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Annexes to the Progress Report from the OHS Forum

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Annex 1

Concept note on the OHS Global Repository

In its third progress report to the HLCM (document CEB/2022/HLCM/4), the OHS Forum committed to submitting a concept note on the OHS Global Repository which would elaborate on the options on the type of digital platform, the different audiences, the content, the governance of the repository, including the cost associated with its maintenance, for the HLCM consideration at its October session.

Background

The need for a digital platform through which OHS norms and standards applicable to the UN system would be made available to different UN audiences was identified early on when the HLCM approved the 2021-2022 Action Plan of the OHS Forum (see Annex 1 of document CEB/2021/HLCM/11/Add.1). The necessity for such a repository was further emphasized in the recommendations resulting from the 2021 OHS survey¹: the recommendation stressed that *“Creating a centralized, digital repository allows all UN employees to access information whenever and from wherever it is needed, regardless of the resource capabilities of an organization. Thus, the interagency digital library transfers the entrenched organizations’ knowledge and expertise to the organizations with less resources available.”*

A similar recommendation was made by the COVID-19 First Line of Defense (FLOD) Task Force in its 2022 Lessons Learned report.

Furthermore, with the implementation of the decision made by the HLCM at its April session to encourage the Resident Coordinators to lead a coordinated UN Country Team approach to OHS risks and to establish joint local OHS Committees as a technical advisory mechanism, it became obvious that such OHS Committees at country level would need to access updated OHS information. The OHS Global Repository would be the first place where the Committees could search for guidance.

In parallel, as the CEB Taskforce on the Future of the UN Workforce also works on a UN-wide repository of good practices on organizational culture, the OHS Forum contacted the Task Force members responsible for such a repository given the similarities of both projects, to exchange views and explore areas for collaboration.

With this background in mind, the present document provides the HLCM with the outcome of the Forum’s research and with the recommendation on the way forward. It addresses the purpose of the OHS Global Repository; the digital solution recommended; the governance and sustainability of the repository; and the next steps.

¹ See Annex 1 of document CEB/2022/HLCM/4: Action point 2 - Launching an OHS Global Repository System

Purpose of the OHS Global Repository

Internal discussions within the OHS Forum concluded that the repository should serve several purposes:

- To be the ‘go to’ website where the UN-wide workforce, wherever it works and whatever UN entity it belongs to, would access information on the OHS norms and standards applicable to the UN system;
- To be the resources platform for OHS Committees, whether they are at headquarters, regional or country level, as well as for OHS practitioners;
- To allow for a restricted access to the OHS Forum members and selected OHS practitioners for sensitive information and knowledge sharing.

Digital solution

The need for repositories of information accessible to a large UN audience irrespective of the UN entity they belong to is not new, and the OHS Forum considered that it should explore existing solutions rather than designing its own platform. Building a dedicated website was found resources demanding, resources that precisely the OHS Forum does not have. Discussions with the CEB Secretariat, the Task Force on the Future of the UN Workforce, the Mental Health Strategy Global Lead and with DCO helped identify viable options. Given the large audience in mind (the whole UN workforce), SharePoint, PowerBI and Teams platforms were not considered to be adequate solutions.

On the other hand, it was found that the UN Policy Portal and the Knowledge Gateway, which are already operational, would be the right platforms to host the OHS Global Repository.

The UN Policy Portal [Policy Portal \(un.org\)](https://un.org/policy-portal) is the public online repository of administrative policy documentation and resources that guide the administrative regulation of the United Nations Secretariat. Its content is organized within thematic areas of human resources, travel, health and well-being, procurement, finance and budget, information and technology and property management.

The Health and Wellbeing thematic area is divided into Medical Services and Staff Wellbeing and its content is under DHMOSH’s responsibility. With DHMOSH’s agreement, the OHS Forum, in particular Workstream 2 responsible for OHS norms and standards, would provide the structure of the OHS pages and in the initial phase, i.e. prior to the establishment of a fully operational UN-wide OHS management system, would vet the documents to be posted.

While the UN Policy portal is a public platform which can be seen by visitors external to the UN, the Knowledge Gateway is only accessible to the UN-system personnel wherever they work and whatever UN entity they belong to. The Knowledge Gateway is the one-stop shop where UN-system personnel can find administrative and operational guidance and communities of practice.

The policy documents posted on the UN Policy Portal are mirrored in the Knowledge Gateway, which in addition contains SOPs, guidelines, FAQs, etc. The Knowledge Gateway, both in English and French, has accessibility features and searchability capability, and can host videos, infographics and other multimedia content.

It is proposed that the Occupational Health and Safety pages of the Knowledge Gateway [Occupational Health and Safety \(sharepoint.com\)](#) would contain the OHS norms, standards and policies applicable to the UN system globally as well as practical guidance documents and SOPs for those involved in OHS matters, including Resident Coordinators, UN Country Teams and OHS Committees. Guidance for OHS practitioners (physicians, nurses, counselling, safety, and to a certain extent security professionals) could also be included, as well as duty station health assessments, health and safety Standard Operating Procedures (e.g. MEDEVAC).

The Communities of Practice tab would give the link to a more restricted access platform through authentication, like SharePoint or Teams, which could address the specific need of the members of the OHS Forum to review drafts before making them public or to share documents that are not meant to be public, between them. For instance, it could include UNMD guidance documents, survey result reports and other sensitive information, such as the list and location of medical facilities that can offer critical care to UN personnel, as well as record of any legal agreement with such facilities.

Governance and sustainability

While the structure and the content of the OHS Global Repository hosted by both the UN Policy Portal and the Knowledge Gateway will be initially provided or vetted by the OHS Forum, in particular Workstream 2 responsible for OHS norms and standards, it is expected that once the UN-wide OHS management system has been put in place, the responsibility for managing the OHS repository, vetting and updating the information available and granting access to the restricted community of practice will be transferred to the UN entity in charge of UN-wide OHS matters.

There is no cost associated with the use of the UN Policy Portal and the Knowledge Gateway. However, it should be stressed that managing the OHS pages and ensuring not only their up-to-date content but also developing FAQs and other documents making the content more practical and digestible to interested staff require dedicated human resources that will have to be planned in the UN-wide OHS management system which ultimately will be responsible for the management of the OHS Global Repository.

Next steps

Once the HLCM has endorsed the recommendation made in the present document, the OHS Forum will be in touch with the UN Secretariat's teams respectively managing the UN Policy Portal and the Knowledge Gateway.

The structure/taxonomy of the OHS pages will be provided by the OHS Forum's workstream 2.

The members of the OHS Forum will suggest the content which will be vetted by the whole Forum. As most of the Forum's members are also members of the UN functional networks that have responsibilities in OHS matters (Medical Directors group, Staff Counselors group, HR network, IASMN, etc.), they will be in a position to provide relevant policy documents or links originating from their respective functional networks.

It is expected that by Quarter 2 of 2023, the initial content of the OHS Global Repository will be populated. Links to websites that contribute to prevent and address safety and occupational health hazards will also be provided.

Once this is in place, the OHS Forum, through the participating organizations and the inter-agency mechanisms, will run a communication campaign throughout the UN system to inform the UN workforce of the availability of OHS information through the UN Policy Portal.

The UN entities will be encouraged to provide the link of the OHS Global Repository in their own intranet pages dedicated to OHS matters.

Conclusion

The OHS Forum is seeking the HLCM endorsement of the proposal contained in this document and will inform this Committee on the progress made in the implementation at its next session.

Annex 2

Taxonomy of OHS Standards

Identification of UN standards, guidelines and tools on specific occupational hazards

Workplace hazards

Any taxonomy or classification will perhaps not be exhaustive to include all exposures or scenarios; thus, the categories may not necessarily be mutually exclusive. Rather there will always be a possible overlap between the types of exposures at workplace.

A taxonomy of workplace hazards would serve the purpose of prevention and protecting workers. A clear concept of workplace hazards in occupational safety and health will aid in addressing hazard abatement interventions. If the hazard is effectively defined, then risks can be assessed and addressed based on the hierarchy of controls¹.

A hazard is any source of potential damage, harm, or adverse health effects on something or someone. For example, Benzene is the hazard; leukaemia is the harm caused; bullying is the hazard; and depression, anxiety, and stress is the harm caused.

This approach of workplace hazard-based classification will apply to all occupations, both in fieldwork and administrative and managerial tasks. It will further help cultivate both an understanding, commitment, and a culture of safety in the different organizations.

