the implementation of medical standards and HQPS-compliant processes, a number of instruments, including self-reporting tools, are used: clinical audits, clinical adverse events reporting systems, culture of safety surveys, patient experience surveys, hospital evaluations tools and HQPS hospital assessments. The Medical Support Manual for United Nations Field Missions established clear-cut reporting requirements (what/when/how) for self-reporting tools. The review found that, to a great extent, the time frames for HQPS-related reporting are observed by field health facilities.

75. **Clinical compliance snapshots.** DHMOSH developed a Clinical Pathway Compliance Dashboard, which serves as a real-time tool to monitor several metrics and ensure adherence to standardized clinical pathways, facilitating continuous improvement in healthcare delivery. According to information comprised in the dashboard (see figure IV), between July 2023 and May 2024, 1,776 clinical pathway audits were conducted in 120 United Nations health facilities, at the headquarters and field levels (including United Nations peacekeeping operations).

Figure IV
Status of compliance with HQPS between July 2023 and May 2024



Source: DHMOSH (July 2024).

76. **There is room to improve HQPS compliance.** The clinical audits generated 961 recommendations for process improvements and 763 for training. The level of compliance is shown in numbers and as a percentage. Figure IV shows that 418 clinical audits found full compliance with the four tracked categories (recommended numbers of physicians, nurses and laboratory technicians and pathway compliance or non-compliance, per health facility). Furthermore, the dashboard comprises compliance/non-compliance data for each health facility.

77. **A modest number of HQPS-certified health facilities.** No data were readily available at the time of conducting the review to conclude how many United Nations health facilities globally have in place HQPS-compliant processes. However, according to publicly available information, between 2021 and 2023, one headquarters-based medical clinic (UNHCR) and four peacekeeping operation hospitals successfully completed quality and patient standards assessments.[46] Feedback received from the Clinical Governance Section of DHMOSH also revealed that, as a result of 10 HQPS hospital assessments conducted by mid-2024, three hospitals failed the assessment.[47]

78. All hospitals in the field are required to comply with HQPS standards in a phased manner according to an implementation timeline set by the DHMOSH Medical Director. According to health practitioners, implementation of HQPS standards is not a one-time effort but is dynamic and ongoing process. The Inspector acknowledges that the preparations for and conduct of a comprehensive assessment requires additional efforts from all stakeholders. Confounding factors in conducting such assessments include the unavailability of certified assessors and the floating staff complement having a tenure of only two to three years. Bearing in mind that illness is the highest cause of health fatalities among field personnel, including peacekeepers, the importance of achieving HQPS compliance cannot be overstated. To manage the shortage of certified assessors, the organizations are encouraged to actively promote and organize HQPS courses, e-learning courses in particular, and to establish a pool of assessors to conduct HQPS assessments system-wide, across different locations. Similarly, clinics are encouraged to reach level 1 status and, based on their own assessment experience, to consider becoming assessors.

79. **Towards a culture of quality.** There may be a certain reluctance among health personnel to deal with new and standardized HQPS procedures and protocols. This underscores the need for building a culture of quality for HQPS. The review found that the main cost in implementing HQPS standards is mostly related to changing the behaviour of health personnel. This includes the costs for implementing sustainable solutions in HQPS training and reinforcing standards. The lack of compliance may lead to additional costs, including patients seeking compensation for preventable harm. To ensure better compliance, the organizations should factor HQPS into job descriptions and/or terms of reference for United Nations health personnel. In a similar vein, using clinic patient experience survey dashboards can also boost HQPS compliance as they provide a clear picture of United Nations health facilities' performance trends over time and generate comparable data to allow comparison among United Nations clinics and hospitals. The Inspector notes that, usually, the data collected through surveys and dashboards are used internally. Organizations are encouraged to increase transparency over patient surveys' results through public reporting. By making such data publicly available, accountability will be enhanced, and the surveyed health facilities will be incentivized to improve quality of care. The value of these tools is exemplified by the Clinic Patient Experience Survey Dashboard administered by the Clinical Governance Section. Between 2021 and 2023, 165 United Nations clinics provided data to the dashboard, across four domains (getting a timely appointment, care and information; provider communication with patient; providers' use of information to coordinate care; and patient's rating of healthcare provider) with over 22,000 records available for data analysis. The dashboard

[46] A4+ first progress report.

[47] As of 9 July 2024, there were eight HQPS hospital assessments pending.

highlighted that around 56 per cent of patients gave high rates to the facility they visited (9 or 10 out of 10).[48]

B. Health infrastructure

80. **Health infrastructure is the foundation for the delivery of safe and quality healthcare services.** Health infrastructure is an all-encompassing term for the facilities and services that contribute to a population's health. In its broadest sense, health infrastructure includes the health personnel, the buildings where health services are delivered as well as buildings that support healthcare delivery (e.g. laboratories), and the underlying systems needed to support these facilities, including water and electricity. It also encompasses associated capital assets such as medical equipment and digital technologies. Fit-for-purpose health facilities must be clean, functional, climate-resilient and well prepared for disasters and other emergencies.

81. **United Nations health infrastructure in the field is often reported to be insufficient or inadequate.** Clinics and hospitals in the field vary greatly among duty stations, which in turn affect the type of healthcare that United Nations personnel will receive. According to responses provided to the JIU questionnaire, many health facilities, notably those deployed in remote areas, lack proper maintenance and essential medical equipment, therefore posing a challenge in ensuring adequate duty of care for United Nations personnel. Healthcare staff shortages and a lack of skills were also mentioned as part of the problem. 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.

82. **Understanding the challenges.** To comprehend the situation, the responses provided by some health practitioners during the interviews and the data included in relevant United Nations documents, in particular in non-classified audit reports, were analysed. During the period 2015/16–2023/24, the Office of Internal Oversight Services (OIOS) conducted 14 audit reports related to Medical Services deployed in the field,[49] covering nine peacekeeping and special political missions of varying sizes and life cycle stages. The reports covered high and medium risks in the provision of medical services, which included, inter alia: compliance with established guidelines and procedures governing the provision of medical services in field missions, medical support arrangements, delivery of healthcare services, emergency response capabilities, medical inventory and waste management, cost recovery and performance monitoring of health facilities. In total, 76 recommendations were issued. Box 2 presents data disaggregated by audited mission, number of audits and recommendations. The analysis of data revealed gaps in terms of compliance with existing requirements related to capacity and capabilities of health facilities in the field. As detailed below, some of the gaps were common not only to audited peacekeeping missions' Medical Services but also to other health facilities, including clinics that have operated under various United Nations ownerships.

[48] According to the interviewed healthcare professionals, the data generated by clinic patient experience surveys is more factual and objective than the data captured through clinic patient satisfaction surveys.

[49] This figure and box 3 do not include three OSH-focused OIOS audits (2021/072-UNMISS, 2023/093-UNSOS/UNSOM, 2023/095-MONUSCO).

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)

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

83. **Gaps related to adequateness of field health facilities.** The Medical Support Manual for United Nations Field Missions stipulates that, in order to secure the health and well-being of the field personnel, all health facilities must fully comply with promulgated standards of care. Yet, many field health facilities were not compliant with United Nations standards in terms of equipment and operational readiness. In particular, there were shortfalls in self-sustainment capacity (insufficient medical equipment, space constraints, etc.). Consequently, the delivery of high-quality medical services and their quality was put at risk.

84. **Gaps related to adequateness of maintenance programmes for medical equipment and drug inventory management systems.** All field health facilities should have in place formal medical equipment maintenance programmes, adequate drug inventory management systems and inventory management controls. In their absence, service delivery is not guaranteed and there is always the risk of waste and financial losses to the organizations from excessive (and expired) quantities of drugs and supplies and poorly maintained equipment supplies. United Nations hospitals[50] are expected to report regularly under the hospital evaluation tool's specified impact categories such as malfunctioning medical equipment, insufficient supply of consumables, inability to perform surgery and inability to accept new intensive care patients due to the absence of personnel. Table 6 illustrates the failure by some hospitals to comply with reporting obligations and/or to deliver uninterrupted healthcare services due to inadequate medical equipment.

[50] Hospitals are defined as level 1, level 1+, level 2 and level 3 and are evaluated on a rolling basis based on their rotation dates. Between May and October 2024, 19 troop-contributing country hospitals were in place: 6 level 1, 7 level 2, 5 level 2+ and 1 level 3. There are no hospitals in 4 peacekeeping operations: UNFICYP, UNMIK, UNMOGIP and UNTSO.

Table 6
Monitoring service delivery in the field hospitals, 1 November 2022–31 October 2024

Reporting period	*Number of hospitals (number of peacekeeping operations)*	*Number of hospitals submitting reports*	*Number of hospitals reporting service interruptions*	*Description of service interruptions*
1 November 2022–31 April 2023	23 (8)	19	–	–
1 May 2023–31 October 2023	20 (8)	18	2	Malfunctioning equipment impacted delivery of care for 7 days in the UNDOF hospital and for 95 days in one of the 6 UNMISS hospitals in place. Insufficient supply of consumables impacted delivery of care for 277 days in 1 UNMISS hospital.
1 November 2023–30 April 2024	19 (7)	13	1	UNMISS reported that on 247 days (81.5 per cent) malfunctioning ultrasound equipment impacted delivery of care, and that on 30 days (9.9 per cent) hospitals were unable to accept Intensive Care Unit patients and to perform surgeries due to the absence of staff.
1 May 2023–31 October 2024	19 (8)	17	1	Malfunctioning equipment (desktops in the reception area) impacted delivery of care for 7 days in the UNDOF hospital.

Source: Prepared by JIU based on data provided in A4+ progress reports (see https://peacekeeping.un.org/en/action-peacekeeping).

85. **Gaps related to adequateness of CASEVAC mechanisms.** To ensure timely and responsive medical care in all emergencies, Medical Services in the field are required to establish an effective CASEVAC system, which entails meeting the 10-1-2 timeline. While rare, there were instances in 33 per cent of audited Medical Services when casualty evacuation did not meet the 10-1-2 timeline.

86. **Gaps related to adequateness of cost-recovery arrangements for provided services.** The Medical Support Manual provides that health services are integrated and made available to all personnel of the United Nations country team comprising United Nations agencies, funds and programmes, on a fee-for-service arrangement. Generally, cost-recovery arrangements have been in place for health services, including medical evacuation (MEDEVAC) services provided to United Nations entities' personnel. Yet, some health providers did not have in place a policy guidance (e.g. memorandum of understanding) for providing MEDEVAC on humanitarian grounds for United Nations and/or for non-United Nations entities, a fact that prevented them from ensuring full cost recovery.

87. **Gaps related to support planning.** The Medical Support Manual requires health facilities in the field to implement comprehensive support plans taking into consideration relevant health threats, the standards of care and cost-effective use of medical assets to serve both civilian and uniformed United Nations personnel. The review found that less than 20 per cent of OIOS-audited Medical Services developed/updated and implemented such plans.

88. **Gaps related to deployment and distribution per location of health facilities.** Many health facilities were established without sufficiently considering the most optimal option for distribution per location and the possible implementation of the integrated modular concept recommended in the Medical Support Manual. As a result, in some field locations, notably in Africa and Middle East, health facilities of different levels were located in close proximity to each other. This has led to low utilization rates in two thirds of audited peacekeeping missions' Medical Services where the average utilization rate of United Nations-owned equipment clinics and contingent-owned

medical facilities was well below 40 per cent. For instance, in one peacekeeping operation that had established 41 medical facilities (3 United Nations-owned equipment level I clinics, 35 contingent-owned level I and 3 contingent-owned level II clinics), the review indicated low utilization rates, ranging between 0.3 and 10 per cent over a two-year period. The Inspector notes that the heavy concentration of health facilities of different levels in some areas of operations was rarely determined by operational requirements. These situations could have been avoided by better support planning.

89. **United Nations health infrastructure in the field may need more attention.** A closer look at United Nations field clinics may reveal similar challenges and gaps. Very few organizations shared data on the capacity and capabilities of non-peacekeeping clinics, notably UNDP and WFP clinics. The lack of specific data prevented the review to assess their adequateness in terms of capacity/capabilities, their utilization rates and their cost efficiency and effectiveness, However, it can be assumed that some of the afore-mentioned gaps can also apply to some of those clinics. As acknowledged by several organizations (UNHCR, United Nations Secretariat, WFP), the conditions and health standards in United Nations clinics in the "deep field" are not always compliant with minimum standards and may require corrective actions. These clinics are handled either through direct implementation through affiliate contracts or temporary contracts or through external healthcare providers. In the case of direct implementation, there is either a lack of training, technical oversight, supervision or monitoring or all of this. External health care providers (if properly selected) may come with an internal quality management system and clinical governance structure – but this comes at a significant cost. Even if there are external healthcare providers giving direct care to personnel, there is still a need for United Nations clinical oversight and administrative governance, which is often not the case.

90. **Oversight over health infrastructure in the field must be strengthened.** The Inspector sought to clarify if the internal oversight offices of participating organizations have pronounced any inadequacy, insufficiency or suboptimal performance of the United Nations clinics and of other non-contingent-owned equipment healthcare facilities. The review found that, in the last decade, with the exception of two audits of UNJMS (United Nations Office at Geneva Medical Service and United Nations Office at Nairobi Joint Medical Service), no other audits were identified in relation to field-based health facilities. One possible explanation of this situation is that Health Services are considered a support function, which typically receives less high-risk classification and priority. Yet, the inability to deploy adequate and appropriate healthcare facilities and capabilities that meet the organizations' duty of care to protect, promote and monitor the health of the United Nations workforce constitutes a high risk and, in the Inspector's opinion, it should be assessed as such. This point is recognized, for instance, in the 2023 DOS Support Risk Register where the residual risk level of healthcare management and OHS domains are assessed as "high".[51] The internal oversight offices are encouraged to include healthcare and OHS management in their audit risk universe and prioritize them for more consistent and comprehensive coverage, in accordance with their audit methodology. Furthermore, it is suggested that internal oversight offices also conduct audits of non-peacekeeping health facilities in the field, taking account of the recurrent gaps identified in this review and the lessons learned during the COVID-19 pandemic.

91. **Inconsistent application of the risk management approach.** The review found inadequate mandatory health support in the field, as well as weak risk-based

[51] The risk level is assessed as "high" in the UNHCR and WFP Risk Registers (for the same domains) and as "medium" in the FAO, ILO and WHO Risk Registers (for other health-related categories.

healthcare management. According to several responses to the organizational questionnaire, not all organizations and/or senior managers at the country level follow the One United Nations approach to health support planning. One organization revealed that "50 per cent of 612 [United Nations] duty stations do not meet all mandatory health support elements".

92. **Unilateral clinic decisions undermine duty of care and health system efficiency.** The practice of closure 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 should be avoided. Box 3 summarizes 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

- 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.

93. **Current International Civil Service Commission (ICSC) duty station classification methodology is not the same as a health risk assessment of the duty station.** As part of the United Nations system, organizations apply the classification of duty stations established by ICSC according to conditions of life and work. Often, this predetermines the decisions on the establishment of health facilities and their level of care in the duty station area. However, the ICSC classification does not contain adequate quantitative and qualitative criteria against which to draw accurate conclusions as to the level of healthcare support that should be available to personnel (and dependants). The Inspector concurs with the views expressed by interviewed health professionals that the ICSC duty station classification methodology should not be interpreted to be a health risk assessment of the duty station, but as the broad guideline that it is.

94. **Prioritizing the risk management approach to improve access to healthcare.** Health Risk Assessment methodologies[52] are in place to evaluate access to healthcare in the field duty stations, to ensure objective assessment of existing gaps and to recommend optimal solutions. However, these methodologies are not broadly applied due to the persistence of outdated practices and/or lack of funding to implement them. Weak implementation of the risk management model in managing field health facilities has often resulted in the absence of or outdated medical/health support plans in field duty stations. Developing a comprehensive medical/health support plan based

[52] Developed by UNMD, the Health Risk Assessment methodologies include the assessment of the mandatory health support elements which are the minimum health standards for a duty station.

on the health risks of the duty station is crucial for the deployment of fit-for-purpose health facilities and the optimal distribution of health facilities in the area of operations.

95. The implementation of the following recommendation is expected to improve 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.

96. **Enforcing the risk management approach.** The actions aimed at enforcing a risk-based approach may include, inter alia: (a) establishing mandatory UNMD technical clearance for any clinic footprint change affecting United Nations personnel and/or dependants; (b) prioritizing evidence-based decisions anchored in common metrics (utilization, travel/access time, after-hours demand, epidemiology, MEDEVAC trends, cost and quality of host-nation providers); (c) ensuring that no field clinic is opened/closed/restructured without United Nations country-team-endorsed health support plan (risk profile, referral/medical evacuation pathways, service mix, sustainability plan); and (d) setting consolidation plans and timelines for country-team-level solutions. In sum, a country team-led, health support plan-anchored and data-driven model, with UNMD technical clearance, is required to ensure that health facilities are fit for purpose, duplication is avoided and MEDEVAC is used as a last resort.

97. Bearing in mind the unstable funding environment and the need to optimize costs and achieve efficiencies, the Inspector believes that there is an opportunity for the organizations to support a global assessment of United Nations health infrastructure, including a full review of clinics operating under various United Nations ownerships, including walk-in clinics (at the headquarters, regional and field levels). The main result of such an assessment would be the issuance and implementation of recommendations aimed at rightsizing United Nations healthcare infrastructure and prioritizing sustainability and scalability when setting up local solutions.

98. **Novel approaches that offer lower-risk solutions in remote locations are needed.** The approach to health support in the field used by United Nations organizations is usually tiered. The personnel will use United Nations health providers that are already available in the field location. If such facilities are not available or are substandard, collaborative inter-agency efforts could be undertaken to establish a United Nations health facility that would meet the United Nations HQPS standards. If setting up an efficient and effective local alternative is not possible, before opting for an outsourcing healthcare solution, organizations could also consider deploying mobile healthcare units and enhancing virtual solutions capable of offering real-time telemedicine services. Utilization of artificial intelligence could be also explored as a potential novel option to facilitate certain medico-administrative and OHS management data-related tasks.

99. **Outsourcing healthcare it is not without risks.** It appears that outsourcing is the preferred solution of some organizations to create access to healthcare in field locations. The Inspector acknowledges that the utilization of third-party clinical administrators enables drawdown, notably in emergency environments. Yet, as conveyed during the interviews by health practitioners, outsourced providers have a limited understanding of personnel occupational health needs, including trust and data privacy. The lack of responsiveness required in hardship locations or in emergencies is another concern of personnel. Against this backdrop, the combined use of outsourced services and United Nations providers could be a more productive approach.

100. **A systemic approach is required to improve access to healthcare in deep field locations.** One commonality for deep field duty station locations, notably in Africa, is the persistence of insufficient funding dedicated to health infrastructure and an apparent lack of clarity on the duty of care responsibility of organizations towards personnel deployed there. Organizations are encouraged to consider sustainable funding solutions to health facilities deployed or to be deployed in deep field locations in Africa in order to ensure uninterrupted delivery of standardized healthcare services. When access to healthcare at a given duty station is severely limited, specific mitigation measures should be in place before the deployment of personnel. This principle is applied consistently when it comes to security matters. However, the same approach is not followed on healthcare matters, with scanty resources allocated to establish mitigation measures. This leads to a higher than acceptable risk profile exposure.

C. Medical arrangements for emergency preparedness and emergency medical support

101. 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. Other elements of emergency medical support are first aid, life-saving surgery, etc.

102. **Revamping UNMERT.** 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 UNMERT model, as adopted and operationalized in 2004, relies on a central capacity of expertise supporting the field with the help of a few trained field professionals volunteering for additional duties. The central capacity is embodied by the UNMERT section of DOS/DHMOSH, which employs only one medical officer who is expected to provide 24/7 monitoring, review plans and ensure training, advice, and support in the field if necessary. Beyond the obsolescence of such a model, relying on volunteers is a risky approach. UNMERT was not specifically intended as an inter-agency support function and its activity, with a few exceptions, was restricted to the peacekeeping field. According to interviewees, such a model no longer aligns with modern approaches of managing medical emergencies. Its scope should go beyond peacekeeping missions. Considering past experiences and lessons learned, including from COVID-19, a working group of senior medical officers revisited and refined the UNMERT scope, terms of reference and incident command system. Updated UNMERT terms of reference recommend a precise structure of networks of UNMERT coordinators and members and the nomination, in every country or mission, of UNMERT focal points. The proposal

includes the establishment of a formal coordination centre with a professional structure, and identifies seven potential services to be delivered by UNMERT (see figure V below) and a cost-sharing mechanism for some support functions. The proposed UNMERT 2.0 concept is aimed at addressing the shortcomings of existing emergency coordination support mechanisms. **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 the 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 V
UNMERT 2.0 concept

Source: DHMOSH/UNMERT (June 2024).