Hazards at Workplace:

1. **Safety hazards** include tools, machinery, materials, handling, tractors, welding, etc. Also covered are the prevention of slips, trips, and falls, as well as driving tips and working safely with compressed air. These could lead to traumatic injury, fatality or short or long-term disability.
 - a. Machinery (e.g., unguarded machines, lock out – tag out,)
 - I. ILO [C119 - Guarding of Machinery Convention, 1963 \(No.119\)](#)
 - II. ILO [R118 - Guarding of Machinery Recommendation, 1963 \(No. 118\)](#)
 - III. ILO Code of Practice on [Safety and health in the use of machinery](#)
 - IV. ILO Occupational Safety and Health – A Guide of Labour Inspectors and other stakeholders [Machinery, plant and equipment](#)
 - V. ILO information on [Electrical Safety](#)
 - VI. [UN minimum standards on living and working conditions](#)
 - VII. [WFP Personal Protective Equipment](#)
 - VIII. [WFP Housekeeping](#)
 - IX. [WFP Forklift Safety](#)
 - X. [WFP Portable Power Hand tools and Equipment](#)
 - XI. [UNOPS Minimum health and safety requirements for contractors](#)
 - b. Spaces (e.g., Confined space, hyperbaric pressure-divers)
 - I. ILO [C176 – Safety and Health in Mines Convention, 1995 \(No. 176\)](#)
 - II. ILO [R183 - Safety and Health in Mines Recommendation, 1995 \(No. 183\)](#)

¹ https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_232886.pdf

- III. ILO [R192 - Safety and Health in Agriculture Recommendation, 2001 \(No. 192\)](#)
- IV. ILO [Code of Practice on Safety and health in agriculture](#)
- V. [UN minimum standards on living and working conditions](#)
- VI. [WFP Personal Protective Equipment](#)
- VII. [WFP Housekeeping](#)
- VIII. [UNOPS Minimum health and safety requirements for contractors](#)
- c. Working at heights (e.g., falls, slips)
 - I. ILO information on [Working at height](#)
 - II. ILO information on [Slips and Trips](#)
 - III. [UN minimum standards on living and working conditions](#)
 - IV. [WFP Elevated Work Platform](#)
 - V. [WFP Personal Protective Equipment](#)
 - VI. [WFP Housekeeping](#)
 - VII. [WFP Forklift Safety](#)
 - VIII. [UNOPS Minimum health and safety requirements for contractors](#)
- d. Vehicles (e.g., traffic collisions at work)
 - I. ILO [R161 - Hours of Work and Rest Periods \(Road Transport\) Recommendation, 1979 \(No. 161\)](#)
 - II. ILO [Guidelines on the promotion of decent work and road safety in the transport sector](#)
 - III. ILO information on [Vehicles in the Workplace](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. UNSMS [Guidelines and Standards on Road Safety UNSMS](#)
 - VI. [WFP Personal Protective Equipment](#)
 - VII. [WFP Housekeeping](#)
 - VIII. [WFP forklift Safety](#)
 - IX. [UNOPS Minimum health and safety requirements for contractors](#)
- e. Client interactions or field conflicts (e.g., intentional injuries caused by violence)
 - I. ILO [Violence and Harassment Convention, 2019 \(No. 190\)](#)
 - II. ILO [Violence and Harassment Recommendation, 2019 \(No. 206\)](#)
 - III. ILO [Guide on Convention C190 and Recommendation No. 206 on violence and harassment at work](#)
 - IV. ILO report [Safe and healthy working environments free from violence and harassment](#)
 - V. ILO [SOLVE: Integrating Health Promotion into Workplace OSH Policies](#)
 - VI. ILO publication [Gender equality and women's empowerment in the world of work in fragile, conflict and disaster settings](#)
 - VII. ILO publication [How to promote disability inclusion in programmes to prevent, address and eliminate violence and harassment in the world of work](#)
 - VIII. [UN minimum standards on living and working conditions](#)
 - IX. [UNOPS Minimum health and safety requirements for contractors](#)
- f. Major hazards / Accidents
 - I. ILO [C174 - Prevention of Major Industrial Accidents Convention, 1993 \(No. 174\)](#)

- II. ILO [R181 - Prevention of Major Industrial Accidents Recommendation, 1993 \(No. 181\)](#)
- III. ILO Code of Practice [Prevention of major industrial accidents](#)
- IV. ILO manual [Major Hazard Control: A Practical Manual](#)
- V. [UN minimum standards on living and working conditions](#)
- VI. [WFP Personal Protective Equipment](#)
- VII. [WFP Housekeeping](#)
- VIII. [UNOPS Minimum health and safety requirements for contractors](#)

2. **Physical hazards** are substances or activities that threaten your physical safety. They are the most common and are present in most workplaces at one time or another. These include hazards related to the work environment that can cause injury, illness, and death.

- a. Thermal (e.g., cold and hot weather conditions, lighting,)
 - I. ILO [C120 - Hygiene \(Commerce and Offices\) Convention, 1964 \(No. 120\)](#)
 - II. ILO [R120 - Hygiene \(Commerce and Offices\) Recommendation, 1964 \(No. 120\)](#)
 - III. ILO [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - IV. ILO Code of Practice [Ambient Factors in Workplace](#)
 - V. [UN minimum standards on living and working conditions](#)
 - VI. [Guidelines Air pollution \(UNHCR\)](#)
 - VII. [WFP Personal Protective Equipment](#)
 - VIII. [WFP Housekeeping](#)
- b. Indoor Air (e.g., moulds, dampness, indoor temperature)
 - I. ILO [C148 - Working Environment \(Air Pollution, Noise and Vibration\) Convention, 1977 \(No. 148\)](#)
 - II. ILO [R156 - Working Environment \(Air Pollution, Noise and Vibration\) Recommendation, 1977 \(No. 156\)](#)
 - III. ILO [R120 - Hygiene \(Commerce and Offices\) Recommendation, 1964 \(No. 120\)](#)
 - IV. [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - V. [Guidelines Air pollution \(UNHCR\)](#)
 - VI. [UN minimum standards on living and working conditions](#)
 - VII. [WFP Personal Protective Equipment](#)
 - VIII. [WFP Housekeeping](#)
- c. Radiation (e.g., ionizing and non-ionizing radiation)
 - I. ILO [C115 - Radiation Protection Convention, 1960 \(No. 115\)](#)
 - II. ILO [R114 - Radiation Protection Recommendation, 1960 \(No. 114\)](#)
 - III. ILO [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - IV. ILO Code of Practice [Ambient Factors in Workplace](#)
 - V. ILO [International Basic Safety Standards for Protection Against Ionizing Radiation and for the Safety of Radiation Sources. IAEA Safety Series No. 115](#)
 - VI. ILO manual [WASH@Work](#)
 - VII. IAEA [Occupational Radiation Protection](#)
 - VIII. [Guidelines Air pollution \(UNHCR\)](#)
 - IX. [UN minimum standards on living and working conditions](#)

- X. WFP Personal Protective Equipment
- XI. WFP Housekeeping
- d. Noise and vibrations (e.g., machine-generated, heavy vehicles)
 - I. ILO [C148 - Working Environment \(Air Pollution, Noise and Vibration\) Convention, 1977 \(No. 148\)](#)
 - II. ILO [R156 - Working Environment \(Air Pollution, Noise and Vibration\) Recommendation, 1977 \(No. 156\)](#)
 - III. ILO [R120 - Hygiene \(Commerce and Offices\) Recommendation, 1964 \(No. 120\)](#)
 - IV. ILO Code of Practice [Ambient Factors in Workplace](#)
 - V. [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - VI. ILO Code of Practice [Protection of Workers against Noise and Vibration](#)
 - VII. [UN minimum standards on living and working condition](#)
 - VIII. WFP Personal Protective Equipment
 - IX. WFP Housekeeping
 - X. WFP Personal Protective Equipment
- e. Fires including electrical hazards (e.g., chemical reactions, ignitions, short circuits)
 - I. ILO [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO [R177 - Chemicals Recommendation, 1990 \(No. 177\)](#)
 - III. ILO [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - IV. ILO information on [Fire Safety](#)
 - V. ILO information on [Electrical safety](#)
 - VI. ILO information [Fire Risk Management](#)
 - VII. [UN minimum standards on living and working conditions](#)
 - VIII. WFP Personal Protective Equipment
 - IX. WFP Housekeeping
- 3. **Ergonomic hazards** result from a mismatch of the job to the worker and product to the user resulting in work-related musculoskeletal as well as other cognitive and ergonomic challenges.
 - a. Workstations (e.g., maladapted screen, work desk, chair or a standing workstation)
 - I. ILO [Principles and guidelines for human factors /ergonomics \(HFE\) design and management of work systems](#)
 - II. [UN minimum standards on living and working conditions](#)
 - III. [UN Guidelines for Ergonomic Workstations and Work with Computers](#)
 - IV. WFP Personal Protective Equipment
 - V. WFP Housekeeping
 - b. Repetitive movements
 - I. ILO [Ergonomic Check Points](#)
 - II. [UN minimum standards on living and working conditions](#)
 - III. [UN Guidelines for Ergonomic Workstations and Work with Computers](#)
 - IV. WFP Personal Protective Equipment
 - V. WFP Housekeeping
 - c. Manual lifting (e.g., heavy lifting)

- I. ILO [C127 - Maximum Weight Convention, 1967 \(No. 127\)](#)
 - II. ILO [R128 - Maximum Weight Recommendation, 1967 \(No. 128\)](#)
 - III. ILO information on [Manual Lifting](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. [WFP Personal Protective Equipment](#)
 - VI. [WFP Housekeeping](#)
- d. Vibrations (e.g., Driving heavy vehicles, handheld devices)
- I. ILO [C148 - Working Environment \(Air Pollution, Noise and Vibration\) Convention, 1977 \(No. 148\)](#)
 - II. ILO [R156 - Working Environment \(Air Pollution, Noise and Vibration\) Recommendation, 1977 \(No. 156\)](#)
 - III. ILO [R120 - Hygiene \(Commerce and Offices\) Recommendation, 1964 \(No. 120\)](#)
 - IV. ILO Code of Practice [Protection of Workers against Noise and Vibration](#)
 - V. ILO information on [Vibrations](#)
 - VI. [UN minimum standards on living and working conditions](#)
 - VII. [WFP Personal Protective Equipment](#)
 - VIII. [WFP Housekeeping](#)
4. **Chemical hazards** occur when the workers are exposed to hazardous chemicals through inhalation, absorption through the skin, or ingestion and swallowing. These could result in fatal health outcomes such as cancer, but debilitating health problems such as asthma or chronic skin diseases.
- a. Asphyxiants (e.g., carbon monoxide)
 - I. ILO [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO [R177 - Chemicals Recommendation, 1990 \(No. 177\)](#)
 - III. ILO Code of Practice [Occupational exposure to airborne substances harmful to health](#)
 - IV. ILO/ WHO [International Chemical Safety Cards \(ICSCs\)](#)
 - V. [UN minimum standards on living and working conditions](#)
 - VI. [WFP Personal Protective Equipment](#)
 - b. Corrosives (e.g., sulphuric acid)
 - I. ILO [C170 – Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - III. ILO/WHO [International Chemical Safety Cards \(ICSCs\)](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. [WFP Personal Protective Equipment](#)
 - c. Irritants (e.g., nickel chloride)
 - I. ILO [C170 – Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO [Code of Practice on Occupational exposure to airborne substances harmful to health](#)
 - III. ILO/WHO [International Chemical Safety Cards \(ICSCs\)](#)
 - VII. [UN minimum standards on living and working conditions](#)
 - VIII. [WFP Personal Protective Equipment](#)

- d. Sensitizers (e.g., Chlorine)
 - I. ILO [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - III. ILO/WHO [International Chemical Safety Cards \(ICSCs\)](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. [WFP Personal Protective Equipment](#)
- e. Carcinogens (e.g., Asbestos, Benzene)
 - I. ILO [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO [R147 - Occupational Cancer Recommendation, 1974 \(No. 147\)](#)
 - III. ILO [C162 - Asbestos Convention, 1986 \(No. 162\)](#)
 - IV. ILO [R172 - Asbestos Recommendation, 1986 \(No. 172\)](#)
 - V. ILO [C136 - Benzene Convention, 1971 \(No. 136\)](#)
 - VI. ILO [R144 - Benzene Recommendation, 1971 \(No. 144\)](#)
 - VII. ILO Code of Practice on [Safety in use of Asbestos](#)
 - VIII. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - VI. ILO/WHO [International Chemical Safety Cards \(ICSCs\)](#)
 - IX. [WFP Personal Protective Equipment](#)
- f. Teratogens (e.g., thalidomide, ionizing radiation)
 - I. ILO [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - IX. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - X. [UN minimum standards on living and working conditions](#)
- g. Mutagens (e.g., Hydrogen Peroxide, Benzene)
 - I. [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. Guidelines [Occupational exposure to airborne substances harmful to health](#)
 - III. [UN minimum standards on living and working conditions](#)
 - IV. [WFP Personal Protective Equipment](#)
- h. Reactive (e.g., Nitric Acid)
 - I. [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - XI. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - XII. [UN minimum standards on living and working conditions](#)
 - XIII. [WFP Personal Protective Equipment](#)
- i. Flammable (e.g., Acetone)
 - I. [C170 - Chemicals Convention, 1990 \(No. 170\)](#)
 - II. ILO R115 - Workers' Housing Recommendation, 1961 (No. 115)
 - III. ILO Code of Practice on [Occupational exposure to airborne substances harmful to health](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. [WFP Personal Protective Equipment](#)

5. **Biological hazards** refer to any micro-organism, cell or other organic material that may be of plant, animal or human origin, including any which have been genetically modified, and which can cause harm to human health. This may include but is not limited to bacteria, viruses, parasites, fungi, prions, DNA materials, bodily fluids, and any other microorganisms and their associated allergens and toxins. Health impacts could include infectious and non-infectious diseases and injuries.

Biological agents can be classified into four groups

- a. Group 1 biological agents means one that is unlikely to cause human disease (e.g., E.Coli).
 - I. ILO [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - II. ILO [Technical guidelines on biological hazards](#)
 - III. ILO information on [Harmful Chemical and Biological agents/substances](#)
 - IV. [UN Kitchen hygiene and equipment guidelines. UN](#)
 - V. [UN minimum standards on living and working conditions](#)
 - VI. [WFP Personal Protective Equipment](#)
- b. Group 2 biological agent means one that can cause human disease and might be a hazard to workers; it is unlikely to spread to the community; there is usually effective prophylaxis or treatment available (e.g., Staphylococcus, HIV).
 - I. [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - II. ILO [Technical guidelines on biological hazards](#)
 - III. ILO information on [Harmful Chemical and Biological agents/substances](#)
 - IV. [UN Kitchen hygiene and equipment guidelines.](#)
 - V. [UN minimum standards on living and working conditions](#)
 - VI. [WFP Personal Protective Equipment](#)
- c. Group 3 biological agent means one that can cause severe human disease and present a serious hazard to workers; it may present a risk of spreading to the community, but there is usually effective prophylaxis or treatment available (e.g., Sars COV-2, Tuberculosis).
 - I. ILO [Recommendation HIV and AIDS Recommendation, 2010 \(No. 200\)](#)
 - II. ILO [R115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - III. ILO [Code of Practice on HIV/AIDS and the World of Work](#)
 - IV. ILO [Technical guidelines on biological hazards](#)
 - V. ILO [Guidelines for workplace TB control activities - The contribution of workplace TB control activities to TB control in the community](#)
 - VI. WHO/ILO, Preventing and mitigating COVID-19 at work, policy brief, 19 May 2021 <https://www.who.int/publications/i/item/WHO-2019-nCoV-workplace-actions-policy-brief-2021-1>
 - VII. WHO, Considerations for public health and social measures in the workplace in the context of COVID-19
Annex to considerations in adjusting public health and social measures in the context of COVID-19
10 May 2020 <https://www.who.int/publications/i/item/considerations-for-public-health-and-social-measures-in-the-workplace-in-the-context-of-covid-19>

- VIII. WHO, Q&A: Tips for health and safety at the workplace in the context of COVID-19
26 June 2020 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-tips-for-health-and-safety-at-the-workplace-in-the-context-of-covid-19>
 - IX. WHO, Roadmap to improve and ensure good indoor ventilation in the context of COVID-19, 1 March 2021, <https://www.who.int/publications/i/item/9789240021280>
 - X. IASC Minimum standards on duty of care in the context of COVID-19
 - XI. <https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Minimum%20Standards%20on%20Duty%20of%20Care%20in%20the%20Context%20of%20COVID-19%20.pdf>
 - XII. UN Kitchen hygiene and equipment guidelines. UN
 - XIII. [UN minimum standards on living and working conditions](#)
 - XIV. UN [Policy on HIV/AIDS in the workplace](#)
 - XIV. WFP Personal Protective Equipment
- d. Group 4 biological agent means one that causes severe human disease and is a serious hazard to workers; it may present a high risk of spreading to the community; there is usually no effective prophylaxis or treatment available (e.g., Ebola virus, Nipa virus).
- I. ILO [Recommendation No. 115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - II. ILO [Technical guidelines on biological hazards](#)
 - III. ILO briefing note [Ebola Virus Disease: Occupational safety and health](#)
 - IV. UN Kitchen hygiene and equipment guidelines
 - V. [UN minimum standards on living and working conditions](#)
 - XV. WFP Personal Protective Equipment
6. **Psychosocial and organizational hazards** are elements of the work environment, management practices, or organizational practices that pose a risk to physical and mental health, including worker well-being.
- a. Work organization (e.g., monotonous work, precarious work, contingent work, alone work, work-intensity, open-office)
 - I. ILO [Recommendation No. 102 - Welfare Facilities Recommendation, 1956 \(No. 102\)](#)
 - II. ILO [Recommendation No. 115 - Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - III. ILO [Workplace Stress: A collective challenge](#)
 - IV. ILO [Stress Prevention at Work Checkpoints. Practical improvements for stress prevention in the workplace](#)
 - V. ILO [Safe and healthy working environments free from violence and harassment](#)
 - VI. UN [Employment and accessibility for staff members with disabilities in the United Nations Secretariat](#)
 - VII. [UN minimum standards on living and working conditions](#)
 - VIII. UN [Introduction of an occupational safety and health management system](#)