103. **CASEVAC/MEDEVAC.** The proposed revamping of UNMERT and the desired enhancement of emergency medical coordination support, which also covers CASEVAC and MEDEVAC, shows that improving the speed and quality of medical care for United Nations system personnel in the field remains an important objective. It should be clarified in this context that UNMERT interfaces with both mechanisms when activated, but does not subsume MEDEVAC (medical/entitlements) or CASEVAC (operations/aviation). This clarity prevents duplication and improves response times. Five organizations (FAO, ILO, UNHCR, United Nations Secretariat, WIPO) have organizational MEDEVAC policies and processes in place while the other entities have access to the MEDEVAC capacities of the aforementioned group of organizations. Given its largest footprint in the field, the United Nations Secretariat has well-laid-down policies and procedures for carrying out CASEVAC/MEDEVAC

missions.[53] Yet, simplification, decentralization and flexibility are needed to shorten the chain of command, notably during emergencies and in high-risk environments. When it comes to CASEVAC, the Inspector notes that as a result of full-scale CASEVAC stress tests conducted in several peacekeeping missions, the DOS Medical Support Section identified weaknesses in the medical chain of care and rectified them, including by updating, in 2020, the casualty evacuation policy.[54] In contrast, the 2000 administrative instruction on medical evacuation (ST/AI/2000/10) still awaits updating. It was suggested by several interviewees that this policy should be closely aligned 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 COVID-19 pandemic. While the MEDEVAC mechanisms largely functioned effectively, 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. One particular concern is that the policy contains terms and provisions which are subject to interpretation and that there are lots of new complexities that have come with MEDEVAC requests, such as definitions of staff types (international, national, local, etc.), the definition of regional area of care, and questions related to other relevant policies (for instance, regarding provisions on entitlements and benefits of personnel and eligible dependants) which have evolved over time, and this creates difficulties in implementing the policy in an effective and fair manner (e.g. risks of a discriminatory approach as it concerns certain staff types or personnel). Based on the above, **the Inspector suggests that the Secretary-General update the 2000 administrative instruction on medical evacuation.** It was also stressed during the interviews that when using the MEDEVAC services of another entity, sometimes operational realities will dictate that the entity providing such services will need to adapt its procedures to align to the "client" entity's management structures, and that the cost-sharing arrangements are not clear in all cases. The Inspector observes that 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.**

D. Some issues related to healthcare workforce management and coordination

104. **Challenges and limitations.** 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. DHMOSH is the only entity entrusted to support effective coordination of medical support in the field, including through strategic planning and management of the United Nations medical workforce. However, DHMOSH does not hold direct line authority over health facilities administered by other organizations (e.g. UNDP) or their health workforce. While the revised 2024 Medical Support Manual refers to the main functions of DHMOSH in

[53] In the United Nations context, CASEVAC is the more complex of the two processes to implement effectively, as it involves medical, aviation and logistics elements from civilian and military components.

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

the area of medical workforce management, its role remains largely advisory, limited to entities and locations under its responsibility.

105. **Limited role of DHMOSH in assessing and optimizing the medical workforce in the field context.** The assessment of existing staff capabilities and staffing risks is currently performed by field human resources teams, which manage the needs as part of their broader workforce planning responsibilities. DHMOSH has little say in addressing staffing gaps of health personnel, including recruitment of medical personnel to fill critical and hard-to-fill positions. It acts only as a technical adviser for the recruitment exercise and only when the field requests advice. This limits the ability of DHMOSH to influence or standardize the recruitment process and/or ensure that the best practices are followed universally. The Inspector was informed about cases when medical personnel in the field were hired against the explicit recommendations of DHMOSH not to do so given the failure of some applicants to meet the required qualifications and standards for technical clearances. Such accountability gaps undermine efforts aimed at ensuring that "healthcare services in the [United Nations] system are delivered by the right people who have the right skills and in the right place".

106. **Blurred lines of authority and accountability.** As the medical personnel and the healthcare facilities that DHMOSH oversees in terms of technical supervision are situated in and have contracts with other entities, the responsibility and accountability lines get blurred. This impedes DHMOSH in effectively exercising technical authority over the field health personnel it supervises, as it has little, if any, influence in decision-making related to employment, budgets and workplans, and no involvement in the performance management process of the entities concerned. According to responses provided to the organizational questionnaire, "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". This situation is reminiscent of the one described in the 2011 JIU report on the subject. It appears that delegation of authority to the field dilutes lines of authority and accountability and also affects, as shown above, medical workforce planning and recruitment.

107. **Need for clear roles and responsibilities for technical supervision.** The review found that reporting to DHMOSH is more a friendly supervision rather than a formalized activity. For instance, to ensure cooperation from field Medical Services on establishing an audit process for medical entitlements (sick leave, MEDEVAC, employment and travel clearances),[55] the Services were invited to share statistics on medical entitlement cases based on the understanding that the request was not an "exercise in checking up on clinic, but [one] to assist practice and provide better reporting". It is evident that for operational and other practical reasons the control environment needs to be monitored but not merely in terms of a "good practice". In the absence of delegated technical authority, DHMOSH 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 Inspector is of the view that the issuance of a Secretariat administrative instruction on medical technical supervision will strengthen the role of DHMOSH in providing support and guidance and exercising central medical technical supervision, while maintaining local accountability.

[55] Field medical services have been provided delegated authority on medical entitlements (sick leave, MEDEVAC, employment and travel clearances) in line with the Secretary-General's management reform report (A/72/492/Add.2).

108. 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

109. **Joint/support medical services.** Organizations can subscribe to healthcare services for their field personnel offered by UNJMS operated in regional hubs (offices away from Headquarters and regional commissions) and by United Nations clinics and other health facilities deployed in field locations. Most regional UNJMS and United Nations clinics (including UNDP- and UNHCR- administered clinics) are managed as a common service. Support medical services (WFP clinics and other health facilities) are managed as service providers (through service level agreements). 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 and termination, among others. According to some agreements, certain services are included in mandatory health services packages (e.g. United Nations Office at Nairobi Joint Medical Service), while others are optional for signatory entities. In terms of billing, the signatory entities' respective share for the year may be billed annually, or in shorter intervals, such as quarterly or monthly. The (unit) prices are reflected in price lists. 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. Currently no formal United Nations mapping or list recording the number of cost-shared/common Medical Services and/or health facilities that provide medical services is available. However, according to the United Nations Booking Hub,[56] 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.

110. **The costing methodologies.** In general, the costing method is based on fees per capita (or headcount) for certain services and/or a fee-for-service whereby fees are charged against actual utilization for other services. Table 7 presents the main cost methodologies used in the United Nations system as part of cost-sharing arrangements.

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

Table 7
An overview of the main cost-sharing methods for healthcare services

Costing method	*Description*	*Usage*	*Comments*
Pro-rata based on staff headcount	Each participating entity contributes proportionally based on the number of staff eligible to access services	Used by United Nations Office at Geneva Medical Service, United Nations clinics (UNDP) and some peacekeeping Medical Services (e.g. UNMISS)	
Fee-for-service	Subscribing entities pay only for the services provided, based on established unit of charges (per consultation, vaccination, etc.)	Used where United Nations clinics act as a vendor (e.g. with non-United Nations entities)	Requires data tracking systems. Can be administratively complex
Hybrid model	A costing methodology combining the per capita and fee-for-service method	Used by WFP clinics and some UNJMS operating in regional hubs (United Nations Office at Nairobi, Economic Commission for Latin America and the Caribbean, Economic and Social Commission for Western Asia, etc.)	

Source: Prepared by JIU based on information contained in some United Nations documents, including memorandums of understanding/service-level agreements.

111. **Cost-recovery through insurance.** 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. In recent years, WFP implemented a cost-recovery model through insurance, in addition to the contributions paid by service users to the WFP clinics' budgets. This is a good practice. Leveraging insurance-based income may enhance the financial sustainability of cost-shared/common medical services. 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.**

112. **Optimizing costing methods.** The financial sustainability of cost-shared/common Medical Services could be further optimized through more responsive and balanced costing methodologies. The Inspector notes that, in the last decade, most Medical Services providers switched from a usage-based to headcount-based costing model. For instance, the United Nations Office at Geneva Medical Service did so in 2017. For the health providers, the headcount-based costing is more efficient and effective as it secures a stable revenue that facilitates planning, personnel hiring and availability of core services to all clients when needed. Conversely, the headcount-based versus usage-based costing model is still a matter of consideration by some service users. The health providers and subscribing entities need to interact more actively in order to arrive at costing methods that suit them best. 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.[57] **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.**

113. **Opting out may have drawbacks for the provision of healthcare.** The participating 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.[58] As was noted by some interviewees, opt-out decisions are often taken arbitrarily by field managers, sometimes based on financial biases, without any prior consultation with healthcare professionals on 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. 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.**

114. **Appropriate supervision.** The problem raised above brings to the fore the issue of supervision. The medical personnel within the United Nations system, notably at the field level, are supervised by managers without the appropriate technical background. This is also true for the management committees of United Nations clinics that offer common medical services. A more sensible approach would be to have managers with the right background, who are close at hand both physically and in the time zone, and able to motivate the doctors and nurses to improve their operations and themselves as managers. In the view of the Inspector, the composition of clinic management committees should be re-evaluated to ensure that technical chairing is exercised by the technical supervisors of the United Nations clinics from DHMOSH. Such technical leadership would be better positioned to ensure that quality standards are implemented, health occupational risks mitigated and overall management, including financial management, is optimized.

115. **Securing sustainability and continuity of cost-shared Joint/Common Medical Services.** 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

[57] For instance, the 2011 agreement and memorandum of understanding covering the activity of the United Nations Health Care Centre in Addis Ababa do not reflect changes that occurred in its structure, including the opening of four new satellite clinics.

[58] The undesirable effects of such practices were reported by some regional medical services (Economic and Social Commission for Western Asia Medical Service, United Nations Health Care Centre, etc.).

memorandum of understanding concerning common services,[59] may enhance the financial sustainability of cost-shared/common Medical Services and, by doing so, build a stronger disincentive to arbitrary opting out.

116. 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 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.

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

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

117. Occupational health and safety is a multidisciplinary field concerned with the health, safety and well-being of people at work. In accordance with obligations under duty of care,[60] United Nations system organizations are required to provide their workforce with an enabling and supportive workplace in which health and well-being risks are managed through prevention measures and effective responses to illnesses, incidents and accidents. As a cross-cutting activity, OHS is a shared responsibility across the organization, where Health Services play an important but specific role. Occupational health support measures are largely incorporated into Health Services' occupational health delivery.

118. **United Nations system-wide OHS framework, governance and implementing machinery.** Health Services have played a key part in the adoption and implementation of OHS policies and standards at the system-wide level and in their own organizations. Such policies and standards introduce a structured approach to managing OHS. The United Nations OHS framework initiated by UNMD and endorsed in 2015 by HLCM[61] provides a clear structure[62] and an implementation guide[63] 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 OHS 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 OHS framework/system

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

119. **Endorsement by CEB does not translate into OHS capacity in the field.** The review sought to understand to what extent commitments expressed within CEB to duty of care and OHS were re-enforced in terms of actual implementation by participating organizations. As part of the organizational questionnaire, the organizations were requested to provide information on the status of implementation of selected Duty of Care Task Force recommendations and OHS framework, using a matrix that included key questions from the OHS Forum surveys to assess the progress of selected components.[64]

[60] Duty of care is defined as a non-waivable duty to manage foreseeable risks that may harm or injure United Nations personnel and eligible family members in the line of duty. See CEB/2018/HLCM/17.
[61] See CEB/2015/HLCM/7/Rev.2.
[62] United Nations OHS management system framework.
[63] United Nations OHS management system framework: further implementation guide (2022).
[64] As per annexes 1 and 2 of the JIU organizational questionnaire.

The responses received between June and September 2024 from 20 JIU participating organizations mirrored, according to respondents, those provided to the 2023 OSH Forum survey. In general, around half of the organizations have made progress or are in the process of implementing Duty of Care Task Force recommendations[65] and provide essential OHS resources, including first aid and medical kits, personal protective equipment and post-exposure prophylaxis kits (see annex VII). The review found that the implementation of the OHS framework's components is ongoing and in different stages in participating organizations (see annex VIII). Although high-level commitments were captured in system-wide documents, conversion from documents to managerial action and drive, notably at the field level, was lacking. Generally, the progress in OHS framework implementation has been rather limited, and the information collected through the 2021 and 2023 OSH Forum surveys, as well as through the JIU organizational questionnaire, confirms this finding. Table 8 shows that only six organizations adopted an ad hoc OHS policy, seven created an OHS oversight body and four established a mechanism for the promulgation of OHS standards and use such standards in the organizational OHS management system. While 12 organizations confirmed the existence of incident reporting capabilities and 6 of OHS risk registers, few organizations started identifying data sources and risk mapping, which is critical for proactive risk-based hazard management and incident prevention. The OHS capacity remains suboptimal, as only nine organizations reported the establishment of OHS committees at the headquarters level and six at the regional or country levels.

Table 8
Status of OHS framework implementation in areas of particular relevance, as of 31 September 2024

OHS framework and system				*OHS capacity-building at the regional or country levels*					
OHS policy	*OHS oversight body*	*Headquarters OHS committee*	*Headquarters OHS focal points*	*OHS committees*	*OHS focal points*	*Sufficient resources to implement OHS management system*	*Incident reporting system*	*OHS risk register*	*OHS 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	UNHCHR	ILO	IMO	United Nations Secretariat	UNICEF		IMO	UNHCR	WFP
UNOPS	UNICEF	UNAIDS	ITU		UNHCR		UNDP	UNOPS	
WFP	United Nations Secretariat	UNHCR	UNAIDS	WFP	UNOPS		UNHCR	WFP	
		United Nations Secretariat	UNHCR	WHO	WFP		United Nations Secretariat		
	UN-Women		United Nations Secretariat		WHO				
	WFP	WFP					UNOPS		
		WHO	UNOPS				UNRWA		
			WFP				WFP		
			WHO				WHO		
							UN-Women		

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

[65] Annex 1 of the JIU questionnaire did not include areas related to medical insurance and the United Nations System Workplace Mental Health and Well-being Strategy.

120. **OHS committees.** The presence of OHS committees at the headquarters, regional and/or country levels and of other resources dedicated to the OHS and well-being of United Nations personnel has gradually increased over the years. The review was not in a position to determine the number or proportion of OHS committees established in the field, as the information provided by organizations was incoherent. Only one organization reported that it established "100 [per cent] of OHS structures in all regions". According to the United Nations Secretariat, "half of [United Nations] Resident Coordinators have convened at least one interagency OHS committee meeting in country to discuss OHS risks and mitigation activities". It appears that the level of commitment in this area remains rather low as more than half of organizations indicated the unavailability of these indispensable structures. Generally, local committees that are in place function at varying degrees of effectiveness and commitment. In some duty stations, OHS-specific initiatives are not prioritized by senior managers and members struggle with fragmentation and overlap of scope with some functions such as human resources, safety and security, etc., resulting in the need for health professionals to take the lead and drive OHS implementation. Yet, the coordination and implementation role of local OHS committees in meeting obligations under duty of care is not only critical but also irreplaceable. Without this coordination structure it would be difficult to reduce duplication of efforts, share resources and expertise, identify and address occupational health risks in a timely manner and enhance emergency preparedness in the field. The Inspector encourages UNMD to examine and decide if the OHS committee should be considered a complementary minimum health support standard that must be available at every duty station, and recognized as such, in order to ensure full implementation of the OHS framework in the field across the United Nations system.

121. **OHS focal points.** As shown in table 8, OHS focal points exist mostly at headquarters (10 organizations) and, to varying degrees at regional (8 organizations) and country and mission levels.[66] The review found that many organizations do not have the required financial and human resources to appoint OHS focal points and that most OHS focal points are volunteers.[67] The OHS tasks are rarely included as a formal component in their job description; they have limited technical capability in risk assessment and safe risk mitigation plans and there is no externally recognized professional training in OHS. Personnel rotation in organizations causes the movement of OHS focal points and affects the sustainability of OHS implementation. Furthermore, in many organizations, there has been no professional supervision around OHS tasks, either directly in their location or via matrixed reporting to relevant headquarters structures. Sometimes, in the absence of OHS officers, the focal points are expected to fulfil their roles. Yet, OHS is a technical discipline. Requesting OHS focal points to deliver OHS expertise in the field would be a substandard approach that does not meet the duty of care requirements for the provision of OHS services. As some capacity for OHS management is vested in the use of focal points, more attention needs to be paid to defining their roles and responsibilities and properly training them to realize coherent and accountable OHS management practices across an organization.

122. **OHS is a joint responsibility.** The review found that a few organizational Health Services have been required to act as the owners of the organizational OHS management system. In one case, the establishment and implementation of the organizational OHS management system was incorporated in the mandate of the

[66] The global number of OHS focal points in the field is unknown as very few organizations were in position to share a precise figure. For instance, the United Nations Secretariat pointed out that 36 per cent of United Nations country teams had a dedicated OSH focal point, with OHS being integrated in their performance management.

[67] In UNHCR, 79 per cent of OHS focal points (238 of 302) are volunteers.

Health Service concerned as a main function. Such demands are unwarranted. The OHS framework purposefully underscores that "OHS is a line management responsibility and cannot be addressed by a Health Service operating in isolation from management action". It is also understood that the Health Services have advisory and supporting roles in the planning and implementing of OHS systems, programmes and services. They have provided support to OHS committees, wherever they exist (headquarters, regional and field locations), creating opportunities to address the most prevalent occupational health risks. These roles could be further enhanced once occupational health and occupational safety are integrated functionally within the organization and, preferably, within the organizational Health Service, which is not yet the case in the most organizations. 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.**

123. **OHS expertise needs to be delivered by OSH professionals.** Both the OHS framework and ISO45001 require that OHS expertise be delivered by OHS professionals and qualified safety officers. The industry standard is one OHS professional for approximately 3,000 personnel, varying with the nature of the industry and the number of sites covered. The review found that no organization is meeting this standard. Organizations cannot provide a safe working environment and prevent work-related injury and illness without sufficient access to a dedicated OHS capability. Occupational health requires post-graduate training, not just having a doctor in the workplace. Occupational safety requires safety officers with industry-level qualifications. Participating organizations are encouraged to recognize at all levels that OHS is a professional specialization and that additional efforts are needed to improve the professional OHS capability, notably in the field.

124. **Incident reporting system.** An incident reporting system is an important element of an organizational OHS management system. Organizations need to record and manage workplace health incidents (accidents, injuries and illnesses). This record must be sufficiently detailed to allow organizations to understand the circumstances leading to the accident or the cause of the disease and take the necessary remedial steps to prevent recurrence. Through the organizational questionnaire, organizations provided information on OHS incidents during the period 2020–2023, including category of incidents and the number of claims for compensation (see table 9). Of 12 organizations that reported having an OHS 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, WIPO) or for some years only (IAEA, UNESCO, UNFPA, UPU).

Table 9
Personnel affected by occupational safety incidents, 2020–2023

	Occupational safety incidents and claims for compensations															
	Headquarters 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[a]	2	1	–	1	1	(1)	–	1	–	–	–	–	–	–	–	–
ILO	4	2	7	11	4	2	7	11	1	–	–	1	1	–	–	1

	Occupational safety incidents and claims for compensations															
	Headquarters 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*
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	4	12	28	31
UNICEF	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
UNIDO	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
United Nations Secretariat[b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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	–	–	–	2	–	–	–	1	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
WIPO[c]	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
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
WHO	X	X	X	X	18	12	21	33	X	X	X	X	27 (1)	12 (1)	6 (2)	24

Source: Prepared by JIU based on information provided by participating organizations.
Note: X represents no records available; figures in parentheses represent number of deaths.
Abbreviation: N/A, not applicable.
[a] ICAO utilizes MEDFAR Clinical Solutions as an incident reporting system.
[b] WIPO clarified that the data are reported by its Health Service and/or Security Service.
[c] The United Nations Secretariat indicated that the data are managed by the Advisory Board on Compensation Claims.