- IX. [UN Retention in service beyond the mandatory age of separation and employment of retirees](#)
- b. Job control (e.g., lack of participation/representation in decision making)
 - I. ILO Guidelines on occupational safety and health management systems ILO-OSH 2001
 - II. ILO [Workplace cooperation: a practical guide](#)
 - III. UNIDO Rules and responsibilities: Staff committee, HS inspectors, employer and employee, authorities, rights and duties, responsibilities
 - IV. UN [Staff Management Consultation Machinery](#)
 - V. [UN minimum standards on living and working conditions](#)
- c. Work schedule (e.g., time pressures, insufficient breaks, shift work)
 - I. ILO [C001 - Hours of Work \(Industry\) Convention, 1919 \(No. 1\)](#)
 - II. ILO [C014 - Weekly Rest \(Industry\) Convention, 1921 \(No. 14\)](#)
 - III. ILO [C030 - Hours of Work \(Commerce and Offices\) Convention, 1930 \(No. 30\)](#)
 - IV. ILO [C047 - Forty-Hour Week Convention, 1935 \(No. 47\)](#)
 - V. ILO [C106 - Weekly Rest \(Commerce and Offices\) Convention, 1957 \(No. 106\)](#)
 - VI. ILO [C171 - Night Work Convention, 1990 \(No. 171\)](#)
 - VII. [UN minimum standards on living and working conditions](#)
 - VIII. UN [Flexible Working Arrangements](#)
- d. Interpersonal relationships (e.g., harassment, bullying, discrimination)
 - I. ILO [Violence and Harassment Convention, 2019 \(No. 190\)](#)
 - II. ILO [Violence and Harassment Recommendation, 2019 \(No. 206\)](#)
 - III. ILO Report on [prevention of stress and violence at the workplace](#)
 - IV. [UN minimum standards on living and working conditions](#)
 - V. UN [Psychosocial Support in Crisis Situations](#)
- e. Work-life balance (e.g., home-based office, remote office, lifestyle diseases)
 - I. ILO [Workers with Family Responsibilities Convention, 1981 \(No. 156\)](#)
 - II. ILO [Workers with Family Responsibilities Recommendation, 1981 \(No. 165\)](#)
 - III. ILO [Part-Time Work Convention, 1994 \(No. 175\)](#)
 - IV. ILO [Part-Time Work Recommendation, 1994 \(No. 182\)](#)
 - V. ILO [Workers' Housing Recommendation, 1961 \(No. 115\)](#)
 - VI. ILO [Management of alcohol- and drug-related issues in the workplace. Code of practice](#)
 - VII. ILO brief [Practical Guide on Teleworking during the COVID-19 pandemic and beyond](#)
 - VIII. ILO Training guide [Integrating Health Promotion into Workplace OSH policies](#)
 - IX. ILO WHO and ILO Healthy and safe telework: Technical brief <https://apps.who.int/iris/rest/bitstreams/1406780/retrieve>
 - X. UN [Workplace Mental Health and Well-Being Strategy. UN](#)
 - XI. [UN minimum standards on living and working conditions.](#)
 - XII. UN [Psychosocial Support in Crisis Situations. UN](#)
 - XIII. UN [Training Program For Managers in High Risk Environments](#)

- XIV. [UN Employee Assistance in case of Substance Abuse / Alcohol](#)
- XV. [UN Family, maternity leave and Paternity Leave](#)
- XVI. [UN Official Travel](#)
- XVII. [UN Policy on Breast Feeding](#)
- XVIII. [UN Normal Working Hours \(New York\)](#)
- XIX. [UN Policy on Breastfeeding](#)

Health workers:

1. ILO [Nursing Personnel Convention, 1977 \(No. 149\)](#)
2. ILO [Nursing Personnel Recommendation, 1977 \(No. 157\)](#)
3. WHO and ILO, [Caring for those who care: guide for the development and implementation of occupational health and safety programmes for health workers](#)
4. WHO and ILO, [Occupational safety and health in public health emergencies: a manual for protecting health workers and responders](#)
5. WHO, [Occupational hazards in the health sector <https://www.who.int/tools/occupational-hazards-in-health-sector>](#)

Construction workers:

1. ILO [C167 - Safety and Health in Construction Convention, 1988 \(No. 167\)](#)
2. ILO [Code of practice on safety and health in construction](#)
3. ILO [Code of practice on safety and health in building and civil engineering work](#)
4. ILO [Training package in occupational safety and health for the construction industry](#)
5. ILO [Safety, health and welfare on construction sites: A training manual](#)
6. UNDP [Health and Safety in Construction and Infrastructure projects](#)
7. UNIDO Working places and construction sites: How are the requirements in buildings, outside of buildings, in working areas, workshops , factories on construction sites? Fire protection, First Aid Measures and Installations, Nonsmoker protection.

Transport Workers:

1. ILO [C153 - Hours of Work and Rest Periods \(Road Transport\) Convention, 1979 \(No. 153\)](#)
2. ILO [R161 - Hours of Work and Rest Periods \(Road Transport\) Recommendation, 1979 \(No. 161\)](#)
3. ILO [Guidelines on the promotion of decent work and road safety in the transport sector](#)

Emergency preparedness and services:

1. ILO [Guidelines on decent work in public emergency services](#)
2. UN [Evacuations procedures New York](#)

General OSH norms and guidelines international institutions:

1. ILO [C155 - Occupational Safety and Health Convention, 1981 \(No. 155\)](#)
2. ILO [R164 - Occupational Safety and Health Recommendation, 1981 \(No. 164\)](#)
3. ILO [C161 - Occupational Health Services Convention, 1985 \(No. 161\)](#)
4. ILO [R171 - Occupational Health Services Recommendation, 1985 \(No. 171\)](#)
5. ILO [C187 - Promotional Framework for Occupational Safety and Health Convention, 2006 \(No. 187\)](#)
6. ILO [R197 - Promotional Framework for Occupational Safety and Health Recommendation, 2006 \(No. 197\)](#)
7. ILO [Work Improvements in Small Enterprises \(WISE\)](#)
8. ILO [Improving working and living conditions for agricultural families programme \(WIND\)](#)
9. UN [GUIDANCE ON THE UNSMS ROLE IN OCCUPATIONAL SAFETY & HEALTH \(OSH\)](#)

10. World Bank [Environmental, Health, and Safety \(EHS\) Guidelines](#)
11. [OECD guidance on Safety Performance Indicators concerning Chemical Accidents](#)
12. IAEA [Safety Standards](#)
13. IAEA [THE AGENCY'S HEALTH AND SAFETY MEASURES](#)
14. IAEA [Leadership and Management for Safety](#)
15. **UNIDO** General regulations: That contains duties of employee and employer, working place and risk assessments, Information, marking and signs, accidents, maintenance, cleaning and certifications.
16. **UNIDO** Working tools and equipment: General regulations, set up, usage, dangerous operation, approval, Certification, maintenance
17. **UNIDO** Working materials: Dangerous material, evaluation. Forbidden and banned material, marking and signs, tables, limits and measurements, list of materials.
18. **UNIDO** Working procedures: Personal protection equipment, noise protection, Health protection, specific requirements for various types of work, electrical, welding etc...
19. **UNIDO** Actual guidelines and directives: Specific and actual guidelines for your respective working area
20. **UNOPS** Minimum health and safety requirements for contractors
21. **UNOPS** Health & Safety & Social & Environmental Management
22. **UNSS** Living and Working Standards in High Risk Environments

Other relevant ILO OSH conventions by occupation and trade sectors:

- [C30 Hours of Work \(Commerce and Offices\) Convention, 1930](#)
- [C32 Protection against Accidents \(Dockers\) Convention \(Revised\), 1932](#)
- [C45 Underground Work \(Women\) Convention, 1935](#)
- [C53 Officers' Competency Certificates Convention, 1936](#)
- [C54 Holidays with Pay \(Sea\) Convention, 1936](#)
- [C55 Shipowners' Liability \(Sick and Injured Seamen\) Convention, 1936](#)
- [C56 Sickness Insurance \(Sea\) Convention, 1936](#)
- [C57 Hours of Work and Manning \(Sea\) Convention, 1936](#)
- [C58 Minimum Age \(Sea\) Convention \(Revised\), 1936](#)
- [C62 Safety Provisions \(Building\) Convention, 1937](#)
- [C68 Food and Catering \(Ships' Crews\) Convention, 1946](#)
- [C69 Certification of Ships' Cooks Convention, 1946](#)
- [C73 Medical Examination \(Seafarers\) Convention, 1946](#)
- [C74 Certification of Able Seamen Convention, 1946](#)
- [C75 Accommodation of Crews Convention, 1946](#)
- [C76 Wages, Hours of Work and Manning \(Sea\) Convention, 1946](#)
- [C92 Accommodation of Crews Convention \(Revised\), 1946](#)
- [C93 Wages, Hours of Work and Manning \(Sea\) Convention \(Revised\), 1949](#)
- [C94 Labour Clauses \(Public Contracts\) Convention, 1949](#)
- [C106 Weekly Rest \(Commerce and Offices\) Convention, 1957](#)
- [C108 Seafarers' Identity Documents Convention, 1958](#)
- [C109 Wages, Hours of Work and Manning \(Sea\) Convention \(Revised\), 1958](#)
- [C110 Plantations Convention, 1958](#)
- [C112 Minimum Age \(Fishermen\) Convention, 1959](#)
- [C113 Medical Examination \(Fishermen\) Convention, 1959](#)
- [C114 Fishermen's Articles of Agreement Convention, 1959](#)
- [C120 Hygiene \(Commerce and Offices\) Convention, 1964](#)