125. **OHS incident data collection needs improvement.** 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 9, the number of reported incidents in 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. Nine such occurrences were recorded by five organizations in the referenced time frame. The slow implementation of and ongoing changes to the incident reporting systems may have been also factors that led to possible inaccurate data that lack, in some cases, statistical significance. It was only in one case that the incident data were directly confirmed by the data collected between 2020 and 2023 on compensation claims (ILO). The notification of occupational accidents and diseases is generally linked either to a compensation scheme or to a statutory requirement of reporting to the competent body. While 19 organizations confirmed the availability of methodologies or procedures for the

settlement of claims for compensation of death, disability and other loss of function of a permanent nature attributable to specific traumatic safety incident(s) or resulting from exposure to occupational stressors (the only exceptions being UNESCO, UNFPA, UNOPS and UN-Women), some reported bigger numbers of submitted claims than the number of incidents actually recorded for the corresponding years. It should be noted in this context that incident reports may support personnel compensation claims but are not in themselves acceptance by an organization that the illness or injury is service-incurred (this rests with compensation boards). 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.** Still in this context, it was observed that the coding or description of accidents and injuries, as reported through the organizational questionnaire, were done mostly by healthcare personnel, which is another indication that safety officers may be unavailable in many organizations. In the view of the Inspector, coding of injuries should be typically done by medical healthcare personnel for the injury/illness component, and safety officers for the safety accidents component. This would prevent coding decisions by personnel who are not familiar with classifications or taxonomies which are not within their professional remit. The Inspector notes that several taxonomies are currently used, notably the ILO taxonomy where the emphasis is on industrial accidents. This approach is suboptimal. Organizations are encouraged to revise and adjust the taxonomies related to incident reporting and ensure that they use a unified taxonomy that integrates all OHS categories and that is embedded in the web-based multi-source platforms that are shared by multiple stakeholders.

126. **Linking OHS and well-being risk assessments to the corporate risk register.** 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. This approach is illustrated by the UNHCR practice where country risk registers include OHS risks through the enterprise risk management system. These are then derived by the regional OHS committees and the advisory OHS committee to determine the top regional OHS risks and global OHS risks, respectively. The Inspector notes, in this context, that the delays in implementation of the OHS framework due to lack of OHS internal structures, personnel resources and insufficient investment in employee health, safety and well-being are incorporated as corporate risks in the risk registers of three organizations, which illustrates their risk appetite concerning duty of care (UNDP, United Nations Secretariat, WFP). According to the responses to the organizational questionnaire, nine organizations have included OHS risks in their corporate registers and risk management processes (FAO, IAEA, ILO, ITU, UNAIDS, UNESCO, UNHCR, United Nations Secretariat, WFP). 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.

127. The implementation of the following recommendation is expected to enhance accountability and mitigate the OHS 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.

128. **Implementation of the OHS framework demands prioritization at the same level as the United Nations security component.** The development and implementation of an OHS structure with all supporting policies, standards, information technology structures, training, monitoring and evaluation and compliance measures requires a proper implementation plan with sufficient resources. Only three organizations reported (with some caveats) that the allocated human resources and funding were sufficient to implement the organizational OHS management system. The review found that 90 per cent of organizations lack sufficient resources to implement the OHS framework, notably in the field, and this may explain the limited progress in implementation within United Nations system in the past decade. In particular, as acknowledged by the OHS Forum, "occupational safety is not managed across the [United Nations] system in the same way that the security component is managed by [the Department of Safety and Security].[68] However, OHS incidents constitute the absolute highest risk for United Nations personnel. While the data for non-uniformed personnel, as illustrated in table 9, are rather inconclusive, OHS-related accidents and illnesses of uniformed personnel are significantly higher. The incident data from the United Nations Secretariat show that, from 2012 to 2017, OHS injuries and illness outnumbered security injuries by approximately 10 to 1.[69] Similarly, from 2022 to 2024, the ratio between OHS and non-OHS causes to fatalities increased more than three times and reached 10 to 1.[70] **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.**

129. **Achieving efficiencies by minimizing the costs arising from weak OHS delivery capacity.** Apart from their impact on the health and well-being of United Nations 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 OHS delivery capacity and insufficient OHS practices in participating organizations. It is estimated that the financial losses due to preventable peacekeeping accidents, incidents and events related to OHS hazards can be as high as $250 million per year (A/74/533, para. 71). At a time when declining revenues of organizations have led to funding constraints, a key aspect is not only how to achieve efficiencies but also how to minimize the costs arising from weak OHS delivery capacity. Against this backdrop, it would be beneficial to base the optimization and efficiency-driven proposals on cost-benefit analysis. The review found that no such 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.**

[68] CEB/2023/HLCM/17, p. 10.
[69] See, for example, guidance on United Nations security management system role in OSH, p. 3.
[70] Data extracted from the notification of casualties system (NOTICAS) confidential reporting tool (as at 11 November 2024).

V. Improving health workforce data and evidence

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

130. **A blurred picture of the workforce health situation.** 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 10) 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 as the reference was often made to a single data point, with no corroborating evidence from other relevant sources. This raises the question of the effectiveness of health data collection and analysis, health data comprehensiveness and internal data-sharing, especially bearing in mind that all organizations except three (IMO, UNESCO, UN Tourism) reported that they collect such data centrally and most organizations confirmed that they have in place adequate data collection tools and systems, including medical management systems (Earthmed, Cority, etc.).

Table 10
Workforce health status in participating organizations

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

Source: Prepared by JIU based on 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.

131. **Limited health data collection and analysis, and insufficient health data consolidation.** The review identified a number of shortcomings in this area. More than half of the 23 organizations that shared information on data collection (FAO, IAEA, ITC, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNIDO, UNOPS, UNRWA, WHO, WMO) only collect health-related data for staff, but not for affiliated personnel. Nine organizations (IAEA, UNAIDS, UNDP, UNESCO, UNFPA, UNIDO, UNRWA, UPU, WMO) do not collect disaggregated data. For organizations which outsourced their health services, health data are arguably collected by their service providers, while sick leave-, absence- and benefits-related data are collected by the organizations themselves. Within the organizations, the information is collected by

different offices and functions, sometimes using different or multiple data collection and management systems. While there may be good reasons to use different management systems to collect and administer specific categories of health-related data by various organizational units (confidentiality requirements, etc.) there is a lack of data consolidation and information-sharing across functions, including with regard to occupational health data. This impedes the effective use of available data at the corporate level.

132. **A wide array of health-related data is collected.** While the types vary across organizations, the collected information typically includes medico-administrative data (sick leave data, compensation claims, disability accommodation requests, etc.) and medical data (information on physical and mental health from employees). Based on their medical data collection, 11 organizations identified, in descending order, the most prevalent health problems of their workforce (FAO, IAEA, ICAO, ILO, IMO, UNHCR, UN-Women, UPU, WFP, WIPO, WHO). Box 5 provides a summary of the data shared by these organizations. Notwithstanding the availability of health-related data, they are rarely used to drive efficiency and improve health outcomes. Only two organizations (ICAO, 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, WHO) were able to indicate the percentage ratio attributable to work-related conditions.

Box 5
The most prevalent health problems of the United Nations workforce

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

Source: Responses to the JIU questionnaire.

133. **Health reporting practices vary.** Different practices are followed in organizations on how the collected health data are reported and made available to stakeholders. The majority of organizations include workforce health data in their internal management reports, including those for senior and executive management. About half of the organizations that provided information indicated that they do not include such data in workforce-related reports (FAO, IAEA, ICAO, IMO, ITC, UNAIDS, UNDP, UNESCO, UNICEF, UNRWA, WHO, WMO). Only one organization confirmed that it reports some workforce health-related data to its legislative organs and governing bodies (UNESCO), while another indicated that such data are provided upon request (United Nations Secretariat).

134. **Leveraging health-related data.** Setting aside the abstractness of the WHO definition of health [71] and the difficulties pertaining to how to translate into operational language the concept of health, understanding the workforce health status is of practical importance. This would be a starting point to employ health status

[71] Health is a state of complete physical, mental and social well-being, and not merely the absence of diseases and infirmity.

indicators, monitor the workforce health trends and use evidenced-based data for health interventions and health promotion. It may also offer a general indication of health-related costs for the organization, provided that the cost management, as underscored in the previous chapter, may become a critical component of OHS. Data on the health workforce are a prerequisite for evidence-informed policy. Regularly reporting it 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 organizational and system-wide levels

135. **Health surveys.** Surveys are data sources that can help to evaluate workforce health status and produce, among others, disease prevalence estimates. Participating organizations confirmed that they had used a variety of internal and external surveys to collect health-related data. The review found that only six organizations (FAO, UNESCO, UNHCR, United Nations Secretariat, WFP, WIPO) conducted organizational surveys in recent years (2018–2023). Most of those surveys were cross-sectional and included health and well-being-related sections or questions: global staff surveys (UNESCO, WFP), engagement surveys (WIPO) and employee satisfaction surveys (FAO). Health and well-being-focused surveys were conducted by the United Nations Secretariat (United Nations staff health surveys and COVID-19-related surveys covering several organizations)[72] and UNHCR (pregnancy health risk assessment survey, safety culture survey, global customer satisfaction survey on guesthouse accommodation).

136. **Standardizing health surveys.** The data collected from personnel through organizational surveys are without doubt useful for individual organizations as they generate information to better understand the health and wellness of their own workforce. Yet, it may be insufficient for evidence-based health interventions as these tools are not used systematically given existing capacity and resource constrains and may also have methodological limitations. It should be noted in this context that the methodology in survey development, implementation and data assessment must be sound so that organizations produce similar recommendations with regard to their workforces. **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.** 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.

137. **Increasing the role of system-wide health surveys.** 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

[72] Two regional Joint Medical Services (United Nations Office at Geneva Medical Service and United Nations Office at Nairobi Medical Service) conducted their own health and well-being-focused surveys and questionnaires (post travel health survey, wellness survey, etc.).

format across the United Nations system organizations, launched simultaneously, to have the same data to benchmark.

138. **Towards a United Nations centralized health data collection and management framework.** The precursor of such an instrument is the United Nations health intelligence (UNHI) survey.[73] As acknowledged by several interviewees, UNHI has been the only basis for assessing their organizations' workforce health status. The UNHI survey[74] covers key health and wellness data. Its design is based on validated health and wellness survey tools, and it has been adapted to the United Nations context. It uses comparable metrics and targets similar subsets of respondents that are comparable to each other. It also has dashboard capacities that allow for the interactive interpretation of data and comparison of results, which are made available for each individual participating organization. The UNHI 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. The Inspector was informed that, after more than a decade of implementation, the United Nations health intelligence survey needs revalidation and upgrading of its questionnaire. UNHI 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 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 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

139. **Sick leave records.** The review found that most participating organizations collect statistics on sick leave absences, but less so with regard to data on sick leave costs. A total of 22 organizations submitted information on certified sick leave (CSL) during the period 2019–2023 and only 5 shared complete information for the same period on the total cost borne on account of missing workdays due to sickness. In several cases, the data sets contained inconsistent information, and this raised the issue of accuracy of CSL records in some organizations. While the majority of CSL is typically for limited durations, a certain proportion is due to long-term sickness. The lack of the latter data did not make it possible to establish the proportion of long-term sick leave in participating organizations. Table 11 presents general statistics about the incidence of CSL and corresponding expenditures.

[73] UNHI is also known as the United Nations-wide staff health and wellness survey.

[74] JIU/REP/2023/4 includes more information on the UNHI survey and two related informal recommendations.

Table 11
Overview of data on sick leave and sick leave-related expenditure

Organization	*Total number of CSL days (2019–2023)*	*Total number of long-term sick leave days (2021–2023)*	*Average number of CSL days per staff member each year (2019–2023)*					*Average number of CSL days per staff member (2019–2023)*	*Total expenditure due to sickness per (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	–	–	–	–	–	–	–	–	–
United Nations Secretariat	969 630[e]	–	5.83	5.23	4.97	5.96	5.45	5.23	–
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[f]	7.04	5.96	2.62	5.43	7.49	5.96	–
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	3 965[g]	–	–	3.14	4.94	3.17	2.22	3.14	–

Source: Prepared by JIU based on 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).

140. **Benchmarking sickness absence.** 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. In fact, only a handful of organizations were in a position to share such information. Not surprisingly, there

is no system-wide benchmark for organizational annual average CSL per staff or a clear understanding of what the desired range should be for the CSL annual average within an organization. From the Inspector's point of view, comparing against an organizational and/or United Nations benchmark would be beneficial for both the organization and managers. Such a dynamic annual benchmark would make it possible to determine if there is a sickness-related absence problem and to further assess the underlying causes of the significant differences between organizational units as well as among United Nations organizations. **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.**

141. **Average number of sickness-related absences for the last five years is 5.05 days per staff member.** On the basis of data shared by several organizations and as a result of his own research and calculations, the Inspector determined the organizational averages of sickness-related absences for 22 participating organizations. The analysis of table 11 shows that, during the period 2019–2023, the average figures for organizational CSL 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. Further analysis of data shows that the organizations' CSL averages are evenly distributed when compared with organizational CSL average number. To the Inspector's knowledge, no study was conducted within the United Nations system to authoritatively determine the system-wide CSL 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.**

142. **Small variations of total CSL numbers per year.** The review found that, while the total number of CSL days per year fluctuated in the participating organizations, the differences in the incidence of CSL over the period of five years were not significant. Even the COVID-19 pandemic did not alter the CSL organizational patterns, likely due to teleworking options granted extensively to United Nations system personnel. In the aggregate, from 2019 to 2023, the total number of CSL days for 24 organizations amounted to 2,550,329.

143. **CSL costs unknown.** Understanding the financial implications to organizations resulting from sick leave burden 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 CLS-related direct costs for all participating organizations. Two of seven organizations that shared data on their annual expenditures due to sickness did so partially. Total expenditure for those organizations during the period 2019–2023 amounts to approximately $51 million. While partial, these data alone confirm that working days lost through sick leave can represent a significant financial impact on United Nations system organizations. **The Inspector recommends that organizations, that have not done so 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

144. Various inter-agency structures relevant to health, safety and well-being have operated under the High-level Committee on Management of the United Nations 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 illustrated in JIU/REP/2023/4 (figure VI). 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. To some extent, the newly established coordination body illustrates the cross-functional approach favoured by HLCM that consists of combining the portfolios of the OHS Forum, the United Nations System Mental Health and Well-being Strategy and other relevant structures and initiatives. The United Nations Occupational Health and Safety Coordination Mechanism, by virtue of its specific mandate and parameters, cannot fulfil the role of a HLCM health technical network. It is UNMD, a self-funded structure, functioning on a fully voluntary basis, that has provided expert input and guidance to HLCM on many health-related matters. Both structures are key to supporting inter-agency cooperation in the area of health, safety and well-being.

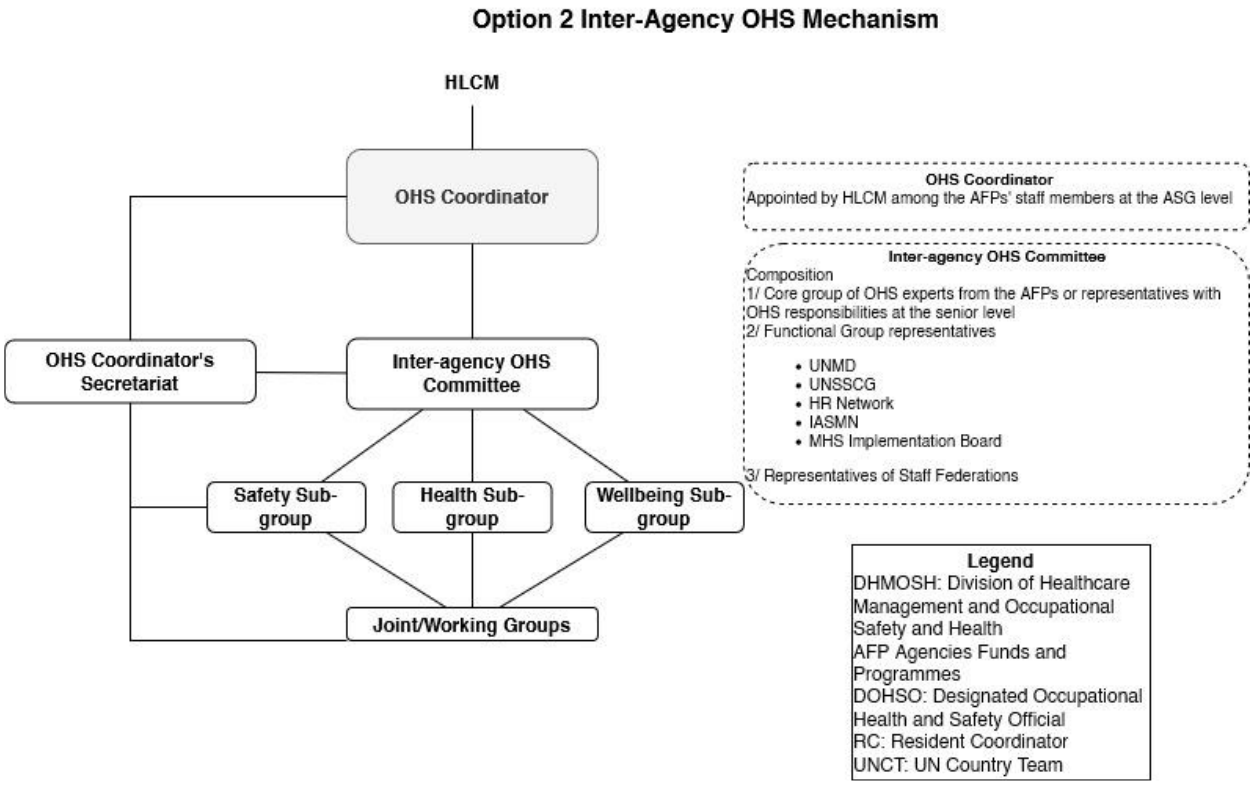
A. United Nations Occupational Health and Safety Coordination Mechanism

145. Almost 15 years ago, the first JIU review of the Medical Services (JIU/REP/2011/1) recommended the creation of a coordination body in the OHS area, the United Nations Network on Occupational Safety and Health. The proposed body was derived from the Inter-Agency Security Management Network model and was reflective of realities at that time. In considering the recommendation, the participating organizations concluded that the concept of coordination and its parameters needed further in-depth discussion. However, there is no recorded follow-up to this recommendation. In April 2024, HLCM endorsed the United Nations Occupational Health and Safety Coordination Mechanism and its governance structure, including an OHS coordinator and an inter-agency OHS committee supported by a secretariat (see figure VI). Essentially, the new structure is aimed at addressing fragmentation and inefficiencies in OHS services and improving the response to OHS risks across United Nations entities. It is expected that "the mechanism would mainly work on a harmonized preparedness of OHS risks, on strengthening OHS risk assessment, on OHS policies and practices; its coordination role involving some decision-making would be activated in case of OHS hazards affecting the [United Nations] personnel globally or regionally".[75] However, the Mechanism has no authority to enforce the implementation of the OHS accountability framework, which promotes OHS risk management across all relevant functions (human resources, health, security) and into the work of United Nations resident coordinators and country teams. It remains to be seen if this model, which was one of the three options (the second option) proposed by the OHS Forum, would prove effective. Officials from several organizations underscored that most responsibilities attributed to the Mechanism (system-wide coordination, expert advice, capacity-building, etc.) depend upon availability of dedicated OHS experts. For instance, the

[75] CEB/2023/HLCM/17, p. 6.

secretariat supporting the OHS coordinator should be staffed with OHS experts or should be able to rely on OHS experts of the United Nations organizations. Currently few of the United Nations organizations have such a capability. It was also acknowledged that the Mechanism's capability to coordinate efficient action in the case of the occurrence of OHS hazards[76] or crises affecting the United Nations system globally, regionally and locally is limited. Furthermore, while a cost-sharing arrangement is envisaged to support the Mechanism's functionalities, the funding sufficiency remains an open question notably in the current environment of financial austerity. The executive heads of participating organizations are strongly advised to ensure a sustainable funding arrangement to support the Mechanism, notably its coordination capability to prevent and respond to OHS hazards affecting United Nations personnel. The Inspector underscores in this context that one priority area for post-pandemic inter-agency cooperation identified by organizations in their responses to the JIU questionnaire refers to the necessity of improving coordination and response mechanisms: at the global level, by creating a unified global health emergency response framework; at the regional level, by enhancing regional coordination for emergency response; and at the field level, by strengthening local emergency response capabilities.

Figure VI
United Nations Occupational Health and Safety Coordination Mechanism structure



Source: OHS Forum, sixth activity report.

[76] Workplace safety hazards with clear health implications are considered OHS issues.