[C123 Minimum Age \(Underground Work\) Convention, 1965](#)
[C124 Medical Examination of Young Persons \(Underground Work\) Convention, 1965](#)
[C125 Fishermen's Competency Certificates Convention, 1966](#)
[C126 Accommodation of Crews \(Fishermen\) Convention, 1966](#)
[C129 Labour Inspection \(Agriculture\) Convention, 1969](#)
[C133 Accommodation of Crews \(Supplementary Provisions\) Convention, 1970](#)
[C134 Prevention of Accidents \(Seafarers\) Convention, 1970](#)
[C137 Dock Work Convention, 1973](#)
[C141 Rural Workers' Organisations Convention, 1975](#)
[C145 Continuity of Employment \(Seafarers\) Convention, 1976](#)
[C146 Seafarers' Annual Leave with Pay Convention, 1976](#)
[C147 Merchant Shipping \(Minimum Standards\) Convention, 1976](#)
[Protocol of 1996 to the Merchant Shipping \(Minimum Standards\) Convention, 1976](#)
[C152 Occupational Safety and Health \(Dock Work\) Convention, 1979 \(No. 152\)](#)

Color coding:

Blue ILO

Green WHO

Grey IAEA

Bottle green UNSS

Yellow occur UNIDO

Orange UN

Red UNHCR

Violet WFP

Brown UNOPS

Annex 3

Process for collecting, vetting and developing OHS standards applicable to the UN System

1. The foundation for the assessment of existing OHS standards and for the development of new OHS standards applicable to the UN system is an agreed taxonomy of occupational hazards (by September 2022).
2. The taxonomy will serve to structure the Global OHS Repository which should be available for access by the whole UN personnel by end of Q1/2023.
3. The taxonomy and the OHS repository should be comprehensive enough to cover the needs of different UN agencies, with due adaptation.
4. Unless provided otherwise, OHS standards posted on the OHS repository are not prescriptive but are to be considered as guidance or recommendations for the UN agencies who can adapt them to their specific context and operations.
5. The OHS Forum will collect the OHS standards already used or developed by UN agencies and inter-agency mechanisms, like UNMD, UNSSCG, HR network, IASMN, and organize them according to the taxonomy. This will help identify possible gaps that need to be addressed.
6. In the event that a UN technical network has developed a specific OHS standard which has subsequently been endorsed at the inter-agency level, the OHS Forum will post it (or its link) in the OHS repository.
7. In the event that a UN agency has developed a specific OHS standard, the OHS Forum will assess, or coordinate its assessment with the relevant UN technical network, whether it should be recommended to the whole UN system or whether it needs adjustment. In either case, the OHS standard in question (or the link to it) will be posted in the OHS repository.
8. In the event that several documents have been developed to address the same OHS hazard, the OHS Forum will assess, or coordinate its assessment with the relevant UN technical network, as to which one is the most adequate, or whether they should be combined or adjusted to cover different contexts of the same hazard. In either case, the document resulting from such an assessment (or the link to it) will be posted in the OHS repository.
9. In the event that the OHS Forum has identified gaps, the OHS Forum will coordinate with a UN agency or a UN technical network, supported by OHS experts, with the view to developing the new OHS standard, which will be reviewed by the Forum for vetting and subsequently posting in the OHS repository.
10. When a UN agency or a UN functional network wants to formulate a new OHS standard, such a work should be done in coordination with the OSH Forum who may provide guidance or refer to existing and already internationally endorsed standards.
11. In assessing existing OHS standards or in reviewing new OHS standards that have been developed, the OHS Forum will endeavour that there is no contradiction with existing standards, before the OHS standards are posted in the OHS repository.



UN OHS FORUM

Occupational Health & Safety Incident Management Guideline

Annex 4

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01 SUMMARY

The “Birds triangle” and other incident analysis models demonstrate that an effective Occupational Health and Safety (OHS) incident management program generates an incident database, which if well classified and analysed, over time, provides reliable predictive OHS indicators for preventing future major incidents, and for making more informed business decisions. A good incident reporting culture in an organization, linked to standard response actions, is an important component of effective corporate risk management.

The workplace is constantly faced with diverse range of occupational health and safety (OHS) hazards, often leading to near misses, harm to person(s) or damage to other assets of the organization due to the failure or absence of hazards and risks control defences. Further to this, the world of work has changed and introduced new working modalities. Some of the changes in the approach and ways of work now include remote working or telecommuting from different locations, working at off-site locations not well designed and adapted for prolonged sedentary work, increased use of newer technologies and innovations, etc. Whilst these are great opportunities to advance the course of work, they challenge the traditional ways of managing health and safety incidents at work. For instance, the UN system’s traditional policy definition of service-incurred incidents or accidents may no longer be wholly applicable to the new context of work.

This guideline reviews literature from a number of publications on Occupational Environment, Health and Safety (EHS) incident management, in different industries, and offers UN organizations guidance on how to develop and sustain an OHS incident management program in their places of work. A number of digital or software applications have also been recommended for UN organizations to consider when planning and deploying their OHS incident management programs.

Furthermore, the guideline introduces the use of OHS incident management principles to address workplace incidents incurred from newly diagnosed occupational diseases or work-related illnesses, as well as work related mental health conditions.

02 INTRODUCTION

An Occupational Health and Safety (OHS) incident is an unplanned event that resulted, or could have resulted in loss(es) in the organization, such as; unintended harm to person(s), damage to property or reputation, loss of confidence among member states, breach of regulatory compliance, etc. Close calls or near misses, and dangerous occurrences are also considered as incidents. The incident management process therefore aims to: identify and report, respond to, investigate, record, and analyse exposure to health and safety hazards at work, with the goal of contributing to the continual improvement of workplace health and safety by preventing recurrence of the incidents.

2.1 Purpose

This guideline offers UN system organizations concise and best practice overview of the incident management process and its underlying principles. It provides an overview of incident recognition, reporting, classification, investigation and review, as well as their analysis, communication, and closure. The guideline offers recommendations on digital or software solutions that could support the deployment and administration of the incident management process.

2.2 Scope

The content of this document can be adopted by UN organizations to manage all classes of occupational health and safety (OHS) incidents on their premises, and within their operations around the world. It applies to all personnel of the organization and any person who may be affected by the undertaking of the organization.

2.3 How may this guideline be used?

This guideline consolidates best practice approaches to incident management in various organizations and across different industries based on a systematic literature review. The intention is to guide UN agencies in the design of their incident management programs. The guideline is not mandatory, but it provides a basis for organizations to understand how effective OHS incident management could

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contribute to operational risk management, through ensuring that lessons learnt from investigated and reviewed incidents are applied to avoid recurrence. Where the guideline is not used, organizations would need to plan and implement an equivalent incident management program, which is able to prevent incident recurrence and supports the organization's risk management processes. In this guideline, organizations will find acceptable methods rather than prescriptions, as well as practical "how-to" advice.

2.4 General Requirements

- (a) UN organizations should implement and maintain procedures and other arrangements for the effective management of OHS incidents (including near misses).
- (a) Contractors and other service providers are also subject to the requirements while on the premises of UN organizations or while engaged in off-site activities (not on their own premises).
- (b) Organizations should ensure that personnel have the necessary competencies, appropriate for their role in the incident management process (Incident Reporter, Notifier, Lead Incident Reviewer/Team Member, etc.), to be able to perform their role effectively.

03 DEFINITIONS

- 3.1 Adverse Event:** Includes accidents and incidents, which may or may not cause harm.
Harm: Incident related loss(es) incurred by the organization. This may include; injury, illness, or death of person(s), regulatory compliance breach, reputation or property damage, loss of member states confidence, loss of business opportunity, etc.
- 3.2 Accident:** An unplanned event that results in harm.
- 3.3 Incident:** An unplanned event or circumstance that resulted or could have resulted in harm.
- 3.4 Near Miss / Close Call / Near Hit:** An event that, while not causing harm, had the potential to cause harm under different condition(s).
- 3.5 Dangerous Occurrence (DO):** Readily identifiable event as defined under national laws and regulations, with potential to cause an injury or disease to persons at work or the public, ([according to ILO](#)).
- 3.6 High Potential Incident (HPI):** This is defined as any event which under slightly different circumstances (in terms of timing and/or location), may have resulted in potentially serious injury or ill health of people, or damage or loss of property, plant, materials or the environment or loss of business opportunity.
- 3.7 Significant Incident:** Defined as one where;
 - (a) the actual incident level is High or greater in OHS Consequence definitions, or
 - (b) the potential incident level is High or greater in OHS Consequence definitions, or
 - (c) the prevailing legislative environment requires immediate reporting of the specific incident type.
- 3.8 Lost Time Injury (LTI):** These are injuries where the injured is unable to perform his / her normal task, on the calendar day following the day of the incident.
- 3.9 Disabling Injury:**
 - (a) Any occupational injury / ill health to a person that arises from an incident occurring during the course of his / her employment. Disabling Injuries are those that render the person unable to return to the workplace to perform the full duties of their regular work on the next calendar day, or result in permanent disability, or prevent staff from effectively performing the duties related to their regular work. The day of the incident is excluded when counting the number of days lost due to the disabling injury. (This may exclude weekends and public holidays as defined by the ILO).

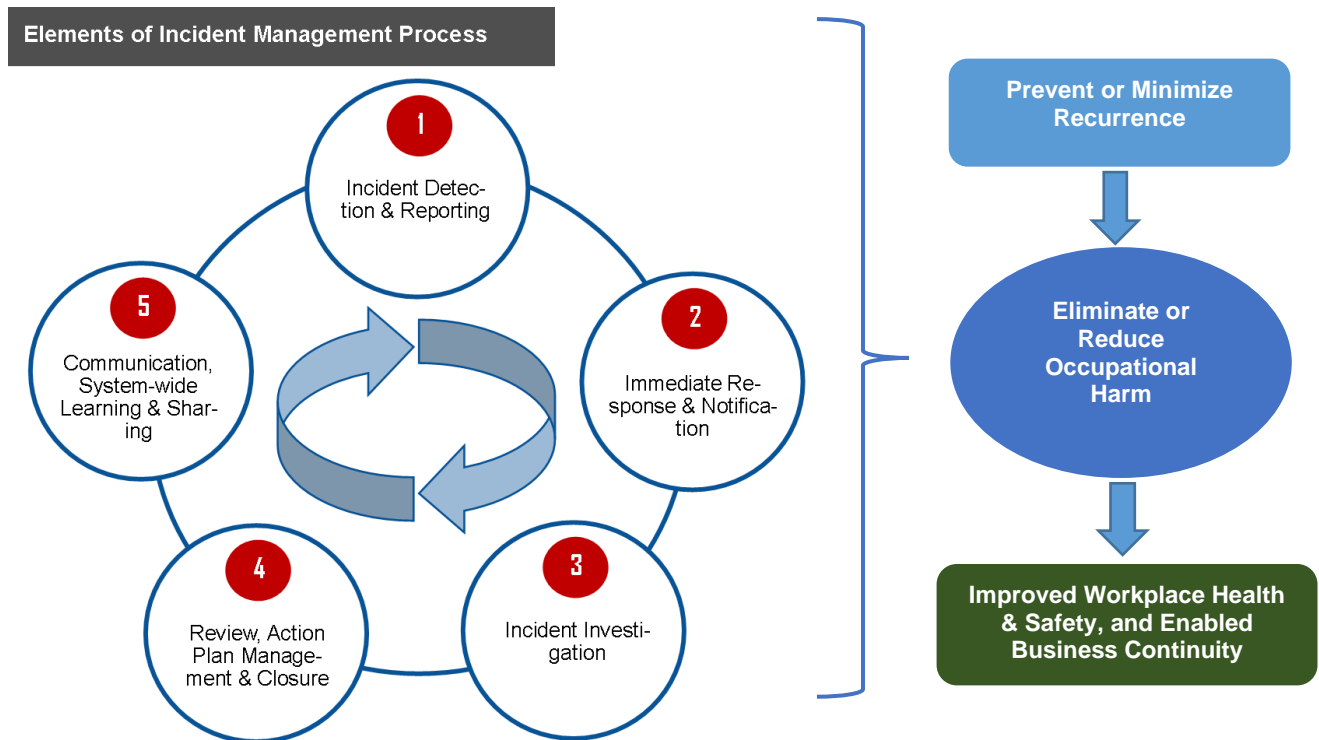
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- (b) Where the injured person does not lose working time on the days following the injury, but is later booked off work by a medical practitioner in respect of the injury concerned, this shall also be classified as a Disabling Injury. The date of injury to be recorded as from the date the injured is booked off work.
 - (c) Where the injured person is booked off work for a second or subsequent time as a result of a lost time injury, such an occurrence shall not be regarded as a further Disabling Injury. Any additional days lost due to the above should also be recorded.
- 3.10 Restricted Work Case:** Any occupational injury or illness, which renders the person, although at work but unable to perform the full duties of his/her regular work on the next calendar day, after the day of the injury, should be recorded as a Restricted Work Case. A restricted work case may be reassigned to undertake other duties instead of the usual duties.
- 3.11 Dressing Case (Injury with no Loss Time):** Dressing cases are defined as those minor injuries requiring medical care, provided by a physician or trained professional medical personnel which do not result in time lost. This treatment may require some sort of follow-up treatment.
- 3.12 First Aid Case (FAC):** First Aid Cases (FACs) are cases of minor work-related injury or illness (with no lost work days), which can normally be treated by the victim himself or herself or by an appropriately trained First Aider. This may include the application of non-prescription medicines, such as: antiseptic ointment, and wound dressings. When a medical professional gives the treatment to a harmed worker that meets the description in this definition, the case remains an FAC.
- 3.13 Commuting Accident:** An accident occurring on the direct way between the place of work and (a) the worker's principal or secondary residence; (b) the place where the worker usually takes his or her meals; or (c) the place where the worker usually receives his or her remuneration, which results in death or personal injury involving loss of working time ([according to ILO](#)).
- 3.14 Occupational Disease:** An '**occupational disease**' is any disease caused primarily by exposure at work to a physical, organisational, chemical or biological risk factor or to a combination of these factors. Occupational diseases are mostly those listed in the relevant OHS regulatory guidelines, as resulting from exposure to risk factors at work. The recognition of an occupational disease may be linked to compensation if a clear causal link is established between an occupational exposure and the disease. ([according to EU-OSHA](#))
- 3.15 Work-related Disease** A '**work-related disease**' is any illness caused or made worse by workplace factors. This includes many diseases that have more complex causes, involving a combination of occupational and non-work-related factors ([according to EU-OSHA](#))
- 3.16 Occupational Injury:** Personal injury sustained from an occupational accident.
- 3.17 Occupational Fatality:** Death of a person directly attributable to an occupational injury (fatal injury) or occupational disease.
- 3.18 Root Cause:** An initiating event or failing from which all other causes or failings arise. This is always related to a management, planning, or organisational weakness or failure. Incident review processes must strive to identify the root cause, because if they do not, then there is a high likelihood of a repeat or similar event occurring in the future.
- 3.19 Third Party:** An independent person, company or agency that is not part of the organization capturing the data.
- 3.20 Third Party Incident:** It generally refers to incidents involving an Organization's equipment, transport, or premises, but the injured party is neither an employee nor a contractor. Incidents resulting in injuries, illnesses, or damages arising from people without contracts or no direct ties with the organization may be recorded as Third Party incidents. Community-related fatalities, linked to Organization's activities, may also be classified as third-party incidents.

04 OVERVIEW OF INCIDENT MANAGEMENT PROCESS

4.1 Overview

Incident management generally include the phases shown in Figure–1 below. The phases may be modified to fit the specific needs and approach of each UN agency. Importantly, the phases should support the implementation of the best practice principles of incident management outlined under section 4.2.



Figure–1 *Adopted from Australian Commission on Safety and Quality of Health*

4.2 Best Practice Principles of Incident Management

Incidents managed under these principles are more likely to be resolved with an acceptable outcome for all involved, and will reduce the risk of similar incidents occurring in the future.

<p>4.2.1 Transparency:</p>	<p>Providing an honest and open explanation of what happened, why it happened, and what actions have and will be taken to minimize impact and/or prevent recurrence.</p>
<p>4.2.2 Accountability:</p>	<p>Management have an accountability to prevent incidents, as far as reasonably possible. In the event of an incident, a system should be in place to ensure their prompt detection and reporting, immediate response, notification, and investigation, followed by subsequent OHS risk management process.</p>
<p>4.2.3 Management commitment:</p>	<p>Comprehensive health and safety policy supporting OHS incident management and resourcing are imperative to impactful incident management process.</p>

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4.2.4 Employee involvement:	Through employee involvement and engagement, a culture of awareness, recognition and reporting of incidents can be established. It enhances their overall appreciation of OHS risk management.
4.2.5 Open, fair and just culture:	UN agencies create a culture where everyone feels safe to report incident and participate in their investigation. Everyone involved in an incident is treated fairly in line with a just culture using a system-based approach.
4.2.6 Integration of lessons into organizational risk management:	The seamless integration of incident management into the overall risk management to continually improve workplace health and safety.