B. United Nations Medical Directors Network

146. **A long-standing voluntary professional group.** UNMD has been a technical peer group since the 1980s, focusing on harmonizing Medical Services policies, streamlining best practices of healthcare delivery and advancing the implementation of OHS across the United Nations system. The group is composed of, but not limited to, the Medical Directors and Chiefs of Medical and Health Services of the United Nations system organizations with a medical/health service, and affiliated multilateral or government entities as observers. UNMD has made numerous contributions to the United Nations system, including critical contributions during major health emergencies (Avian flu, Ebola, COVID-19, etc.). Over the years, it has been the driving force behind many accomplishments at the inter-agency level related to system-wide healthcare management. In the OHS area, the achievements include the endorsement of the UNMD statement on the need for an OHS policy for the United Nations system organizations, the endorsement by HLCM of the OHS framework in 2015, the establishment of the CEB Task Force on Duty of Care in high-risk environments, the extension of the Task Force to all risk environments, the establishment of the OHS Forum in 2020 and the adoption of the United Nations Occupational Health and Safety Coordination Mechanism. In April 2024, in parallel to the adoption of Mechanism, HLCM also endorsed the UNMD Strategy for 2023–2030,[77] which is aimed at enhancing the physical, mental and social health of the United Nations workforce by promoting standardized health practices and providing coordinated responses during health crises. The strategy, through its first two goals (advancing OHS at the system-wide level and ensuring technical lead in health emergencies and crises) highlights existing interdependencies with the Mechanism.

147. **Sustainability challenges.** The strategy also details the mission, vision, objectives and planned contributions of UNMD to inter-agency programmes of work across the United Nations system and implicitly the challenges derived from its precarious unrecognized status. The review found that there is deep concern pertaining to the long-term sustainability of this structure and its contribution to inter-agency cooperation. It relies on the volunteering and enthusiasm of a small and shrinking group of senior health professionals. The upcoming retirement of most medical directors, coupled with ongoing downgrading and reduction of posts, may lead to a significant reduction of experienced, senior-level medical experts in the United Nations system. Similarly, the ongoing generational change may bring new perspectives on the validity of the volunteering concept that underpins the UNMD model and the current form of interaction with HLCM.[78]

148. **The issue of UNMD recognition.** In 2005, UNMD was accepted as a working group of HLCM.[79] At its forty-seventh session, HLCM briefly debated the need for the recognition of UNMD as an official technical network,[80] but "a decision was delayed, allowing for further consultation and alignment with existing structures".[81] 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 health and well-being of the United Nations workforce, there is now a recognized need to have fit-for-purpose leadership at the

[77] See CEB/2024/3.
[78] According to the existing arrangement, UNMD has reporting lines to the HLCM Human Resources Network and should coordinate and align with the Network in advance of each HLCM session.
[79] CEB/2005/3, para. 76 (b).
[80] Through a letter addressed to the CEB Chair in October 2021, the UNMD Chair requested the formal recognition of UNMD as an official CEB technical network.
[81] CEB/2024/3, para. 42.

system-wide level. At present, the role of UNMD does not allow 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), etc. This limitation contributes to fragmented accountability and the uneven adoption of common health-related standards in the United Nations system. Many officials from participating organizations and all interviewed health professionals agreed that the lack of recognition prevents UNMD from realizing is mission and fulfil its "de facto" role as a health technical network of HLCM. The Inspector fully shares this standpoint and also underscores that, in view of the long-standing cost-sharing arrangement in place that underpins the work of UNMD, no significant budgetary implications are foreseen in the case that HLCM approves the request.

149. 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 the United Nations Medical Directors Network, in order to provide strategic advice on health developments and inter-agency leadership on health-related management issues.

Annex I

List of formal and informal recommendations

Chapter	*Type*	*Recommendation statement*
II	Formal	**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.**
II	Informal	*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.*
II	Formal	**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.**
II	Formal	**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.**
II	Formal	**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.**
II	Informal	*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.*
II	Informal	*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.*
II	Informal	*The Inspector encourages organizations to prioritize the value-based approaches in procurement of medical items to maximize the ultimate value of money.*
II	Informal	*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.*
II	Informal	*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.*

Chapter	*Type*	*Recommendation statement*
II	Informal	*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.*
III	Informal	*The Inspector recommends that organizations that did not do so to 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.*
III	Formal	**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.**
III	Informal	*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 the 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.*
III	Informal	*The Inspector suggests that the Secretary-General update the 2000 administrative instruction on medical evacuation.*
III	Informal	*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.*
III	Formal	**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.**
III	Informal	*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.*
III	Informal	*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.*
III	Informal	*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.*
III	Formal	**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.**

Chapter	*Type*	*Recommendation statement*
IV	Informal	*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 with the principles stipulated in the occupational health and safety framework.*
IV	Informal	*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.*
IV	Formal	**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.**
IV	Informal	*To meet the obligations under the duty of care in the area of occupational health and safety, participating organizations are strongly advised to prioritize the 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.*
IV	Informal	*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	Informal	*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.*
V	Informal	*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.*
V	Informal	*The 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 an appropriate cost-sharing funding solution for the United Nations health intelligence survey in order to ensure its sustainability and resourcing.*
V	Informal	*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.*
V	Informal	*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.*

Chapter	*Type*	*Recommendation statement*
V	Informal	*The Inspector recommends that organizations that have not done so 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	Formal	**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 the United Nations Medical Directors Network, in order to provide strategic advice on health developments and inter-agency leadership on health related management issues.**

Annex II

Mapping of health facilities and health workforce in the United Nations system (March 2025)

Health facilities	*Number of health facilities*	*Number of health personnel*	*Operating authority*	*Location/Location area*
Health Services located at headquarter duty stations		17	FAO	Rome
		17	WFP	Rome
		5	ICAO	Montreal
		6	ILO	Geneva
		2	IMO	London
	11	2	ITU	Geneva
		22	UNHCR	Geneva
		3	WIPO	Geneva
		15	WHO	Geneva
		5	UNESCO	Paris
		34	United Nations Secretariat	New York
United Nations Joint Medical Services (JMS) and United Nations Health Centres located in regional duty stations		16/18	United Nations Secretariat (United Nations Office at Geneva Medical Services (MS))	Geneva
		22	United Nations Secretariat (United Nations Office at Nairobi JMS)	Nairobi
		17	IAEA (United Nations Office at Vienna JMS)	Vienna
	7	64	United Nations Secretariat (Economic Commission for Africa United Nations Health Care Centre (UNHCC))	Addis Ababa
		3	United Nations Secretariat (Economic Commission for Latin America and the Caribbean MS)	Santiago
		5	United Nations Secretariat (Economic and Social Commission for Asia and the Pacific United Nations Medical Centre)	Bangkok
		5	United Nations Secretariat (Economic and Social Commission for Western Asia JMS)	Beirut
Clinics operated by individual United Nations organizations	66[1]		United Nations Secretariat	Located in United Nations offices away from headquarters
	56		United Nations clinics (administered by UNDP)	Located in field duty stations
	27		WFP	Located in field duty stations

[1] Some 66 medical facilities and health centres operated by the United Nations Secretariat (see United Nations Secretariat Medical Facilities list available on iSeek). The list includes also Medical Services and Healthcare Centres located in the United Nations Offices Away from Headquarters and in the regional commissions' headquarters duty stations).

Health facilities	*Number of health facilities*	*Number of health personnel*	*Operating authority*	*Location/Location area*
Hospitals deployed in United Nations peacekeeping missions	Level I+ hospitals 7	237		Deployed in various United Nations peacekeeping missions
	Level II hospitals 7	453		Deployed in various United Nations peacekeeping missions
	Level II+ hospitals 5	333		Deployed in various United Nations peacekeeping missions
	Level III hospitals 1	92		Kadugli, Sudan
	Level IV hospitals –	–		–
Medical units deployed in United Nations peacekeeping operations	62	27	United Nations Secretariat (United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic)	Central African Republic
	40	91	United Nations Secretariat (United Nations Mission in South Sudan)	South Sudan
	15	5	United Nations Secretariat (United Nations Interim Force in Lebanon)	Lebanon
	9	12	United Nations Secretariat (United Nations Interim Security Force for Abyei)	Abyei Area
	4	6	United Nations Secretariat (United Nations Disengagement Observer Force)	Israel-Syrian Arab Republic Disengagement in the Golan
	1	21	United Nations Secretariat (United Nations Mission for the Referendum in Western Sahara)	Western Sahara
	1	4	United Nations Secretariat (United Nations Peacekeeping Force in Cyprus)	Cyprus
	1	10	United Nations Secretariat (United Nations Support Mission in Libya)	Libya
United Nations examining physicians[2]		908		Located across the world

Source: Prepared by the Joint Inspection Unit based on data provided by participating organizations.

[2] United Nations Examining Physicians are appointed by United Nations Secretariat- Healthcare Management and Occupational Safety and Health Division, based on the recommendations made by United Nations resident coordinators and World Health Organization Representatives. They are not given any United Nations formal contract, and they charge fees for their services.

Annex III

Health-related policy guidance for organizations with own Health Services[3]

Organization	*Formal document for Health Services mandate*	*Health-related policies, guidelines, standard operating procedures*
FAO		– Administrative Manual, 323 Sick leave – Administrative Manual, 342 Compensation for Death, Injury or Illness – Administrative Manual, 343 Health Protection and Medical Insurance Plan – Administrative Manual, 409 Medical Travel – Guidance: Stay Healthy Before, During and After Missions – Pre-Deployment Guide for FAO Personnel in High-Risk Environments (November 2023) – Fundamental Principles of Occupational Health and Safety (OHS) in FAO.
ICAO		– Guided by the United Nations Common System practices and the plans established by its own medical doctors. – ICAO medical service addresses occupational health and safety matters. – ICAO is in the process of drafting the OHS framework, aligned to the United Nations OHS guidelines and recommendations.
ILO		– ILO Staff Regulations (December 2023) – ILO Medical evacuation and transportation for medical purposes (Internal Governance Documents System (IGDS) No. 341, Version 2) – ILO The administration of sick leave in the ILO (IGDS No. 153, Version 1) – ILO Policy on flexible working arrangements (IGDS No. 640, Version 2) – ILO Procedures for flexible working arrangements (IGDS No. 643, Version 1) – Regulations and administrative rules of the Staff Health Insurance Fund, 2022 Edition
ITU		– Occupational Health and Safety (OHS) Policy in process. – Health Service Policy. – Privacy and Confidentiality Policy
UNESCO	UNESCO Human Resources Manual Item 7.2, paragraph 10 “Medical Service”.	– Human Resources Manual Item 13.12 (Medical Examinations) of UNESCO Human Resources Manual relates to medical clearance. – Human Resources Manual Item 16.3 on UNESCO Consultative Committee on Health, Safety and Ergonomics Human Resources Manual – Human Resources Manual Item 16.10 on HIV and AIDS in the workplace – Human Resources Manual Item 16.11 on the non-smoking policy/Alcohol Policy

[3] For mental health policies, please see JIU/REP/2023/4.

Organization	*Formal document for Health Services mandate*	*Health-related policies, guidelines, standard operating procedures*
		– Human Resources Manual Item 16.12 on the employment of persons with disabilities
		– Human Resources Manual Item 16.2 on Anti-Harassment Policy
		– Human Resources Manual Item 18.2 on the Protection from Sexual Exploitation and Abuse
		– The parental and breastfeeding policies.
UNHCR		– UNHCR/HCP/2021/2 Policy on Managing Occupational Health and Safety in UNHCR
		– OHS Manual
		– Administrative Instruction Medical Clearances and Fitness to Work (UNHCR/AI/2022/03/Rev.1)
		– Policy on sick leave management.
		– Policy on medevac.
UNRWA		– UNRWA Area Staff Rules, Cod./A/Rev.25/Amend.154
		– International Staff Rules, cod.i/61/rev.6
		– Maternity Leave PDA5/Part IV/Section I/Rev.8
		– Paternity Leave PDA5/Part IV/Section II/Rev.8
		– Protection from Sexual Exploitation and Sexual Abuse, General Staff Circular No. 01/2024
		– Disability Inclusion in Employment, General Staff Circular No. 05/2020
		– Revision of Area Personnel Directive A/1/Rev.1/Part I/Section I on Telecommuting, PDA1/Part I/Section I/Rev.2
		– Special Education Grant, international personnel directive: i/3/part vi
		– Dependency status and dependency benefits, international personnel directive: i/3/part iii
		– Compensation for Death Injury or Illness, revised PDA6/Part III
		– UNRWA (DRAFT) internal guidance on alcohol and substance abuse
WIPO		– Occupational Safety and Health (OSH) Framework Policy (which is currently being prepared)
		– The WIPO Human Resources Strategy 2022–2026 (directly related to the WIPO Medium-Term Strategic Plan) expressly mentions both the OSH framework and the Mental Health Strategy, setting the tone and direction at the strategic level on these topics.
		– United Nations Mental Health and Well-Being Strategy (used as guiding principles)
		– Terms of Reference of the OSH Committee
		– Policy on confidentiality

Organization	*Formal document for Health Services mandate*	*Health-related policies, guidelines, standard operating procedures*
WFP		– Human Resource Manual – WFP People Policy – WFP Policy on Occupational Safety and Health – Travel Manual – WFP Policy on Reasonable Accommodation for Persons with Disabilities – WFP Policy on Substance and Drug Abuse – WFP Wellness Strategy (2020–2024) – Statement of United Nations Medical Directors' Working Group on Medical Conditions which qualify for the Child Special Dependency due to disability.
WHO		WHO eManual – Section 3, Human Resources and Health Emergencies sections, including • WHO eManual III.4.9 Employment of Persons with Disabilities • WHO eManual III.6.9 Certified sick leave – Return to Work Policy • WHO eManual III.6.28 Flexible working arrangements • WHO eManual III.15 Medical Examinations and Immunizations • WHO eManual XVII.7.1 Occupational Health in Emergencies – Health Services • WHO eManual XVII.7.2 Medical Evacuation Staff Health and Well-Being Services Strategy 2018–2023 Information Note: 31/2015 Subject: Health, Safety and Wellbeing at Work Information Note: 12/2023 Subject: Preventing and Addressing Sexual Misconduct, including sexual exploitation, sexual abuse, sexual harassment and all forms of prohibited sexual behaviour Information Note: 17/2024 Subject: Health, Safety and Wellbeing Committee Membership – WHO eManual – Section
IAEA	The Agency has issued a policy (AM.II/18) that outlines the functions and responsibilities of the Medical Services.	– Section 1: Staff Regulations and Staff Rules Rule 3.04.1 – Medical clearances Rule 7.04.1 – Sick leave Rule 9.01.5 – Medical and security requirements before travel Appendix D: RULES GOVERNING COMPENSATION IN THE EVENT OF DEATH, INJURY OR ILLNESS ATTRIBUTABLE TO THE PERFORMANCE OF OFFICIAL DUTIES – Section 18: Vienna International Centre Medical Service Annex 1: MEDICAL CLEARANCES Annex 2: RESOLUTION OF DISPUTES RELATING TO MEDICAL DETERMINATIONS

Organization	*Formal document for Health Services mandate*	*Health-related policies, guidelines, standard operating procedures*
		Annex 3: GUIDELINES ON RETURN TO WORK FOLLOWING EXTENDED SICK LEAVE – Section 17: Personnel Policies and Procedures Appendix D: ALCOHOL AND SUBSTANCE ABUSE POLICY Appendix H: OCCUPATIONAL HEALTH AND SAFETY POLICY
United Nations	Formal mandate of the Healthcare Management and Occupational Safety and Health Division (DHMOSH) is contained in the latest edition of the Medical Support Manual for United Nations Field Missions (2024)	– ST/SGB/2024/1 Staff Regulations and Staff Rules of the United Nations – ST/SGB/2019/2, Delegation of authority – ST/SGB/2014/3, Employment and accessibility for staff members with disabilities in the United Nations Secretariat – ST/SGB/2024/3, Data protection and privacy policy for the Secretariat of the United Nations – ST/SGB/2024/1, Appendix D, Rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations – ST/SGB/103/Rev.1, Rules governing compensation to members of commissions, committees or similar bodies in the event of death, injury or illness attributable to service with the United Nations – ST/SGB/2007/12, HIV/AIDS in the Workplace Orientation Programme – ST/SGB/2004/11, Payment of insurance proceeds under the malicious acts insurance policy – ST/AI/2011/3, Medical clearances – ST/AI/2005/3, Sick leave – ST/AI/2005/1, Recording of attendance and leave – ST/AI/2000/10, Medical evacuation – ST/AI/2015/3, Medical Insurance Plan for locally recruited staff at designated duty stations away from Headquarters – ST/AI/2007/3, After-service health insurance – ST/AI/2023/2, Parental leave and family leave – ST/AI/1999/16, Termination of appointment for reasons of health – ST/AI/372, Employee assistance in cases of alcohol/substance abuse – ST/AI/2000/14, Coordination of action in cases of death of staff members: Travel and transportation in cases of death or health-related emergency – ST/AI/2004/2, Education grant and special education grant for children with a disability – ST/AI/2010/6, Road and driving safety – ST/IC/2019/15, Flexible work arrangements – ST/IC/2000/70, Medical evacuation – ST/IC/1999/14, Guidelines for ergonomic workstations and work with computers

Organization	*Formal document for Health Services mandate*	*Health-related policies, guidelines, standard operating procedures*
		– ST/AI/2019/1, Resolution of disputes relating to medical determinations – Policy on United Nations Standards for Healthcare Quality and Patient Safety, Ref. DHMOSH/SOP/January/2020 – Guidelines for Technical Clearance Review of Medical Personnel for Deployment to United Nations Field Duty Stations, Ref. No: DOS/DHMOSH/MWFM/2023.4 – Sick leave standard operating procedures Refresher on basic information in the management of sick leave – Audit, Standard Operating Procedure, 31 January 2023 – Critical Elements of Medevac and RAC, Medical Entitlements, Healthcare Management and Occupational Safety and Health Division, United Nations – Guidance on Medical Evacuation for Resident Coordinators/Representatives, Heads of Offices, and Chief of Mission Support/ Director of Mission Support – Critical Elements Sick Leave Management, New and Recertification, Medical Entitlements Team, Healthcare Management and Occupational Safety and Health Division, United Nations – Standard Operating Procedure, Recruitment of Medical Personnel in UNDP-Administered Clinics, Ref. No: DOS/2024.1 – EarthMed Standard Operating Procedure Medical Confidentiality, DOS/2023.06 – EarthMed Auditing of EarthMed Cases, 9 October 2020 – EarthMed User Guide Immunizations, v20210427

Source: Responses to the Joint Inspection Unit organizational questionnaire.

Annex IV

Overview of the procurement practices for medical goods for organizations with own Health Services

Organization	*Procurement centralized (yes/no)*	*Degree of centralization (Decentralized; primarily decentralized; increasingly decentralized; centralized)*	*Key actors in medical equipment procurement*	*Criteria used in procurement (Price, volume, quality, value for many, maintenance needs, green procurement etc.)*	*Details*
United Nations	*Not provided*	Other than small amounts of locally procured supplies which are done via low-value acquisitions, all medical consumables/vaccines/major equipment are obtained via systems contracts under the centralized procurement processes of the procurement division.	*Not provided*	Systems contract availability including price and timing. For equipment or equipment-linked consumables, it is linked to compatibility with current equipment, processes and needs.	The technical advice of suitability of offered consumables, for major equipment items a technical specification of requirements, which could be as simple as the voltage required for the location.
UNHCR	Yes	Based on UNHCR procurement regulation. Each region has a procurement process. This depends on the allowed amount for a five-year window. When they exceed this amount, the process come to the Headquarters Committee on Contracts. – For the Staff Health and Wellbeing Service, most of the contracts are done at headquarters level as the amounts for these contracts would exceed the five-year limit amount at the outset.	Procurement and supply unit in collaboration with Staff Health and Wellbeing Service.	As per internal UNHCR procurement rules (price, provider, volume, technical specifications etc.). Piggyback on other agency contracts (for example, WFP, UNICEF, UNOPS) as per the mutual agreement directives, and in some cases, UNHCR is the contract owner.	For contracts and procurement process which provides services to UNHCR, the Medical Section provides terms of reference, intervenes in technical specifications and technical assessment of proposals, always following UNHCR procurement rules.

Organization	*Procurement centralized (yes/no)*	*Degree of centralization (Decentralized; primarily decentralized; increasingly decentralized; centralized)*	*Key actors in medical equipment procurement*	*Criteria used in procurement (Price, volume, quality, value for many, maintenance needs, green procurement etc.)*	*Details*
UNRWA	Yes	Primarily decentralized	Health Department at fields	Specifications, price, quality, green procurement.	Health Department is responsible for procurement of medications, equipment, lab kits that are used at our health centres for providing healthcare services for our beneficiaries. We do not participate in procurement related to furniture (and it is ergonomic), environment and shared offices (except during the COVID-19 pandemic), healthy water for staff, sanitation, food supplies.
WFP	Yes	Mainly centralized for medical evacuation services and primarily decentralized for the procurement of medical supplies and equipment.	Staff Wellness Division; Supply Chain and Delivery Division – Procurement	– Criteria include quality, pricing volume and maintenance needs. – Quality is determined to ensure compliance with standards and verification of supplier credentials and certifications. – Cost and quality are considered to ensure cost effectiveness of quality products defined by Staff Wellness Division. – Maintenance needs such as after-sales support and provision of adequate training for personnel and comprehensive product documentation.	The medical service unit sets the standards required for medical equipment/supplies and validate the quality and suitability of the procured equipment based on the needs of the organization. Most of the procurement spending is related to medical evacuation services rather than supplies for clinics and equipment.

Organization	*Procurement centralized (yes/no)*	*Degree of centralization (Decentralized; primarily decentralized; increasingly decentralized; centralized)*	*Key actors in medical equipment procurement*	*Criteria used in procurement (Price, volume, quality, value for many, maintenance needs, green procurement etc.)*	*Details*
				– Geographical coverage and capacity of service providers are considered when determining the abilities of relevant service providers to respond to emergencies, for example in case of medical evacuations.	
FAO	Yes	Centralized in FAO Procurement services	Nurses and office assistants	Follows general United Nations Procurement policies	Health services raise purchase orders for low value procurements and draft/review technical sections of bidding documents for system contracts
IAEA	Yes	Increasingly decentralized, most low value purchasing done though Head Nurse with credit card	Medical Director and Head Nurse Office of Procurement Services, if purchases exceed €5,000	Criteria for central procurement: bidding process and value for money	
ICAO	Yes	ICAO Procurement Section (PRO) provides support and services to Secretariat staff and Member States addressing procurements for the Organization (headquarters, regional and regional sub-offices). This includes any procurement of medical supplies and equipment.	Evaluation Committee is composed of: – Occupational Health and Safety (OHS) Specialist – Technical expert – Human Resources Officer	ICAO procurement is done in accordance with the provisions of the ICAO Procurement Code.	ICAO Medical Services does the following: – Prepares a procurement plan for all medical services and equipment required for the year. – Defines the terms of reference and specifications of all medical supplies and equipment to be procured. – Provides technical support during the evaluation of bids

Organization	*Procurement centralized (yes/no)*	*Degree of centralization (Decentralized; primarily decentralized; increasingly decentralized; centralized)*	*Key actors in medical equipment procurement*	*Criteria used in procurement (Price, volume, quality, value for many, maintenance needs, green procurement etc.)*	*Details*
			– Procurement Officer		related to specialized medical supplies and equipment. – Verifies conformity with the specifications provided on receipt.
ILO	Yes	Procurement for medical supplies and equipment is mainly for the headquarters medical services. It is primarily centralized.	– ILO Medical Adviser – Human Resources Development Department Budget Officer – Procurement Officer	The main criteria used for medical procurement are: – Quality and fit for purpose. – Maintenance needs. – Value for money.	The medical services' role in procurement of medical goods and supplies include: – Needs analysis and purchase requisition with budget limits. – Support technical adjudication.
IMO	*Not provided*	*Not provided*	*Not provided*	*Not provided*	
ITU	Yes	*Not provided*	*Not provided*	*Not provided*	
UNESCO	Yes	All medical purchases centralized in the OHS Service. (Some COVID-19 preventive measures, masks and gel were purchased globally by Central Services)	Occupational Health Service	Availability being one of the key criteria.	
WHO	Yes	Centralized	Nurse, Medical Director, Procurement Officer	Adjudication report based on price, quality, value for money etc. following WHO procurement standard process	

Organization	*Procurement centralized (yes/no)*	*Degree of centralization (Decentralized; primarily decentralized; increasingly decentralized; centralized)*	*Key actors in medical equipment procurement*	*Criteria used in procurement (Price, volume, quality, value for many, maintenance needs, green procurement etc.)*	*Details*
WIPO	Yes	Centralized	– Supplies and medication: WIPO Medical Unit – Providers: Various local medical suppliers and pharmacies.	– Local availability: Switzerland, France – Price: SwF 50,000 – ISO certification – Maintenance needs: Monthly maintenance – Green procurement: Green procurement policy does exist within the organization. – The OSH Nurse is responsible for the pharmacy, inventory, supply chain eco-friendly and recycling, as well as equipment maintenance. The Administration is in charge of the budget, purchase requisitions, and supplier follow-up	WIPO Medical Unit independently manages its procurement processes, working closely with the Procurement team when required.

Source: Responses to the Joint Inspection Unit organizational questionnaire.

Annex V

Health Services staffing

Organization	*Total Health Service staff*	*Total Health Service medical staff*	*Health Service staffing, headquarters*	*Health Service staffing, other duty stations*	*Comments/details*
FAO	27	20	– 6 medical officers (2 fixed term, 3 consultants and 1 temporary staff) – 4 nurses (staff) – 7 staff counsellors (all consultants) – 7 office assistants (6 staff and 1 temporary) – 1 ergonomics specialist (shared post with WFP) – 2 physiotherapist (consultants)		
ICAO	5	4	– 2 Occupational Health and Safety (OHS) Professionals – 2 Primary Care Professionals – 1 Admin support staff, provides all medical clearance for headquarters and Regional personnel (Pre-employment, separation, medical, Home Leave, sick leave, Disability review etc.)		
ILO	3.5	2.7	– Full-time Doctor (1) – Part-time Doctor 50% (1) – Daily contract Doctor 20% (1) – Nurses 80% (2) – Daily contract Nurses 20% (1) – Admin Support Staff 80% (2)		Staff Welfare Office has additional staff.
IMO	2.2	1.2	The health and well-being services consist of one consultant Medical Adviser 0.2 full-time equivalent (FTE), one full time Nurse and one temporary technician/administrator.		
ITU	2		Details not provided.		
UNESCO	5.8	5.8	– UNESCO House: servicing staff members and potentially visitors, 1.5 FTE medical officer 2.3 FTE Nurse, 1 FTE medical assistant. – Miollis-Bonvin site: 1 FTE Nurse providing first aid and nursing to members of delegations.	International Centre for Theoretical Physics, has a health unit designed to service students on site.	

Organization	*Total Health Service staff*	*Total Health Service medical staff*	*Health Service staffing, headquarters*	*Health Service staffing, other duty stations*	*Comments/details*
UNHCR	22	21	The Medical Section in the Staff Health and Wellbeing Service: – 1 Chief of Medical Section – 7 regional medical officers – 1 medical analyst – 11 nurses/administrators – 1 medical secretary – 1 business analyst		
WIPO	3	2	Headquarters WIPO Medical Unit: – 1 Senior Medical Advisor – 1 Occupational nurse – 1 Administrative support staff		WIPO maintains a roster of Doctors and Nurses to replace staff during annual leave or to provide extra support as needed.
WFP	38	.37	Staff Wellness Division Medical (WELM) – headquarters – Chief – Headquarters Medical Officer – Doctor – Ergonomist – Physiotherapist and Osteopath – Psychotherapist (2) – Nurses (6) – Administrative (1)	WELM – Regional Medical Officers – Doctors (17) – Public Health Advisor – Nurses (8)	- Only WELM staff of the Staff Wellness Division were included. - Personnel of WFP clinics in the field were not included.
WHO	18	13	Headquarters Geneva: – 1 medical director, – 2 medical officer, – 3 nurses, – 4 admin assistant – 1 technical assistant.	Headquarters Lyon/ International Agency for Research on Cancer : – 1 medical officer. headquarters Kuala-Lumpur: – 1 medical Officer. WHO Regional Office for Africa: – 1 health service with 1 medical officer. WHO Regional Office for the Western Pacific Regional Medical Service team: – 1 Regional Staff Physician and 1 Staff Nurse;	Headquarters Geneva: medical service covering WHO Headquarters Geneva and outposted offices (Budapest, Berlin, Kobe, Tunis), UNAIDS (worldwide), UNICC (United Nations International Computing Centre, worldwide) and Unitaid.

Organization	*Total Health Service staff*	*Total Health Service medical staff*	*Health Service staffing, headquarters*	*Health Service staffing, other duty stations*	*Comments/details*
				WHO Health Emergencies Programme: – Staff physician Ukraine – Staff counsellor Ukraine	
IAEA (VIC MS)	17	12	– 3 doctors (D-1 P-5 P-4) – 6 nurses (G-6 including 1 head nurse G-7) – 5 admin personnel (4 x G-4 and 1 x G-5) – 2 medical aides (G-2) – 1 staff counsellor (Psychologist P-3)		– VIC Medical Service, shared service between the 4 major organizations based at the Vienna International Centre.(IAEA, UNIDO, UNODC and Preparatory Commission for the Comprehensive Nuclear Test Ban Treaty Organization).
United Nations[4]			– 1 Telemedicine Requester – 2 Mental Health Professionals – 3 Telemedicine Specialists – 121 Administrative staff – 287 Nurses – 300 Doctors – 32 staff without mention of their position		Based on information available on i-seek.

Source: Responses to the Joint Inspection Unit organizational questionnaire.

[4] For the joint medical services of United Nations regional hubs and Vienna International Centre Medical Services, please see annex VI.

Annex VI

United Nations regional common service health providers

Common service Health Provider	*Number of beneficiary United Nations personnel*	*Number of United Nations entities covered*	*Budget (resources) (thousands of United States dollars)*	*Number of healthcare staff*	*Level of Joint Medical Services (JMS)/Medical Services (MS) Head*	*Governing document(s) (Agreement/ memorandum of understanding/service level agreement)*	*Governing structure(s) Reporting line and oversight committee*	*Number of health treatments/ services (2024)*
United Nations Office at Geneva (UNOG) MS	Total 16,096	39 entities	Total 3,290,800	18 positions (some part-time)	P-5	Memorandum of understanding for the provision of services by UNOG to OHCHR and to United Nations Volunteers (UNOG/MOU/06-2020)	Chief Human Resources (First Reporting Officer) and Director of Administration (Second Reporting Officer)	n/a
United Nations Office at Nairobi (UNON) JMS	Total 20,000 Staff and family members of staff (affiliate personnel Not counted)	41 entities	Total 2,800,000* * 2023	26 positions (some part-time)	P-5	UNON/SLA/2024 for the provision of Services by UNON MoU Agreement between UNON and the United Nations Support Office for the African Union Mission in Somalia regarding Joint Medical Services, UNCares and Staff Stress Management Counsellor	Director Human Resource Management Service Common Services Management Team Human Resources sub-committee	n/a
Vienna International Centre-JMS	Total 4,800 (circa)	4 entities	Total 2,300,000* * Converted from euro	17	D-1	Administrative Manual Personnel administration and staff welfare AM.II/18 Vienna International Centre Medical Service UNOV common services	Director Division of Human Resources, Department of Management, IAEA	n/a

Common service Health Provider	*Number of beneficiary United Nations personnel*	*Number of United Nations entities covered*	*Budget (resources) (thousands of United States dollars)*	*Number of healthcare staff*	*Level of Joint Medical Services (JMS)/Medical Services (MS) Head*	*Governing document(s) (Agreement/ memorandum of understanding/service level agreement)*	*Governing structure(s) Reporting line and oversight committee*	*Number of health treatments/ services (2024)*
Economic Commission for Africa (ECA)-United Nations Health Care Centre (UNHCC)	Total 22,915	36 entities	Total 3,462,500* * Budgeted	32 (including admin/ logistics) Plus 55 medical, technical and logistics personnel under UNDP contracts	P-5	Agreement on UNHCC in Addis Ababa revised June 2014 Memorandum of understanding between UNHCR/ECA and participating agencies on the provision and use of the United Nations Tigray Clinics UNHCC Administrative standard operating procedure	Director Division of Administration 3 oversight bodies: 1. Executive Committee 2. UNHCC Management Support Committee 3. UNHCC Technical Support Committee	n/a
Economic Commission for Latin America and the Caribbean (ECLAC)-MS	Total 520 (Plus non-ECLAC agencies, funds and programmes colleagues in Santiago, Chile and for Travel and Headquarters Unit travel clearances, all United Nations secretariat colleagues based in Canada, Mexico and Central and South America)	24 entities		3	NO-D	Agreement for the provision of operational support services between ECLAC and the Resident Coordinator in Santiago, Chile ECLAC Services Catalogue	Chief of Human Resources (to Chief (D-1)) NOTE: 1. Technical matters to Dr. Michael Rowell of UNMS United Nations Headquarters 2. Administrative matters to Chief of Human Resources to Head of ECLAC Administration Unit	5,758 (for 2023) 1,257 (Medical/ Travel clearance for 2022)

Common service Health Provider	*Number of beneficiary United Nations personnel*	*Number of United Nations entities covered*	*Budget (resources) (thousands of United States dollars)*	*Number of healthcare staff*	*Level of Joint Medical Services (JMS)/Medical Services (MS) Head*	*Governing document(s) (Agreement/ memorandum of understanding/service level agreement)*	*Governing structure(s) Reporting line and oversight committee*	*Number of health treatments/ services (2024)*
Economic and Social Commission for Asia and the Pacific (ESCAP)-MS	Total 500	24 entities		4	P-4	ESCAP is not a full Joint Medical Service: it offers medical services as a client service provider on a cost-shared basis. Memorandum of understanding between UN-Women and ESCAP Cost-sharing agreement 1988	Chief of Human Resources (to Director DOA) and Healthcare Management and Occupational Safety and Health Division	N/A
Economic and Social Commission for Western Asia-MS	Total 2,452* * 2023 figures.	25 entities	Total 2,098,854* * 2023 figures.	6	P-4	Memorandum of understanding concerning the use of the Joint Medical Service between ESCWA and the Office for the Coordination of Humanitarian Affairs	Head of Medical and Welfare Service Section reports to ESCWA Director Resources Management and Service Development Division and Medical Director Healthcare Management and Occupational Safety and Health Division/NY headquarters	N/A

Source: Responses to the Joint Inspection Unit organizational questionnaire.

Annex VII

Status of implementation of selected Duty of Care Task Force recommendations*

	Area: Predeployment guide				
Organization	*(a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)*	*(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)*	*(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)*	*(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)*	*Details for (a)–(d) (If in progress, specify the percentage)*
FAO	Yes	Yes	Yes		(d) The predeployment guide is posted on the intranet and is available to all employees; however, it is not specifically shared with each newcomer.
IAEA	Yes	No	N/A	N/A	
ICAO	Yes	Yes	Yes	No	(a) N/A to ICAO headquarters and Regional Offices. Staff are deployed on a temporary basis to high-risk area to implement projects, and predeployment guidance is provided through different United Nations Common System and internal tools, before deployment, such as: Duty Station's Security travel advisory from the Department of Safety and Security; Recommended Medical clearances aligned to the provisions of duty station hardship classification; WHO International Travel and Health website; Completion of BSAFE and Protection from Sexual Exploitation and Abuse courses; Briefing provided on Human Resources aspects. (b) N/A to ICAO headquarters and Regional Offices. – Technical Cooperation Programme provides predeployment guidance as a standard package, regardless of the contractual status, which includes information on health, well-being and security matters.

Organization	Area: Predeployment guide (a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					(c) ICAO is planning to update and standardize the predeployment guide based on the best practices within the United Nations system. – Technical Cooperation Programme provides predeployment guidance as a standard package as per Q-2 above, regardless of the contractual status, which includes information on health, well-being and security matters. (d) No – the ICAO Technical Cooperation Programme uses various tools and mechanisms to guide personnel before deployment; however, the predeployment guide developed by the Duty of Care Task Force is not embedded, per se.
ILO	Yes	Yes	Yes	No	(a), (b), (c) This information is provided for staff completing entry medical exams in headquarters – with follow-up appointments for travel briefing as needed. Staff in the field do not have access to this guidance. Individual and confidential sessions (face to face or remotely) with the Staff Welfare Officer are offered to ILO officials assigned to high-risk locations. The content of the sessions is consistent with the resilience briefing standards recommended in the predeployment guide. ILO provides the security and safety predeployment guide as a complement to the Department of Safety and Security online BSAFE training. All ILO staff members are encouraged to undertake BSAFE training upon

Organization	Area: Predeployment guide (a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					recruitment and must have done it prior to any official travel. – Guidance to service contract holders is provided at the local level. ILO policy does not allow for the deployment of consultants in high-risk duty stations with security level 5 and above. (d) Security and occupational safety and health are not included in the induction programme offered to all newly appointed ILO staff.
IMO	N/A	N/A	N/A	N/A	
ITC	N/A	N/A	N/A	N/A	
ITU	Yes	Yes	Yes	Yes	
UNAIDS	Yes	Yes	Yes	N/A	(a), (b), (c) UNAIDS staff deployed to hardship duty stations receive information related to safety, security and well-being and mental health through the focal Human Resources Business partners. A guidance document – The Compass – provides a description of different departments and offices in UNAIDS and World Health Organization (WHO) where staff can get assistance on conditions of employment, health, security etc. It identifies some of the most common situations faced by staff members, and it points staff members to the departments/ offices that they should contact first. A mandatory Security briefing is provided as part of the duty station Department of Safety and Security protocols.

Organization	Area: Predeployment guide (a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					(d) Elements of Duty of Care Task Force are, however, included in the Department of Safety and Security briefings provided to UNAIDS Staff
UNCTAD	N/A	N/A	N/A	N/A	
UNDP	Yes	Yes	No		(a) Pre- and post-deployment sessions are mandatory for personnel deployed to hardship duty stations and are delivered through an external provider (Rome Institute). The briefings are designed to build resilience, strengthen coping skills, support smooth transitions from high-risk assignments and address possible delayed effects. In addition, country-specific information is accessible to all personnel via the UNDP Well-being App, including contact details for local offices, cultural insights, logistics schools and country-specific information. (b) and (c) The services indicated above are available to all personnel and mandatory for those assigned to hardship duty stations. The briefings are designed to build resilience, strengthen coping skills, support smooth transitions from high-risk assignments and address possible delayed effects. In addition, we provide on-demand predeployment sessions for locations such as Amman and Istanbul. Our website also features online webinars on deployment preparation and family deployment.
UNEP	Yes	Yes	N/A	N/A	(a) Yes, our staff deployed to Dadaab and Kakuma are given specific briefing and guidance.

Organization	Area: Predeployment guide (a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					During specific emergencies when required, predeployment guides developed are issued to personnel, e.g. Ebola crisis predeployment guide for personnel responding to the West Africa emergency. (b) As for staff.
UNESCO	No	No	No	No	
UNFPA	Yes	Yes	Yes	N/A	
UN-Habitat	Yes	Yes	N/A	N/A	(a) Yes, our staff deployed to Dadaab and Kakuma are given specific briefing and guidance. During specific emergencies when required, predeployment guides developed are issued to personnel, e.g. Ebola crisis predeployment guide for personnel responding to the West Africa emergency. (b) As for staff.
UNHCR	Yes	Yes	Yes	Yes	
UNICEF	Yes	Yes	Yes	Yes	
UNIDO	N/A	N/A	N/A	N/A	
United Nations				No	(d) No. Occupational Safety and Health (OSH) is required in induction programmes around the workplace, but for all workplaces, not just high-risk duty stations
UNOPS	Yes	Yes	Yes	N/A	(a), (b), (c), (d) Onboarding guidelines are provided to all new UNOPS personnel, regardless of duty station, upon taking up an assignment with UNOPS. Country-specific guidelines are developed by local Human Resources on an ad hoc basis.

Organization	Area: Predeployment guide (a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
UNRWA	No	No	No	No	
UN Tourism	N/A	N/A	N/A	N/A	
UN-Women				N/A	(a) Pre-/post-deployment briefing to be implemented with support from Counsellors/Rome Institute, implementation ongoing; – Do receive briefings from Security (b) Do receive briefings from Security. Global and Local induction, providing briefings on resources. (c) Do receive briefings from Security. Global and Local induction, providing briefings on resources.
UPU					(a), (b), (c), (d) No high-risk location
WFP	Yes	No	No	Yes	(a) Include guide for medical doctors on fitness for deployment for staff, nurses' guide on vaccination status, prophylaxis against disease endemic to the region and travel kits issuance and counselling section on psychological preparedness of staff before deployment.
WHO	Yes	Yes	Yes	Yes	(a) A WHO predeployment package based on the template developed by the former Cross-Functional Task Force on Duty of Care is currently being updated (95%). – Security Services provide predeployment security briefing upon information from Human Resources or deploying WHO Units of any staff and non-staff deployed to high-risk locations.