05 INCIDENT DETECTION & REPORTING

UN agencies, including contactors and their personnel, are required to report all hazards and incidents (including near misses) through [defined and communicated incident reporting channel](#). General routine maintenance on facilities that may pose a threat to OHS should be logged as a hazard or an incident.

06 RESPONSE AND NOTIFICATION

6.1 Immediate Response

- 6.1.1 Take immediate action to contain the adverse impacts of the incident, if safe to do so, and then make the workplace, equipment or building where the incident occurred safe. The priority is **people first, then the environment**, followed by other business continuity interest.
- 6.1.2 The responsible manager or supervisor or personnel in control of the area where the incident occurred shall ensure that personnel are safe and/or where applicable, activate the emergency response in accordance with the UN agency's emergency response plan and relative to the scale of the associated adverse event.
- 6.1.3 Personnel trained in first aid may administer first aid until the arrival of emergency services or other medical personnel. All injuries and illnesses shall be assessed promptly by the site medical personnel and if hazardous substances are involved, the Safety Data Sheet (SDS) should accompany the injured person to the medical clinic.
- 6.1.4 For incidents categorized as high or above, or as HPI or DO, or at the discretion of the Head of Agency or the designated official, the incident site and associated material shall be barricaded and preserved for investigative purposes.
- 6.1.5 Notification of incident to senior management and/or to regulatory authority must occur as soon as it is practicable, and in line with prescribed guidelines, through a defined channel, which may be an electronic notification or reporting platform, to the direct line manager accountable for the area. Clarification of which individual is accountable for the area of work is critical to the investigation and subsequent actions when addressing the hazard and/or incident.
- 6.1.6 Contractor companies are required to notify the relevant UN agency supervising officer of the incident as soon as possible.

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6.2 Initial Assessment

Following the notification, a supervisor or the person in charge will carry out an initial assessment of the incident and obtain some preliminary information and evidence. This may include but not limited to:

- 6.2.1 Obtain the details of all witnesses or involved parties. If possible, it would be good practice to separate the witnesses and obtain signed written statements from them as soon as possible, because witness accounts may change as they discuss the incident with others, and as time passes and some details are forgotten.
- 6.2.2 Examine the scene of the incident and take *photographs, videos, or sketches, measurements etc.* of the scene, and get the scene surveyed if required. The area around the incident may need to be secured or preserved by putting up barricades or caution tapes or other physical barriers to prevent people from walking into the area. Prohibiting access to the area helps to preserve the scene for investigation.
- 6.2.3 Take monitoring samples such as; *water or soil samples, air sampling, gas monitoring, surface wipes samples, etc.*, as needed.
- 6.2.4 The supervisor may require personnel involved in an incident to be tested for alcohol and/or other intoxicating substances, in line with procedures of the organization, and local national guidelines for testing intoxication substances and drugs of abuse. This procedure must be formulated under the Agency's legal counsel.
- 6.2.5 The supervisor shall also ensure immediate corrective actions to preserve the ongoing safety of the site.

6.3 Initial Incident & Hazard Documentation

- 6.3.1 Notification and documentation of all incidents into the UN organization's chosen electronic platform should be completed as soon as reasonably practicable. Line Management is accountable for the initial and subsequent documentation of the events. Initial reports must be logged by the end of the work day or no later than 24 hrs, and be detailed enough to facilitate understanding of the issues.
- 6.3.2 Each event must reach the 'Investigation' stage on submission, and completed by assigning it to the accountable person or supervisor or team (with a team lead).
- 6.3.3 Clarification of who is accountable for any particular workgroup or facility is paramount, so the appropriate person is notified of the assigned hazard or incident. The initial notification is ideally performed in person or electronically as part of the initial assessment and before entry into the recognized electronic platform.

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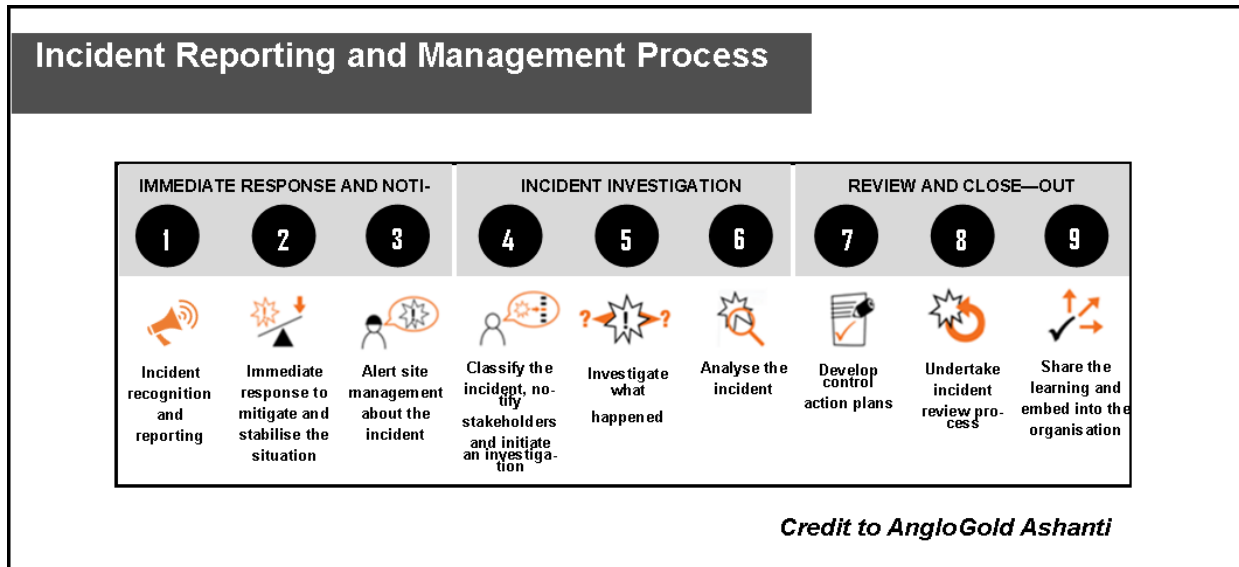


Figure-2

07 INCIDENT CLASSIFICATION

The two determinants of incident and hazard classification are:

- 7.1 **Actual impact of the incident**, which is determined by the actual loss or harm caused by the incident;
- 7.2 **Potential impact of the incident** as assessed by determining the most realistic and credible severest consequence of the incident should a critical control barrier or safeguard have failed.

The incident's **impact** and **risk** levels are determined by matrixes based on pre-defined loss or harm indicators under;

- (a) Occupational Health and Safety (OHS)
- (b) Environmental Impact
- (c) Reputational Damage
- (d) Legal and Regulatory Compliance Breach
- (e) Financial Loss
- (f) Social and Community Damage.

The incident could be classified based on its nature and applicable indicators under the six sub-headings above, and as shown in **annexes 1 & 2** into: **Extreme; Major; High; Moderate; Minor; and Insignificant**.

In instances where incidents classification or liability owner becomes unclear, or it involves third party as defined under sections 3.19 and 3.20 above, the incident investigation and review team are encouraged to seek legal advice from their organization's legal counsel.

It is also worth noting that an incident involving a worker may occur outside the normal working hours and/or usual workplace. In other instances, underlying conditions or other off-the-job exposures or acts may directly lead to harm in the organization's workplaces. In such cases, it may be necessary for the organization's OHS policy expert(s) to give a professional interpretation of whether the incident should be attributed to workplace exposure, and added to OHS performance statistics. Such an interpretation should be made after reviewing the incident investigation's findings.

Occupational Health and Safety Incident Management Guideline.

08 INVESTIGATION & ANALYSIS

An incident investigation aims to identify the root cause and other causative factors of the incident, and to establish appropriate corrective and preventive actions to avoid recurrence.