Organization	Area: Predeployment guide				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)	(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)	(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)	
					– The Staff Health and Wellbeing Department provides health and well-being (medical and psychosocial) predeployment recommendations to personnel (staff and non-staff) deployed in high-risk locations, including Grade 2 and Grade 3 health emergency response. (b) As above (c) A WHO predeployment package based on the template developed by the former Cross-Functional Task Force on Duty of Care is currently being updated (95%). – Security Services provide predeployment security briefing upon information from Human Resources or the deploying WHO Units of staff and non-staff personnel in non-high-risk locations. – The Staff Health and Wellbeing Department provides health and well-being (medical and psychosocial) predeployment recommendations to staff deployed for duty travel. Non-staff deployed to non-high-risk location are referred to external services (travel medicine service), except in case of Grade 2 and Grade 3 health emergency response. (d) In progress (95%) – a WHO predeployment package based on the template developed by the former Cross-Functional Task Force on Duty of Care is currently being finalized.

Organization	Area: Predeployment guide				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Predeployment guide provided to staff deployed to high-risk locations (yes/no)	*(b) Predeployment guide provided to personnel other than staff deployed to high-risk locations (yes/no)*	*(c) Predeployment guide provided to staff and non-staff deployed to non-high-risk locations (yes/no)*	*(d) Predeployment guide developed by Duty of Care Task Force embedded in induction programmes (yes/no)*	
WIPO	N/A	N/A	N/A	N/A	(a) WIPO Staff members are essentially based at headquarters. In case they have missions, they have medical and security briefings. In case the region where the staff member is deployed becomes high-risk, the mission is curtailed, and the staff member's immediate return to headquarters is organized, including in coordination with the Department of Safety and Security. The mission is also cancelled in case of security and medical threats. (b), (c), (d) Ibid.
WMO	N/A	N/A	N/A	N/A	(a) WMO does not operate in high-risk environments.

Organization	Area: Personnel resilience						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)	(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)	(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)	(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)	(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)	(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)	
FAO	Yes	N/A	Yes	N/A	Yes	Yes	(b) This is not the practice in all missions; however, a mission report is mandatory within 30 days from returning to duty station. (d) Not for all missions.
IAEA	Yes	Yes	No	N/A	N/A	No	
ICAO	No	No	No	No	No	No	
ILO	Yes	No	N/A	No	No		(a) The well-being part of our mission is focusing on conditions of living, security measures at residences and monitoring the best way of living within the duty station, most specifically ILO female staff. (f) In Progress – In each duty station security advice, guidance, briefing and standard operating procedures are established, available and compulsory. ILO aims to make this information available in digital format for ease of access and facility to update with the latest information.
IMO		N/A	N/A	N/A	N/A	N/A	
ITC	N/A	N/A	N/A	N/A	N/A	N/A	
ITU	Yes	Yes	Yes	Yes	Yes	Yes	
UNAIDS	Yes	No	Yes	No	Yes	Yes	(a) Briefings are provided by the staff health counsellor as part of regular consultations with regional offices. Additional briefings are provided as requested during periods of increased security warnings.

Organization	Area: Personnel resilience						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)	(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)	(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)	(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)	(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)	(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)	
							(f) As part of the duty station Department of Safety and Security protocols
UNCTAD	N/A	N/A	N/A	N/A	N/A	N/A	
UNDP	Yes	Yes	Yes	Yes	No	Yes	
UNEP	Yes	Yes	Yes	Yes	Yes	N/A	(a) Briefing sessions involving resilience-building as well as regular sessions run by the staff counselling office for staff in the field, initiated by the respective agency or by the staff counselling office. (b) Yes. Staff returning from high-risk stations who received predeployment briefings are debriefed on return through the staff counselling office. (c) They are included with staff. However, debriefing is not consistent, as some staff do not come for it, and it is not mandatory. (d) Yes. Staff returning from high-risk stations who received predeployment briefings are debriefed on return through the staff counselling office. However, debriefing is not consistent, as some staff do not come for it, and it is not mandatory. (e) The staff counselling office provides briefing sessions and detailed trainings for all personnel.

Organization	Area: Personnel resilience						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)	(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)	(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)	(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)	(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)	(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)	
UNESCO	No	No	No	No	No	No	(a) Except security (b) Ibid. (c) Ibid. (d) Ibid. (e) Ibid. (f) Ibid.
UNFPA	Yes	Yes	Yes	Yes	Yes	Yes	
UN-Habitat	Yes	Yes	Yes	Yes	Yes	N/A	(a) Briefing sessions involving resilience building as well as regular sessions run by the staff counselling office for staff in the field, initiated by the respective agency or by the staff counselling office. (b) Yes. Staff returning from high-risk stations who received predeployment briefings are debriefed on return through the staff counselling office. (c) They are included with staff. However, debriefing is not consistent, as some staff do not come for it, and it is not mandatory. (d) Yes. Staff returning from high-risk stations who received predeployment briefings are debriefed on return through the staff counselling office. However, debriefing is not consistent, as some staff do not come for it, and it is not mandatory. (e) The staff counselling office provides briefing sessions and detailed trainings for all personnel.

	Area: Personnel resilience						
Organization	*(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)*	*(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)*	*(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)*	*(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)*	*(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)*	*(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)*	*Details for (a)–(f) (If in progress, specify the percentage)*
UNHCR	Yes	Yes	Yes	Yes	Yes	Yes	(a) Staff counsellors have regular programmes for the high-risk duty stations that include resilience briefings or discussions on different psychosocial risks, their psychosocial impact and how to address them (and cope with them). Cultivate resilience programme is available on UNHCR Well-being platform. (b) End of assignment debriefing is mandatory (and is a condition for the Special Leave with Full Pay granted after such service) for all international staff at the end of their service in high-risk locations. – End-of-Assignment debriefing (c) The resilience briefings offered to staff members also include non-staff deployed to high-risk duty stations. (d) End-of-assignment debriefings are available to non-staff deployed to high-risk locations at request. (e) Psychosocial well-being section organizes virtual and in situ programmes related to resilience. Cultivate resilience programme available on the UNHCR well-being platform is available to everybody. (f) Personnel Administration Section compiles the “Living condition” pamphlets for all operations. In addition, the

Organization	Area: Personnel resilience (a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)	(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)	(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)	(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)	(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)	(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)	Details for (a)–(f) (If in progress, specify the percentage)
							Psychosocial Wellbeing Section has worked with the operations on the production of "local info" for high-risk duty stations available on the UNHCR well-being platform (17/21 are published). The Psychosocial well-being section works with the operational focal points.
UNICEF	Yes	Yes	Yes	Yes	Yes	Yes	
UNIDO	N/A	N/A	N/A	N/A	N/A	N/A	
United Nations							(d) No. The United Nations Secretariat does not have briefing or debriefing for staff going to and from high-risk duty stations from a resilience and psychological standpoint. This was the plan in 2007/2008, but decentralization of deployment and recruitment stopped this initiative. This has been incorporated into the scorecard for the mental health strategy for 2024 and beyond. The Department of Management Strategy, Policy and Compliance will look into that process in the future.
UNOPS	Yes	Yes	Yes	Yes	No	No	(a) 30% (b) 20% (c) 30% (d) 20% (a), (b), (c), (d), (e), (f) The People and Culture Group is piloting psychological preparation briefings and end-of-assignment debriefings for international

Organization	Area: Personnel resilience						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)	(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)	(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)	(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)	(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)	(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)	
							colleagues prior to and post-deployment to hardship duty stations. The pilot is currently including 3 UNOPS hardship locations and, if successful, would be extended further in the future.
UNRWA	No	No	No	No	No	No	
UN Tourism	N/A	N/A	N/A	N/A	N/A	N/A	
UN-Women							
UPU							(a), (b), (c), (d), (e), (f) No high-risk location
WFP	Yes	No	No	No	Yes	Yes	(a) Pre-travel briefing is given, including psychological support, and a follow-up briefing upon arrival. These are conducted by the medical officers, nurses and counsellors. (b) WFP has a wellness platform where staff can reach out for debriefing following missions in high-risk areas. (f) Example is the United Nations Department of Security and Safety weekly incident summary.
WHO	Yes	Yes	Yes	Yes	Yes	Yes	(a) Pre-, during- and post-deployment health and well-being support, including medical and psychosocial support, is provided to staff deployed to high-risk locations through headquarters and regional medical services, and all personnel are encouraged to take advantage thereof.

	Area: Personnel resilience						
Organization	*(a) Briefings provided to enhance resilience of staff deployed to high-risk locations (yes/no)*	*(b) Debriefing process conducted (at the end of missions) for staff deployed to high-risk locations (yes/no)*	*(c) Briefings provided to enhance resilience of non-staff deployed to high-risk locations (yes/no)*	*(d) Debriefing process conducted for staff and non-staff deployed to high-risk locations (yes/no)*	*(e) Briefings provided to enhance resilience of staff and non-staff deployed to non-high-risk locations (yes/no)*	*(f) Country-specific fact sheets prepared for all high-risk locations (yes/no)*	*Details for (a)–(f) (If in progress, specify the percentage)*
							(b) Conducted for complex missions/high-risk locations (c) A predeployment package, including protection and resilience section is currently being updated. A standard operating procedure and framework to systematically deliver to the workforce is currently being developed (f) The Staff Health and Wellbeing Department provides country-specific medical predeployment information for workforce members deployed to Grade 2 and Grade 3 emergency response. – Security Services have country-specific fact sheets included in the security briefings provided to staff.
WIPO	N/A	N/A	N/A	N/A	N/A	N/A	
WMO	N/A	N/A	N/A	N/A	No	N/A	

Organization	Area: Managerial training and support			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Targeted training to managers on staff deployed to high-risk locations (yes/no)	*(b) Targeted training to managers on non-staff deployed to high-risk locations (yes/no)*	*(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)*	
FAO	No	No	Yes	(c) Multiple resources are available to support managers
IAEA	No	No	N/A	
ICAO	No	No	Yes	(a) Not at the moment. – ICAO offices are mainly in non-high-risk locations. – For Technical Cooperation Programme, provides generic United Nations Training, e.g. BSAFE Training/ (b) Depending on availability of resources. (c) N/A – ICAO headquarters. Yes – Limited to Project based personnel – ICAO Technical Cooperation Programme maintains constant email communication and follow-up with Project Coordinators and the concerned Field Personnel, in addition to the UNDP support from the local offices.
ILO		No	Yes	(a) In Progress. Security Management Training is available from the United Nations security management system, targeting the specific conditions of living as explained above. (b) ILO policy does not allow for the deployment of consultants in high-risk duty stations. Overall, contractor staff and external collaborators do not hold managerial positions. (c) Human Resources Partners at headquarters and at the regional level, as well as the headquarters-based Staff Welfare Officer, have regular interactions and provide support to managers in the field.
IMO	N/A	N/A	N/A	
ITC	N/A	N/A	N/A	
ITU	Yes	Yes	Yes	

Organization	Area: Managerial training and support			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Targeted training to managers on staff deployed to high-risk locations (yes/no)	(b) Targeted training to managers on non-staff deployed to high-risk locations (yes/no)	(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)	
UNAIDS	Yes	Yes	Yes	(a), (b) All staff and non-staff personnel are encouraged to complete the Lead and Learn online mental health at work Programme as part of the United Nations System Mental Health and Well-being Strategy. The programme is mandatory for staff with managerial responsibilities.
UNCTAD	N/A	N/A	N/A	
UNDP	Yes	Yes	Yes	(a) Managers are included in the pre- and post-deployment briefings offered to all UNDP personnel serving in high-risk locations. There are specific emails and tasks in the onboarding checklists for Managers covering all personnel they supervise (staff and non-staff), including welcome booklets and onboarding toolkits where the available resources are shared. – Our Executive coaching programme for Managers at the P-4/NO-D level and above prioritizes those who serve in high-risk locations. They are matched with coaches on our roster who have specialized experience in this area. – In addition to Coaching, Managers in high-risk locations have access to counselling services from the first day of their employment (b), (c) See above
UNEP	N/A	N/A	N/A	
UNESCO	No	No	No	
UNFPA	Yes	Yes	Yes	
UN-Habitat	N/A	N/A	N/A	
UNHCR	Yes	Yes	Yes	(a) Although not in constant and structured manner. – In addition to trainings organized by the Global Learning and Development Centre, there are trainings offered by the Division of Emergency and Supply management for senior leaders such as SELP training (Senior Emergency learning programme) for emergency roster of managers to emergency operations) and security management training.

Organization	Area: Managerial training and support (a) Targeted training to managers on staff deployed to high-risk locations (yes/no)	(b) Targeted training to managers on non-staff deployed to high-risk locations (yes/no)	(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)	Details for (a)–(c) (If in progress, specify the percentage)
				(b) Managers are considered to have a central role in assuring the safe workplaces conducive to health and well-being. There are different programmes, guidance materials and tools that offer that approach. – For example, the Psychosocial well-being section developed guidance for managers of the individual case processors available on the UNHCR Well-being platform aimed at prevention of burnout and secondary trauma in teams doing resettlement, refugee status determination and registration. Training on the standard operating procedure for supporting staff following the critical incidents includes managers. The Division of Human Resources developed guidance and facilitated the webinar-series for managers to support them with realignment. (c) Hotline for emergencies from medical as well as staff well-being sections. Regional medical and psychosocial team deployed in regional offices. Managers also have access to coaching provided externally.
UNICEF	Yes	Yes	Yes	
UNIDO	N/A	N/A	N/A	
United Nations				
UNOPS	Yes	Yes	Yes	(a) UNOPS is holding regular quarterly sessions for supervisors at any level, on any contract type and in any location, on "Supporting your own mental health and that of others in the workplace". In 2024, 17% of attendees of the supervisors training sessions were from a hardship location. Targeted training sessions for managers in hardship locations exclusively are in the workplans for 2024. (b) UNOPS is holding regular quarterly sessions for supervisors at any level, on any contract type and in any location, on "Supporting your own mental health and that of others in the workplace". In 2024, 17% of attendees of the supervisors training sessions were from a hardship location.

Organization	Area: Managerial training and support			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Targeted training to managers on staff deployed to high-risk locations (yes/no)	*(b) Targeted training to managers on non-staff deployed to high-risk locations (yes/no)*	*(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)*	
				Targeted training sessions for managers in hardship locations are in the 2024 workplan. (c) Manager and Human Resources well-being support consultations are in the 2024 workplan to be piloted in hardship locations. Confidential and free-of-charge crisis counselling sessions are available to all personnel, including those serving in hardship duty stations.
UNRWA	No	No	No	
UN Tourism	N/A	N/A	N/A	
UN-Women				
UPU				(a), (b), (c) No high-risk location.
WFP	Yes	Yes	Yes	(a) Including Safe and secure approaches to field environment (SAFE), Emergency Trauma Bag (ETB) and Basic Life Support training. (c) Yes, including refresher trainings and online incident reporting system for occupational hazards and injury/illness.
WHO	No	No	No	(a) Security Services adopt the United Nations security management system mandatory security training for managers and staff.
WIPO	N/A	N/A	N/A	(a) The majority of our personnel are located at headquarters; there are no WIPO personnel working in high-risk duty stations.
WMO	N/A	N/A	N/A	

Organization	Area: United Nations minimum living and working standards				
	(a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	*(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)*	*(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)*	*(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)*	*Details for (a)–(d) (If in progress, specify the percentage)*
FAO	Yes	Yes	Yes	Yes	
IAEA	N/A	N/A	N/A	N/A	
ICAO	No	No	No	N/A	(a) ICAO personnel are located in non-high-risk areas. – In case a staff member is deployed on mission to a high-risk area, ICAO uses the UNDP-Department of Safety and Security guidelines in the Field. (b) ICAO personnel are located in non-high-risk areas. – In case a staff member is deployed on mission to a high-risk area, ICAO uses the UNDP-Department of Safety and Security guidelines in the Field (c) The reason being that in the Field Operations, ICAO uses offices premises and accommodation provided through either the United Nations Entities or the State. ICAO Regional Offices comply with United Nations minimum living and working standards (d) ICAO premises headquarters and Regional Offices are aligning living standards with United Nations guidelines.
ILO	No	No	Yes	Yes	(a) ILO employs a very limited number of staff in high-risk environments and specific individual support is provided on a need basis. ILO employs a very limited number of staff in high-risk environments and specific individual support is provided on a need basis. (b) Yes, implemented. (c) Information technology system is in place within ILO to address information technology requirements of the field offices.

Organization	Area: United Nations minimum living and working standards (a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)	(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)	(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
IMO	N/A	N/A	N/A	N/A	
ITC	N/A	N/A			
ITU	Yes	N/A	N/A	N/A	
UNAIDS	Yes	Yes	Yes	Yes	(a) UNAIDS follows minimum operating security standards and minimum operating residential security standards provisions in all duty stations. These reflect High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (b) UNAIDS is compliant with minimum operating security standards and minimum operating residential security standards compliance in all duty stations. Some 70% of UNAIDS offices are co-located with other United Nations agencies and hence are aligned to "United Nations minimum living and working standards" for all new accommodations and office premises in high-risk locations (d) Applicable to office premises not living accommodations
UNCTAD	N/A	N/A	N/A	N/A	
UNDP	No	N/A	N/A	Yes	(d) All UNDP country office premises are compliant with bandwidth requirements for staff and non-staff personnel. – For a lot of UNDP country office premises, UNDP is still deploying Starlink also to make sure country offices also have high-capacity backup satellite link.
UNEP	N/A	N/A	N/A		(a) Implemented by specific responsible agencies with staff at the duty stations

Organization	Area: United Nations minimum living and working standards (a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)	(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)	(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					(b) Implemented by specific responsible agencies with staff at the duty stations (c) Implemented by specific responsible agencies with staff at the duty stations where they provide housing.
UNESCO	No	No	No	No	
UNFPA	Yes	Yes	Yes	Yes	
UN-Habitat	N/A	N/A	N/A		(a) Implemented by specific responsible agencies with staff at the duty stations (b) Implemented by specific responsible agencies with staff at the duty stations (c) Implemented by specific responsible agencies with staff at the duty stations where they provide housing.
UNHCR	Yes	Yes	Yes	Yes	(a) Refer to UNHCR/AI/2019/8 Administrative Instruction UNHCR Provided accommodation in the field (b) Ibid. (c) Ibid. (d) Ibid.
UNICEF	Yes	Yes	Yes	Yes	
UNIDO	N/A	N/A	N/A	N/A	
United Nations					
UNOPS					(a) 30% – Requirements are scattered in various policy instruments. There is need to consolidate all the requirements.

Organization	*Area: United Nations minimum living and working standards*				*Details for (a)–(d) (If in progress, specify the percentage)*
	(a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	*(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)*	*(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)*	*(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)*	
					(b) 30% – Implementation has not been monitored at all locations (c) 80% – Mostly in place but not monitored (d) 70% – There are some remote locations where connectivity remains a challenge the organization shall consider investing in improvements.
UNRWA	No	No	No	No	
UN Tourism	N/A	N/A	N/A	N/A	
UN-Women					
UPU					(a), (b), (c), (d) No high-risk location.
WFP	Yes	Yes	Yes	Yes	(a) WFP standards on living conditions in field accommodation which are based on the High-level Committee on Management-endorsed United Nations minimum living and working standards. Please refer to the Management Services Division and Staff Wellness Division Joint Directive on "WFP Standards on Living Conditions in Field Accommodation" issued on 6 September 2019 (RMM2019/001-RMW2019/001).
WHO	Yes	Yes	Yes	Yes	(a) However, in high-risk locations, the working and accommodation premises are subject to full and mandatory minimum operating security standards compliance. Moreover, headquarters and each region have some forms of occupational health committees or working groups that produce recommendations occupational health standards, and the latter are implemented subject to availability of resources.

Organization	Area: United Nations minimum living and working standards (a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)	(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)	(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					(b) As above. (c) As from July 2021, the United Nations Booking Hub (the former Humanitarian Booking Hub) has been rebranded to embrace more widely United Nations partnerships. It now covers 1,130 service points in 98 countries with 1,150 service managers using it every day and an expected 600,000 humanitarian clients per year. – Developed by WFP with the initial support of UNHCR on accommodation, it now represents the largest United Nations service offering for secure and safe accommodation for the humanitarian community, with 270 United Nations guesthouses in 32 countries from 7 organizations: WFP, UNHCR, UNICEF, IOM, UNFPA, WHO and selected UNDP accommodations. A simple United Nations Quality Checklist allows organizations to monitor common living conditions in United Nations-provided accommodation, streamlining quality standards compliance across countries and Agencies. – In addition, the United Nations Booking Hub hosts, in collaboration with the Department of Safety and Security, links and instructions for the Electronic Travel Advisory (eTA), the TRIP security clearance site and about 250 Department of Safety and Security-listed hotels in selected high-risk areas. – Since 2019, the United Nations Booking Hub has expanded its services to cover passenger mobility and carpooling services, with more than 450 locations from 12 agencies serving

Organization	Area: United Nations minimum living and working standards (a) Policies, procedures or guidance in place reflecting the High-level Committee on Management-endorsed "United Nations minimum living and working standards in high-risk environments" (yes/no)	(b) "United Nations minimum living and working standards" implemented for all new accommodations and office premises in high-risk locations (yes/no)	(c) "United Nations minimum living and working standards" implemented in non-high-risk locations (yes/no)	(d) Existing living accommodations/ office premises compliant with bandwidth requirements for staff and non-staff personnel (yes/no)	Details for (a)–(d) (If in progress, specify the percentage)
					530,000 humanitarian passengers since its launch. – It also hosts more than 75 United Nations Clinics and 35 counsellors to ease access to field wellness services and, from the onset of COVID-19, it also provided global information and online booking for the Global Pax Air Service for the humanitarian community to use emergency flights. (d) When establishing a temporary or permanent office, it is ensured that the office has sufficient bandwidth capacity. However, reviews for compliance with United Nations minimum standard have not been conducted. – Internet connectivity in existing accommodations and office premises are being reviewed to meet the increased bandwidth needs of corporate applications and collaboration tools. This is expected to result in sufficient bandwidth being available for corporate and private use by staff and non-staff personnel in those locations.
WIPO	N/A	N/A	Yes	Yes	(c) WIPO Security and Business Continuity Teams periodically review the situation of external offices as needed and in coordination with the Department of Safety and Security, including on-site visits, depending on the risk level of the location.
WMO	N/A	N/A	N/A	Yes	

Organization	Area: Essential health and safety measures (a) Policies on medical travel for eligible staff and families established to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station (yes/no)	(b) Mechanism established to provide administrative and financial support to Country Representatives to ensure safe transportation for locally recruited staff upon Security Management Team recommendation (yes/no)	(c) Flexible solutions in place to provide basic medical and sanitary essential and standby supplies to staff and non-staff personnel that are difficult to obtain in high-risk locations (yes/no)	Details for (a)–(c) (If in progress, specify the percentage)
FAO	Yes	Yes	Yes	
IAEA	N/A	N/A	Yes	
ICAO	No	Yes N/A	Yes	(a) No policy; however, the practice is that all personnel assigned to any duty station are enrolled into the ICAO medical insurance scheme, global telehealth and the International Employee and Family Assistance Programme, which facilitates medical services being accessed in another duty station if services are not available locally. The services are available and globally, 24/7. (b) Yes, as necessary for Technical Cooperation Programme project-based personnel. i.e. UNSOS air fleet. N/A for ICAO staff based in headquarters and Regional offices. (c) The Technical Cooperation Programme has established memorandums of understanding with United Nations Local Entities, e.g. UNSOS and UNDP, for personnel to use local United Nations clinics or the United Nations compound for accommodation services.
ILO	Yes	Yes		(a) The ILO policy on medical transportation and evacuation (Internal Governance Document System – IGDS 341) and ILO Staff Health Insurance Fund Policies govern this duty of care acts for staff and their eligible dependents. (b) ILO complies with United Nations security management system Residential Security policies and provides security advice support to locally recruited staff upon request. (c) A small stock of essential supplies is kept in headquarters for items that are essential to ILO personnel in high-risk locations and either are hard to obtain or take a long time to be delivered.

Organization	Area: Essential health and safety measures (a) Policies on medical travel for eligible staff and families established to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station (yes/no)	(b) Mechanism established to provide administrative and financial support to Country Representatives to ensure safe transportation for locally recruited staff upon Security Management Team recommendation (yes/no)	(c) Flexible solutions in place to provide basic medical and sanitary essential and standby supplies to staff and non-staff personnel that are difficult to obtain in high-risk locations (yes/no)	Details for (a)–(c) (If in progress, specify the percentage)
IMO	N/A	N/A		
ITC	N/A	N/A	N/A	
ITU	Yes	Yes	Yes	
UNAIDS	Yes	Yes	No	(a) As UNAIDS uses WHO policy frameworks and many of its services, this would be covered under Staff Health and Well-being services. (b) UNAIDS follows Security Management Team recommendations. However, the support would also be contingent on the context and nature of recommendation
UNCTAD	N/A	N/A	N/A	
UNDP	Yes	Yes	N/A	(a) Yes, eligible staff and families required to receive treatment outside of the duty station or the designated regional area of care destination are guided by the UNDP Medical Evacuation Travel Policy: https://popp.undp.org/policy-page/medical-evacuation-travel-met. (b) Yes, transportation costs are covered by the organization
UNEP	Yes	No	Yes	(a) Follows the MEDEVAC ST/AI. We note, however, that it is grossly inadequate for local staff in hardship duty stations. (b) NO, this is currently not in place. (c) Supporting implementation of United Nations medical clinics in Dadaab and Kakuma in conjunction with UNHCR. Cost share agreements are yet to be put in place between UNHCR and agencies at the duty stations to ensure seamless access by staff. The building is also 50% complete in Kakuma, and supply chain challenges are faced with global contracts (80%).
UNESCO	Yes	N/A	No	

Organization	Area: Essential health and safety measures (a) Policies on medical travel for eligible staff and families established to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station (yes/no)	(b) Mechanism established to provide administrative and financial support to Country Representatives to ensure safe transportation for locally recruited staff upon Security Management Team recommendation (yes/no)	(c) Flexible solutions in place to provide basic medical and sanitary essential and standby supplies to staff and non-staff personnel that are difficult to obtain in high-risk locations (yes/no)	Details for (a)–(c) (If in progress, specify the percentage)
UNFPA	Yes	Yes	Yes	
UN-Habitat	Yes	No	Yes	(a) Follows the MEDEVAC ST/AI. We note, however, that it is grossly inadequate for local staff in hardship duty stations. (b) NO, this is currently not in place. (c) Supporting implementation of United Nations medical clinics in Dadaab and Kakuma in conjunction with UNHCR. Cost share agreements are yet to be put in place between UNHCR and agencies at the duty stations to ensure seamless access by staff. The building is also 50% complete in Kakuma and supply chain challenges are faced with global contracts (80%)
UNHCR	Yes		Yes	(a) Medevac administrative instruction 2023 (reviewed) already submitted to the Joint Inspection Unit. (c) Not always implemented due to budget concerns. First aid kits for office, vehicles and emergency trauma bags (based on security recommendation as mitigation measure).
UNICEF	Yes	Yes	Yes	
UNIDO	N/A	N/A	N/A	
United Nations				(a) Yes, The ST/AI on medevac covers essential care. (b) These are not health and safety measures but security, entitlements and budgetary measures. (c) These are not occupational health and safety measures but a Human Resources measure. Staff will not be deployed to locations where they are not fit to work due to conditions in place.

	Area: Essential health and safety measures			
Organization	*(a) Policies on medical travel for eligible staff and families established to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station (yes/no)*	*(b) Mechanism established to provide administrative and financial support to Country Representatives to ensure safe transportation for locally recruited staff upon Security Management Team recommendation (yes/no)*	*(c) Flexible solutions in place to provide basic medical and sanitary essential and standby supplies to staff and non-staff personnel that are difficult to obtain in high-risk locations (yes/no)*	*Details for (a)–(c) (If in progress, specify the percentage)*
UNOPS				(a) 80% – Policy arrangements are in place, but they need to be strengthened, and awareness among personnel could be improved. (b) 60% – Local arrangements at the country level exist, but organization-wide guidance could be established. (c) 60% – Local arrangements at the country level exist, but organization-wide guidance could be established.
UNRWA	No	No	No	
UN Tourism	N/A	N/A	N/A	
UN-Women				(a) Medical Evacuation Policy Applies (b) Managed by Regional Security Specialists
UPU				(a), (b), (c) No high-risk location
WFP	Yes	Yes	Yes	(a) Policy on medical travel and medical evacuations (b) This is guided by the aforementioned policy on medical travel and medical evacuation. (c) Provision of travel kits to staff members being deployed to high-risk locations – Telemedicine constituting provision of online consultations
WHO	Yes		Yes	(a) The Staff Health and Wellbeing Department has a global medical evacuations “MEDEVAC” procedure to secure essential medical care for medical conditions requiring medical intervention that is unavailable or inadequate in the duty station.

Organization	Area: Essential health and safety measures (a) Policies on medical travel for eligible staff and families established to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station (yes/no)	(b) Mechanism established to provide administrative and financial support to Country Representatives to ensure safe transportation for locally recruited staff upon Security Management Team recommendation (yes/no)	(c) Flexible solutions in place to provide basic medical and sanitary essential and standby supplies to staff and non-staff personnel that are difficult to obtain in high-risk locations (yes/no)	Details for (a)–(c) (If in progress, specify the percentage)
				(b) If not covered under the Country Offices or Regional Offices, unforeseen corporate security requirements are covered under the Security Fund – financial support, through advances, for national staff to implement security measures adopted in most if not all high-risk locations. Salary advances may also be facilitated for the purpose. (c) Staff Health and Wellbeing provides a predeployment briefing to staff and non-staff personnel, including a travel medical kit for deployees to high-risk locations.
WIPO	Yes	No	N/A	(b) Given the limited number of WIPO staff outside of Geneva, administrative and financial support is coordinated on a case-by-case basis directly from headquarters if and when required.
WMO	Yes	No	N/A	

Source: Responses to annex I of the Joint Inspection Unit organizational questionnaire.

* The annex is partially based on the Occupational Health and Safety (OHS) Forum Survey developed by the OHS Forum Workstream 1 to assess the progress on the recommendations of the High-level Committee on Management Duty of Care Task Force.

Annex VIII

Status of implementation of selected Occupational Health and Safety Framework components/elements*

Organization	Area: Standards and Guidelines for Occupational Health and Safety (OHS)			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Standard(s) or Guideline(s) for the development of the OHS Management System established (yes/no)	(b) Inclusive OHS oversight body constituted (yes/no)	(c) OHS Policy meets the requirements of the OHS framework (risk register, incident reporting system etc.) (yes/no)	
FAO	Yes	Yes	Yes	(c) Parts of the reporting system is still under work
IAEA	Yes	Yes	No	(c) In progress, 50%
ICAO		No	Yes	(a) 30% – ICAO is finalizing the draft of the OHS framework, aligned with the United Nations guidelines and recommendations. (b) ICAO is the process of establishing an OHS oversight body. (c) A formal Occupational health and safety policy is in the process of being developed.
ILO	Yes	Yes	Yes	(a) ILO has an OSH policy statement from the Director General, a policy on OSH, as well as governance guidelines on the activities of the Committee on Occupational Safety and Health. This includes roles and responsibilities of members of the committee as well as their OSH programmes and activities. The relevant policy document and processes are currently under rigorous review by a dedicated technical working group. (b) ILO has an inclusive Committee on Occupational Safety and Health, inclusive of Management, Staff representatives and technical subject matter experts. Similar bodies are being replicated in the field regional offices. (c) The OHS policy and policy statements are aligned to the ILO Occupational Safety and Health Management System Standards.
IMO	No	No	Yes	(a) 50% (c) 25%
ITC				
ITU				

Organization	Area: Standards and Guidelines for Occupational Health and Safety (OHS)			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Standard(s) or Guideline(s) for the development of the OHS Management System established (yes/no)	(b) Inclusive OHS oversight body constituted (yes/no)	(c) OHS Policy meets the requirements of the OHS framework (risk register, incident reporting system etc.) (yes/no)	
UNAIDS	No	No	N/A	
UNCTAD	Yes	Yes	Yes	(b) Mandate available
UNDP	Yes	No	No	(a) 100% – Ref. High-level Committee on Management OSH Framework (b) UNDP OHS Governance Group to be established (c) There is no OHS Policy in UNDP, only a Strategy
UNEP	Yes	Yes	Yes	(a) 100% – We follow secretariat system. – Locally we have the Occupational Health and Safety Advisory Committee (OHSAC) Terms of Reference issued (b) 100% – OHSAC constituted (c) 80% – There is scope for improvement, and plans are under way to resource this area
UNESCO	No	No	No	
UNFPA				(a) For fire, road safety as indicated above.
UN-Habitat	Yes	Yes	Yes	(a) 100% – We follow secretariat system. – Locally we have the OHSAC Terms of Reference issued (b) 100% – OHSAC constituted (c) 80% – There is scope for improvement, and plans are under way to resource this area
UNHCR	Yes	Yes	Yes	(a) OHS manual (b) Advisory Committee on OHS Terms of Reference for Advisory Committees on OHS,

Organization	Area: Standards and Guidelines for Occupational Health and Safety (OHS)			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Standard(s) or Guideline(s) for the development of the OHS Management System established (yes/no)	(b) Inclusive OHS oversight body constituted (yes/no)	(c) OHS Policy meets the requirements of the OHS framework (risk register, incident reporting system etc.) (yes/no)	
				Regional Committees on Occupational Health and Safety and Local Committees (c) UNHCR/HCP/2021/2 Policy on Managing Occupational Health and Safety in UNHCR
UNICEF		Yes	No	(b) OSH Committee at headquarters links with United Nations and other entities
UNIDO	N/A	N/A	N/A	
United Nations	Yes	Yes	No	(a) Yes. It is the High-level Committee on Management Framework and Secretary-General's bulletin. (b) Yes. (c) No. The policy is not yet developed and cannot be implemented under the current resourcing provision. Also pending alignment with the global United Nations OSH policy framework currently under development by the High-level Committee on Management OHS Forum.
UNOPS	Yes	Yes	Yes	(b) Quarterly meeting of management and bimonthly meetings of the country OHS coordinators (c) In place
UNRWA	No	No	N/A	
UN Tourism	N/A	N/A	N/A	
UN-Women	Yes	Yes	Yes	(a) 30% (b) 100% – Security and Safety Human Resources Facilities (c) 100% – Reporting System
UPU	N/A	N/A	N/A	

Organization	Area: Standards and Guidelines for Occupational Health and Safety (OHS)			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Standard(s) or Guideline(s) for the development of the OHS Management System established (yes/no)	(b) Inclusive OHS oversight body constituted (yes/no)	(c) OHS Policy meets the requirements of the OHS framework (risk register, incident reporting system etc.) (yes/no)	
WFP	N/A	N/A	N/A	(a) 90% OSH Management System Compliance Mechanism is under development (b) Advisory Committee on Occupational Safety and Health (c) Policy requirements incorporated into WFP OSH Management System
WHO	No	No	No	
WIPO	Yes	No	No	(a) The work on consolidation of existing mechanisms under the OSH umbrella is being initiated. (b) Composition and mandate of WIPO OSH Committee being thoroughly reviewed in the context of the consolidation initiative, including creation of an oversight/governing group at the strategic level. (c) Current risk register at the institutional level is focused on security-related risks, and expansion of this risk register to health and safety risks will be considered under OSH review framework once the appropriate bodies have been constituted. – Incident reporting exists, and it is in training phase. – Currently, only medical data are recorded in EarthMed.
WMO	No	No	No	

Organization	*Area: Capacity-building*						*Details for (a)–(f) (If in progress, specify the percentage)*
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	*(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)*	*(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)*	*(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)*	*(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)*	*(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)*	
FAO	Yes	No	No	No	No	No	(b) Committee is only at the headquarters level (c) This is still under way (d) This is planned and under way
IAEA	Yes	N/A	Yes	N/A	No	Yes	(e) In process, 20%
ICAO	Yes	No	Yes	No	No	N/A	(a) ICAO has a Crisis Management Team that oversees, among other issues, health and safety matters for the entire organization. In addition, ICAO has an Advisory Board on Compensation Claims that reviews service-incurred illness, injuries or death cases. ICAO also has a Health and Life Insurance Section Committee whose role is to review the health insurance premiums, the sustainability of the insurance scheme etc. There is also a Social Security and Pension unit within Human Resources dedicated to handling health insurance matters, Malicious Acts Insurance Policy, and non-occupational and occupational insurance matters. (b) While the committees are based in headquarters, input is received from Regional Offices to facilitate the

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
							decision-making by the committees at headquarters. (c) OHS Specialists in ICAO headquarters Medical Services and ICAO headquarters Human Resources Officers. (d) While the focal points are based in headquarters, input is received from Regional Offices to facilitate the decision-making by the focal points at headquarters. (e) Despite the financial and human resources constraints on addressing OHS, OHS management system and procedures are being implemented.
ILO	Yes	Yes	Yes	Yes	Yes	Yes	(a), (b) Headquarters Committee on Occupational Safety and Health is established, as well as OSH representatives in the country offices. Similar Committees on Occupational Safety and Health are being established in the regional offices. Relevant Guidance Documents have been developed and are currently under review.

Organization	*Area: Capacity-building*						*Details for (a)–(f) (If in progress, specify the percentage)*
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	*(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)*	*(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)*	*(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)*	*(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)*	*(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)*	
							(c) The following designated officials have been appointed: – OSH Coordinator – Medical Advisor – Welfare Officer The three are members of the Committee on Occupational Safety and Health and work collaboratively together. (d) OSH representatives appointed at the country and regional offices. (e) Financial and human resources are made available for driving OSH activities through the departmental and sectional budgets of the responsible offices, including the field country offices. (f) Security Management Training is available from the United Nations security management system, targeting the specific conditions of living as explained above.
IMO	No	N/A	Yes	N/A	No	No	
ITC							
ITU	N/A	N/A	N/A	Yes	N/A	N/A	
UNAIDS	Yes	Yes	Yes		Yes		

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
UNCTAD	Yes	N/A	Yes	Yes	No	Yes	(f) As soon as United Nations-OSH trainer requirements are accepted by the Healthcare Management and Occupational Safety and Health Division, official in-house OSH trainings can take place.
UNDP	No	No	Yes	Yes	No	No	(a), (b) OHS Committee to be established (d) 75% (e) Corporate OHS Office and dedicated staff capability not established yet
UNEP	N/A	Yes	N/A	Yes	Yes	Yes	(a) We have only the local committee. (b) OHSAC established. (c) We are represented by United Nations Headquarters. (d) The Secretariat of the OHSAC is the focal point. The secretariat is the Joint Medical Service (JMS) led by the chief of unit. (e) In progress, 50% – Recruitment of a health and safety officer is in progress, and there are staff within the unit assigned OHS tasks. (f) 80% – Staff at JMS are trained at the

Organization	*Area: Capacity-building*						*Details for (a)–(f) (If in progress, specify the percentage)*
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	*(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)*	*(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)*	*(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)*	*(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)*	*(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)*	
							certificate level in OHS acquiring National Examination Board in Occupational Safety and Health certification. Members of OHSAC are due to receive training, which should be completed within the year.
UNESCO	No	No	No	No	No	No	
UNFPA							(c) DHR organized first aid training a few years ago for headquarters personnel.
UN-Habitat	N/A	Yes	N/A	Yes	Yes	Yes	(a) We have only the local committee. (b) OHSAC established. (c) We are represented by United Nations Headquarters. (d) The Secretariat of OHSAC is the focal point. The secretariat is the Joint Medical Service led by the chief of unit. (e) In progress, 50% – Recruitment of a health and safety officer is in progress and there are staff within the unit assigned OHS tasks. (f) 80% – Staff at JMS are trained at certificate

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
							level in OHS acquiring National Examination Board in Occupational Safety and Health certification. Members of are due to receive training and should be completed within the year.
UNHCR	Yes	Yes	Yes	Yes	Yes	Yes	(a) Advisory Committee on OHS Terms of Reference for Advisory Committees on OHS, Regional Committees on Occupational Health and Safety and Local Committees (b) Committees on OHS Terms of Reference for Advisory Committees on OHS, Regional Committees on Occupational Health and Safety and Local Committees (d) See Terms of Reference for Advisory Committees on OHS, Regional Committees on Occupational Health and Safety and Local Committees (e) Budget in place (f) See section 7.2 of the OHS manual

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
UNICEF	No	No	No	Yes	N/A	No	(c) No Specific global committee for this (d) Country-specific and regional staff consultative bodies
UNIDO	N/A	N/A	N/A	N/A	N/A	N/A	
United Nation	Yes		Yes		No		(a) Yes. headquarters OSH Committee, but this is in New York only. (b) Not a headquarters responsibility. – Committees are in place to varying degrees of effectiveness, and commitment at the regional, country and mission levels is recommended or required depending on location. In large part, if local OSH Committees are established, they have no OSH professionals or OSH technical expertise and hence cannot effectively meet the requirements of an OSH Committee. – There is limited capacity for United Nations Headquarters to conduct detailed oversight and monitoring. (c) Yes.

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
							(d) Not a headquarters responsibility. – Focal points exist to varying degrees at the regional, country, and mission levels but in the majority of cases: – Have no externally recognized professional training in OSH. – Have no funding or limited/intermittent funding for training. – Have no inclusion of OSH tasks as a formal component of their job description. – Have no professional supervision around OSH tasks, either directly in their location or via matrixed reporting to headquarters OSH services. – Have limited technical capability in risk assessment and safe risk mitigation plans. – OSH is a technical discipline. A surgical focal point does not remove a patient's appendix, a surgeon removes it. The United Nations requires OSH expertise delivered by OSH professionals,

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	

generally qualified safety officers, and even as an interim measure, the use of focal points is a substandard approach that does not meet the duty of care requirement described in the taskforce's report for the provision of OSH services.

(e) No. The industry standard is one OSH professional for approximately 3,000 personnel, varying with the nature of the industry and the number of sites covered.

– The United Nations Secretariat OSH does not cover Secretariat locations alone but provides a global service framework that integrates multiple end users, therefore including New York-based agencies, funds and programmes such as UNICEF, UNDP etc. The OSH system is integrated with the medical system for efficiency and effectiveness and is structured to be effective.

– UNS OSH has 6 professional technical staff, with

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
							2 conducting associated medical tasks at a 50 full-time equivalent. Staffing for global coverage is from 5 to 50 personnel short of what is required depending on the extent and quality of services provided. In some cases, the funding/posts for these personnel exist, but they are situated in other departments, for example, fire safety services in the Department of Safety and Security. (f) Under development. – One 40-hour course/year for focal points is funded. – One-hour course for all staff nearing completion (with the Capacity Development and Operational Training Service, for roll-out to all staff middle of 2024). – OSH Committee course under development, unfunded. – Eight-hour managerial course under development, unfunded.

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	*(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)*	*(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)*	*(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)*	*(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)*	*(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)*	
							– Externally accredited 28-hour National Examination Board in Occupational Safety and Health course, unfunded. – All unfunded courses and course delivery are on an opportunistic basis.
UNOPS			Yes	Yes		Yes	(a), (b) 50% – Partially done (c), (d) Fully implemented (e) 70% – Occupational safety fully implemented, but occupational health needs additional investment (f) In place
UNRWA	No	No	No	No	No	No	
UN Tourism	N/A	N/A	N/A	N/A	N/A	N/A	
UN-Women							
UPU	Yes	N/A	N/A	N/A	N/A	N/A	Wellbeing Unit established since 2023
WFP	Yes	Yes	Yes	Yes	No	Yes	(a) Advisory Committee on Occupational Safety and Health (b) Regional Wellness Committees (c) Head of OSH (d) OSH Global Network established and functioning

Organization	Area: Capacity-building						Details for (a)–(f) (If in progress, specify the percentage)
	(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)	(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)	(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)	(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)	(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)	(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)	
							(e) Adequate resource capacity for the OSH Unit is needed to ensure sustained implementation of the OSH management system. (f) Institute of Occupational Safety and Health training for Focal Points and stakeholders. The National Examination Board in Occupational Safety and Health sessions for Leadership. – In addition, internal OSH trainings provided.
WHO	Yes	Yes	Yes	Yes	No	No	(d) Ongoing, list of candidates, but training to be developed (f) To be developed
WIPO	No	N/A	No	N/A	No	No	(a) While capacity exists under different core pillars, consolidation work under the OSH umbrella has just begun. (b) Given the modest footprint of WIPO outside Geneva, this will be handled directly by headquarters at the global level. (c) Work in progress. (d) To be managed from headquarters.

	Area: Capacity-building						
Organization	*(a) Headquarters or Global committee for staff health, safety and well-being established (yes/no)*	*(b) Committees for staff health, safety and well-being at the regional or country levels established (yes/no)*	*(c) Headquarters or Global focal point for occupational health and safety designated (yes/no)*	*(d) Focal points for occupational health and safety at the regional or country levels designated (yes/no)*	*(e) Sufficient financial and human resources to implement the OHS management system allocated (yes/no)*	*(f) Targeted training for OHS competencies across staff members at varying leadership levels provided (yes/no)*	*Details for (a)–(f) (If in progress, specify the percentage)*
							(e) This aspect will be considered by the OSH Committee and governing group, among others, once constituted. (f) This has been identified as a priority action in the process of establishment of the WIPO OSH Management Framework.
WMO	No	No	No	N/A	No	No	

Organization	Area: Incident Reporting System			Details for (a)–(c) (If in progress, specify the percentage)
	(a) An incident reporting system for accidents and injuries established (yes/no)	(b) Resources to collate and analyse reporting system data and assign consistent measures to incidents that align with the risk register allocated (yes/no)	(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)	
FAO	Yes	No	Yes	(b) This is not yet finalized for OHS incidents (c) Various resources are available to managers in high-risk duty stations
IAEA	No	No	N/A	(a) In progress, 20%
ICAO		Yes	N/A	(a) ICAO does not possess a collating and analysis reporting system aligned with risk register methodology. (b) ICAO Medical Services utilizes MEDFAR Clinical Solutions as an incident reporting system.
ILO	Yes	Yes	Yes	(a) Incident reporting available online. Medical Unit; OSH Coordinator; and the Human Resources/Compensation Committee collaboratively respond to and address work-related incidents (injuries, illnesses and deaths) to minimize impact and to prevent recurrence as far as reasonably practicable. (b) The incident reporting system and OSH risk assessments have the same definitions and are set according to an Ishikawa (fishbone) diagram. The OSH coordinator collects data for regular improvement (risk assessment and incident reporting system). (c) Human Resources Partners at headquarters and at the regional level, as well as the headquarters-based Staff Welfare Officer, have regular interactions and provide support to managers in the field. The mental health and well-being lead and learn programme is also being promoted among managers regardless of location.
IMO	Yes	No	N/A	
ITC				
ITU	Yes	Yes	Yes	
UNAIDS	No	No	Yes	

Organization	Area: Incident Reporting System			Details for (a)–(c) (If in progress, specify the percentage)
	(a) An incident reporting system for accidents and injuries established (yes/no)	(b) Resources to collate and analyse reporting system data and assign consistent measures to incidents that align with the risk register allocated (yes/no)	(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)	
UNCTAD	Yes	No	Yes	
UNDP	Yes	No	No	(b) Corporate OHS Office and dedicated staff capability not established yet (c) Corporate OHS Office and dedicated staff capability not established yet
UNEP	Yes	Yes	N/A	(a) 80% – This was previously implemented via the local online tool but is currently replaced by the EarthMed portal. The reporting system development to comprehensively address incident reporting is in progress. (b) Resources were previously unavailable; however, this year we have received some funding, and the role is under recruitment. (c) Entity-specific mechanisms not led by United Nations Office at Nairobi JMS.
UNESCO	No	No	No	
UNFPA				
UN-Habitat	Yes	Yes	N/A	(a) 80% – This was previously implemented via the local online tool but is currently replaced by the EarthMed portal. The reporting system development to comprehensively address incident reporting is in progress. (b) Resources were previously unavailable; however, this year we have received some funding, and the role is under recruitment. (c) Entity-specific mechanisms not led by United Nations Office at Nairobi JMS

Organization	Area: Incident Reporting System			Details for (a)–(c) (If in progress, specify the percentage)
	(a) An incident reporting system for accidents and injuries established (yes/no)	*(b) Resources to collate and analyse reporting system data and assign consistent measures to incidents that align with the risk register allocated (yes/no)*	*(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)*	
UNHCR	Yes	Yes	Yes	(a) Cority system in place (b) Regional OHS Committee review and develop risk actions in line with enterprise risk management methodologies. Data obtained from country OHS risks identified. (c) See Strategy on Workplace Mental Health and Psychosocial Wellbeing
UNICEF	No	No	No	
UNIDO	N/A	N/A	N/A	
United Nations	Yes		No	(a) Yes. (b) Partial. OSH staff undertake a review of selected incidents, but the resourcing for global collection, mitigation plan development and analysis is inadequate. – United Nations Headquarters 1 P-4 Safety officer – 1 full-time equivalent (P-4/P-5) OSH officer. (c) No. No resourcing. On an emergency/need basis only.
UNOPS	Yes	Yes	Yes	(b) Global digital system in place which is part of enterprise resource planning. Information from the system displayed in dashboards that are available to all personnel
UNRWA	Yes	No	No	
UN Tourism	N/A	N/A	N/A	
UN-Women	Yes	Yes	Yes	(a) 100% – Intranet Pages (b) 100% (c) 100% – OHS Specialist
UPU	N/A	N/A	N/A	

Organization	Area: Incident Reporting System			Details for (a)–(c) (If in progress, specify the percentage)
	(a) An incident reporting system for accidents and injuries established (yes/no)	(b) Resources to collate and analyse reporting system data and assign consistent measures to incidents that align with the risk register allocated (yes/no)	(c) Mechanism in place to provide continuous support to managers who are serving in high-risk locations (yes/no)	
WFP	Yes	Yes	Yes	(a) Cority Safety Suite (b) Cority Safety Suite, online incident reporting tool and incident investigation modules implemented. OSH risk matrix (based on WFP corporate risk register matrix) integrated into the above-mentioned modules, Incident Reporting/Fact-Finding Process standard operating procedure, dedicated staff working on incident reporting and fact-finding process. Mandatory training for all staff on incident reporting.
WHO	Yes	No	No	(a) Reporting system could be improved.
WIPO	No	No	N/A	(a) The United Nations Secretariat system needs to be adopted by WIPO, and an Internal process needs to be created to use the system (b) The system and risk register has not yet been put in place.
WMO	No	Np	N/A	

Organization	Area: Risk mapping, assessment and mitigation				
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	*(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)*	*(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)*	*(d) Mitigation plans developed and implemented (yes/no)*	*Details for (a)–(d) (If in progress, specify the percentage)*
FAO	No	No	No	No	(a) Not yet (b) Not yet finalized for OHS risk (c) Not yet finalized for OHS risk (d) Not yet finalized for OHS risk
IAEA	No	No	No	No	(a), (b), (c), (d) In progress, 20%
ICAO	No	No	No	No	
ILO	Yes	Yes	Yes	Yes	(a) For every internal reporting of accident/incident, the risk associated is controlled, following the incident investigation and analysis, to ensure that the incident/accident and the related harm do not recur. The risk is escalated and may be registered in the Organizational risk register if it exceeds a certain threshold. (b) According to ILO OSH mechanisms. Calculation of the risk is according to probability and impact/gravity, resulting in three levels of risk ratings. All risks that are above a set threshold must be mitigated and controlled. (c) Priorities are set at the departmental level according to the level of risk identified. These are incorporated into the ILO strategic risk register, which is submitted to the Governing Body within the Organization's Programme and Budget proposals. (d) Each risk assessment includes a mitigation proposal according to hierarchy of control: elimination,

Organization	Area: Risk mapping, assessment and mitigation				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	*(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)*	*(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)*	*(d) Mitigation plans developed and implemented (yes/no)*	
					replacement, engineering, administrative and personal protective equipment. Recently, all offices made a risk assessment for occupational health in order to return to the office safely.
IMO	No	Yes			
ITC					
ITU	N/A	N/A	N/A	N/A	
UNAIDS	N/A		Yes	Yes	
UNCTAD	No	Yes	Yes	Yes	(b) All risks identified and described at UNOG Risk Register ranked in accordance with a defined methodology (c) Identified risks at UNOG Risk Register are consistently reviewed on quarterly basis by the UNOG committee. (d) Treatment actions to mitigate risks reflected at UNOG Risk Register are in place.
UNDP	No	Yes	Yes	Yes	(b), (c) Ref. UNDP OHS Risk Register (d) 50% – Ref. UNDP OHS Risk Register
UNEP	Yes	Yes	Yes	Yes	(a) 100% (b) 100% – Locally developed methodology at UNON. (c) 100% – Through the enterprise risk management, the identified risks are consistently prioritized for action

Organization	Area: Risk mapping, assessment and mitigation				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	*(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)*	*(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)*	*(d) Mitigation plans developed and implemented (yes/no)*	
					(d) 100% – Mass Casualty Incident plans, Area Security plans, Business continuity plans
UNESCO	No	No	No	No	
UNFPA					
UN-Habitat	Yes	Yes	Yes	Yes	(a) 100% (b) 100% – Locally developed methodology at UNON. (c) 100% – Through the enterprise risk management, the identified risks are consistently prioritized for action. (d) 100% – Mass Casualty Incident plans, Area Security plans, Business continuity plans
UNHCR	Yes	Yes	Yes	Yes	(a) Mechanism in place where OHS data are submitted to Enterprise Risk Management to assist Regions and country operations in identifying exposures to include. (b) Ranked based on 5 x 5 risk matrix, identifying low, medium and high risk (c), (d) Risk action plans put in and key performance indicator monitoring in place.
UNICEF	No	No	No	No	
UNIDO	N/A	N/A	N/A	N/A	
United Nations	No	No	No	No	(a) No. Awaiting statistically significant data collection and categorization, in turn, dependent on personnel resources. While the technical system is established, the

Organization	Area: Risk mapping, assessment and mitigation				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)	(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)	(d) Mitigation plans developed and implemented (yes/no)	
					personnel capacity to undertake the work is not available due to resource constraints. Active measures are under way to provide business cases etc. for new personnel, and capability is slowly increasing as these efforts succeed; however, these efforts have resulted in the global system adding less than one qualified professional staff member per year (b) No. Awaiting statistically significant data collection and categorization, in turn, dependent on personnel resources. While the technical system is established, the personnel capacity to undertake the work is not available due to resource constraints. Active measures are under way to provide business cases etc. for new personnel, and capability is slowly increasing as these efforts succeed; however, these efforts have resulted in the global system adding less than one qualified professional staff member per year (c) No. Awaiting statistically significant data collection and categorization, in turn, dependent on personnel resources. While the technical system is established, the personnel capacity to undertake the work is not available due to resource constraints. Active measures are under way to provide business cases etc. for new personnel, and capability is slowly increasing as these efforts succeed; however, these efforts have resulted in the global system adding less than

Organization	Area: Risk mapping, assessment and mitigation				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	*(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)*	*(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)*	*(d) Mitigation plans developed and implemented (yes/no)*	
					one qualified professional staff member per year (d) No. Awaiting statistically significant data collection and categorization, in turn, dependent on personnel resources. While the technical system is established, the personnel capacity to undertake the work is not available due to resource constraints. Active measures are under way to provide business cases etc. for new personnel, and capability is slowly increasing as these efforts succeed; however, these efforts have resulted in the global system adding less than one qualified professional staff member per year.
UNOPS	Yes	Yes	Yes	Yes	(b) There is a UNOPS risk assessment tool. We calculate the risk rating based on a combination of probability and severity. We then apply controls and recalculate the residual risk.
UNRWA	No	No	No	No	
UN Tourism	N/A	N/A	N/A	N/A	
UN-Women	No	Yes	Yes	Yes	(a) Due to insufficient Data (b) Ranked according to Risk
UPU	N/A	N/A	N/A	N/A	
WFP	Yes	Yes	Yes	Yes	(a) Integrated OSH Management System, analysis of incident reporting and output of fact-finding process are feeding hazards list and risk register (Cority Safety Suite) (b) OSH Risk Assessment standard operating procedure Risk Assessment Process.

Organization	Area: Risk mapping, assessment and mitigation				Details for (a)–(d) (If in progress, specify the percentage)
	(a) Analysis of incident reporting system data fed back to the OHS Risk Register (yes/no)	*(b) Identified risks within the Risk Register ranked according to a defined methodology (yes/no)*	*(c) Identified risks consistently prioritized for action by the Organization or the oversight body (yes/no)*	*(d) Mitigation plans developed and implemented (yes/no)*	
WHO	N/A	N/A	N/A	N/A	(a) No formal process; not systematic
WIPO	No	No	No	Yes	(b) Systematic OSH risk mapping and Hazards/Risks/Risks prioritizations have yet to be carried out under the OSH framework to be put in place. (c) Only expressed risks are managed on a case-by-case basis. (d) No comprehensive mitigation plan covering the whole spectrum of risks has been developed, individual mitigation plans are established for travel, and some biological risks (COVID-19, Ebola, Vector-borne infection, …)
WMO	No	No	No	No	

Organization	Area: Standards and Compliance			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Sustainable standards for use in the OHS management system identified (yes/no)	*(b) A mechanism for promulgation of OHS standards established (yes/no)*	*(c) Practice of reporting standards compliance measures back to the oversight body exist/established (yes/no)*	
FAO	Yes	Yes	No	(b) This is not yet finalized for OHS incidents (c) Various resources are available to managers in high-risk duty stations
IAEA	No	No	No	
ICAO	No	No	Yes	
ILO				
IMO	Yes			
ITC				
ITU	N/A	N/A	N/A	
UNAIDS	No	N/A	N/A	
UNCTAD	Yes	No	No	
UNDP	Yes	Yes	No	(a) United States Department of Labor, Occupational Safety and Health Administration, code of federal regulations 1910, available at https://www.osha.gov/laws-regs/regulations/standardnumber/1910. Ibid., code of federal regulations 1926, available at https://www.osha.gov/laws-regs/regulations/standardnumber/1926. ILO Standards. (b) Dedicated page in the OHS SharePoint site. OHS Repository in the OHS SharePoint site.
UNEP	No	Yes	Yes	(a) Work in progress (b) Yes, head of entity promulgates (c) Yes, through OHSAC
UNESCO	No	No	No	
UNFPA				
UN-Habitat	No	Yes	Yes	(a) Work in progress (b) Yes, head of entity promulgates (c) Yes, through OHSAC

Organization	Area: Standards and Compliance			Details for (a)–(c) (If in progress, specify the percentage)
	(a) Sustainable standards for use in the OHS management system identified (yes/no)	*(b) A mechanism for promulgation of OHS standards established (yes/no)*	*(c) Practice of reporting standards compliance measures back to the oversight body exist/established (yes/no)*	
UNHCR	Yes	Yes	Yes	(a) OHS manual (b) Risk action plans put in and key performance indicator monitoring in place reported to Global oversight and regional OHS Committees (c) See section 7.4 of the OHS manual
UNICEF	No	No	No	
UNIDO	N/A	N/A	N/A	
United Nations	No	Yes	No	(a) No. Standards require implementation, monitoring and evaluation and are built on an enforceable organizational policy. The policy is pending both field capability to implement it and further guidance alignment with the High-level Committee on Management regarding an integrated United Nations OSH system. (b) Yes. Using the organization's policy document framework (AIs\ICs, Manuals). (c) No. Insufficient personnel resources for monitoring and evaluation.
UNOPS	Yes	Yes	Yes	(a) Targeting United Nations System Standards, inclusive of ISO 45001 (b) Intranet System OHS Portal (c) UN-Women Security and safety Services Compliance process compliance data uploaded to UN-Women Executive Directors dashboard.
UNRWA	No	No	No	
UN Tourism	N/A	N/A	N/A	
UN-Women				
UPU	N/A	N/A	N/A	
WFP	Yes	Yes	Yes	(c) Incident reporting form
WHO	N/A	N/A	N/A	

	Area: Standards and Compliance			
Organization	*(a) Sustainable standards for use in the OHS management system identified (yes/no)*	*(b) A mechanism for promulgation of OHS standards established (yes/no)*	*(c) Practice of reporting standards compliance measures back to the oversight body exist/established (yes/no)*	*Details for (a)–(c) (If in progress, specify the percentage)*
WIPO	No	No	No	(a), (b), (c) To be addressed under OSH framework that is in development.
WMO	No	No	No	

Organization	*Area: Internal and external communication system* *(a) Internal and external communication to ensure that OHS matters are received, documented and responded to appropriately in place or established (yes/no)*	*Details for (a) (If in progress, specify the percentage)*
FAO	No	(a) In process
IAEA	No	In planning
ICAO	Yes	
ILO		This is accomplished via the staff broadcasts, dedicated OSH intranet pages and local OSH committees.
IMO	Yes	
ITC		
ITU	N/A	
UNAIDS	Yes	
UNCTAD	No	
UNDP	No	
UNEP	Yes	
UNESCO	No	
UNFPA		
UN-Habitat	Yes	
UNHCR	Yes	See section 7.4 of the OHS manual
UNICEF	No	
UNIDO	N/A	
United Nations	No	No. Insufficient personnel resources.
UNOPS	Yes	
UNRWA	No	
UN Tourism	N/A	

Organization	*Area: Internal and external communication system* *(a) Internal and external communication to ensure that OHS matters are received, documented and responded to appropriately in place or established (yes/no)*	*Details for (a) (If in progress, specify the percentage)*
UN-Women		Intranet, Country Missions, UN-Women Security and Safety Compliance Survey.
UPU	No	
WFP	Yes	
WHO	N/A	
WIPO	No	To be addressed under OSH framework that is in development.
WMO	No	

Source: Responses to annex II of the Joint Inspection Unit organizational questionnaire.

* The annex is partially based on the OHS Forum Survey developed by the OHS Forum Workstream 1 to assess the progress on the OHS Framework implementation.

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