- 8.1 The incident investigation process needs to uncover the relevant contributing factors as, well as the root cause, understand their significance in contributing to this and other incidents, and know what is needed to be done to permanently fix them. The type and scale of the investigation will depend on the incident classification as shown in annexes 1 and 2.
- 8.2 For **Extreme, Major or High** Category incidents, a thorough and rigorous incident investigation is required. In this instance, an investigation team must be established, comprised of members relevant to the type of incident. This may include both site-based people and independent subject matter experts. The investigation process must be aligned to the relevant organisational incident investigation model, as depicted in Figures 3 & 4 below.
- 8.3 For **Moderate, Minor and Insignificant** Category incidents, an investigation of lesser complexity may be carried out in order to prevent recurrence of such incidents. The type and extent of the investigation will be at the discretion of senior management, who may decide that certain Moderate, Minor and/or Insignificant incidents should be investigated with the same rigour as an Extreme, Major, or High Category incidents.
- 8.4 The investigation of all incidents (**minor, moderate, or high**) should be led or sponsored by a supervisor or line manager, and should be supported by an OHS professional.
- 8.5 The investigation of incidents classified as **major or extreme** shall be led by a senior manager and supported by a team, of which the composition shall include an independent subject matter expert.
- 8.6 The findings of the investigation shall be documented, preferably, in the electronic incident record system:
 - (a) Minor and moderate incident investigation may use an adopted basic incident investigation model, maintaining the principles and elements of incident investigation, and to be completed within 14 days of the incident's detection.
 - (b) High, Major and Extreme Potential incident investigations require a more comprehensive report generated by the use of a thorough and more rigorous investigation models, such as the Root Cause Analysis model or the James Reason's Accident Causation models, etc. The completion days should not exceed 20 days or as prescribed by relevant regulatory body.
- 8.7 **Who should conduct an incident investigation?**

Ideally, an investigation should be conducted by a team of people who are;

- (a) experienced in incident causation models, some of which have been discussed under section 9.1 below,
- (b) experienced in investigative techniques,
- (c) knowledgeable of relevant legal or organizational requirements,
- (d) knowledgeable in occupational health and safety fundamental principles and operations applicable to the workplace,
- (e) knowledgeable in the work processes, procedures, persons, and industrial relations environment for that particular situation,
- (f) able to use interview and other person-to-person interactive techniques effectively (such as mediation or conflict resolution),
- (g) knowledgeable of requirements for documents, records, and data collection,
- (h) able to analyse the data gathered to determine findings, to reach conclusions, and to make recommendations, well able to establish corrective and preventive actions for avoiding re-occurrence of the incident, and
- (i) where applicable, to include technical task process experts and OHS professionals in the incident investigation team.

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8.8 What are the steps involved in investigating an incident?

- (a) Assign the incident to a responsible team via the organization's incident reporting platform.
- (b) Witness management (provide support, limit interaction with other witnesses, and conduct interviews as needed).
- (c) Complete data collection process.
- (d) Analyse the data, identify the root cause(s) and other contributing factors.
- (e) Report the findings and recommendations.

Competent management personnel, acting as reviewer, should review the incident investigation report and recommendations to ensure completeness. The following actions would be ensured;

- (a) Develop a plan for corrective action and preventive actions (CAPA).
- (b) Implement the plan.
- (c) Evaluate the effectiveness of the implemented CAPA.
- (d) Make changes, if required, for continual improvement.

It is generally recommended that, as far as reasonable and practical, very little time is lost between the moment of an incident and the start of the investigation. In this way, one is most likely to observe the conditions as they were at the time, prevent contamination of evidence, and identify witnesses.

8.9 Why look for the root cause and other contributing factors?

Even in the most seemingly straightforward incidents, seldom, if ever is there only a single cause. Determining the root cause(s) and other contributing factors reveal unsafe conditions and acts that are open to corrections.

For example, an "investigation" which concludes that an incident was due to a worker's carelessness, and goes no further, fails to find answers to several important questions such as:

- (a) Was the worker distracted? If yes, why was the worker distracted?
- (b) Was a safe work procedure being followed? If not, why not?
- (c) Were safety devices in order? If not, why not?
- (d) Was the worker trained? If not, why not?

8.10 How are the evidences collected?

Generally, the steps in the investigation include: investigation team formation, data gathering and analysis, reporting on the findings, conclusions and recommendations for OHS improvement. Sources of evidence and ways they are collected include:

Physical Evidence

Some physical evidences that might need to be preserved or recorded in good time to aid the investigation may include;

- positions of injured workers
- equipment being used
- products being used
- safety devices in use
- position of appropriate guards
- position of controls of machinery
- damage to equipment
- housekeeping of area
- weather conditions
- lighting levels
- noise levels
- time of day

The preservation may be done by taking photographs, videotapes, sketches, or even physical barricading to prevent unauthorized access.

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Witness Accounts

Accounts of witnesses are a vital piece of evidence for investigation. Often, however, witnesses may be under severe emotional stress and fear, which could affect the quality of evidence they provide. The use of the right interview technique, allaying their anxiety and providing balanced reassurance are key to obtaining acceptable quality of information. Training of investigators on interview techniques should be considered as part of the incident investigation upskilling in the UN agency.

The purpose of the interview is to establish an understanding with the witness and to obtain, in their own words, the description of the event:

DO...

- (a) put the witness, who is probably upset, at ease
- (b) emphasize on the real reason for the investigation; which is to determine what happened, how it happened, and why it happened, in order to plan and implement corrective and preventive actions to forestall re-occurrence
- (c) let the witness talk, listen
- (d) confirm that you have the statement correct
- (e) try to sense any underlying feelings of the witness
- (f) make short notes or ask someone else in the team to take them during the interview
- (g) ask if it is okay to record the interview, if you intend to do so
- (h) close on a positive note

DO NOT...

- (a) intimidate the witness
- (b) interrupt
- (c) prompt
- (d) ask leading questions
- (e) show your own emotions
- (f) jump to conclusions

Ask open-ended questions that cannot be answered by simply "yes" or "no". The actual questions you ask the witness will naturally vary with each incident, but there are some general questions that should be asked each time:

- (a) Where were you at the time of the incident?
- (b) What were you doing at the time?
- (c) What did you see or hear?
- (d) What were the work environment conditions (weather, light, noise, smell, etc.) at the time?
- (e) What was (were) the injured worker(s) doing at the time?
- (f) In your opinion, what caused the incident?
- (g) How might similar incidents be prevented in the future?

Asking the right questions is a good approach to establishing what happened. But, care must be taken to assess the accuracy of any statements made in the interviews.

Another technique sometimes used to determine the sequence of events is to re-enact or replay them as they happened. Care must be taken to avoid further injury or damage. A witness (usually the injured worker) is asked to re-enact in slow motion the actions that happened before the incident.

Other Information

Data can be found in documents such as technical data sheets, health and safety committee minutes, inspection reports, company policies, maintenance reports, past incident reports, safe-work procedures, Safety Data Sheets (SDS), and training reports.

8.11 Information to be gathered for the incident analysis and recommendations

At this stage of the investigation most of the facts about what happened and how it happened should be known. This data gathering must have taken considerable effort to accomplish but it represents only the first half of the objective. Now comes the key question - why did it happen?

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Keep an open mind to all possibilities and look for all pertinent facts. There may still be gaps in your understanding of the sequence of events that led to the incident. You may need to re-interview some witnesses or look for other data to fill gaps in your knowledge.

When your analysis is complete, write down a step-by-step account of what happened (the team's conclusions) working back from the moment of the incident, listing all possible causes at each step. This is not extra work, it is a draft which will serve a purpose in the final report writing. Each conclusion should be checked to see if:

- it is supported by evidence
- the evidence is direct (physical or documentary) or based on eyewitness accounts, or
- the evidence is based on assumption.

This list serves as a final check on discrepancies that should be explained.

8.12 How should recommendations be made?

The most important final step is to come up with a set of well-considered recommendations designed to prevent recurrences of similar incidents. Recommendations should;

- (a) be specific and realistic
- (b) be constructive
- (c) address root causes
- (d) address contributing factors
- (e) overall, to ensure that a similar incident does not reoccur

Avoid making general recommendations to save time and effort. For example, you have determined that a blind corner contributed to an incident. Rather than just recommending "eliminate blind corners" it would be better to suggest:

- (a) install mirrors at the northwest corner of building X (specific to this incident)
- (b) install mirrors at blind corners where required throughout the worksite (general)

Note: Do not rush to assign blame. Recommending specific disciplinary action in the investigation report is not advisable and may jeopardize the chances for a free flow of information in future investigations. However, repeated negligent breaches of OHS standards should be addressed using the UN Agency's code of conduct before they result in a catastrophic incident. Therefore, it may be necessary in some cases to indicate that deliberate repeated violations shall be referred to the relevant sections of the UN Agency's code of conduct..

In the unlikely event that you have not been able to determine the causes of an incident with complete certainty, you probably still have uncovered weaknesses within the process, or management system. It is appropriate that recommendations be made to correct these deficiencies.

The Written Report

The software adopted by the organization for incident management may be used to prepare the report, highlighting on: what happened, how it happened, why it happened, what were the root causes and other causal factors, as well as recommended corrective action and preventive actions (CAPA) to avoid recurrence. In the absence of such software, the documented sequence of events from the incident reporting and investigation should be used to generate the report.

In preparing your report, it is important to use evidence from photographs, witness accounts, documentary facts, and laboratory tests of air, water, and/or surface wipe samples, as well as medical or toxicological investigations of biological samples of affected victims or persons.

The report should be well concluded, providing recommendations on CAPA. The report should be shared with personnel, supervisors and management, following the organization's communication guidelines.

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8.13 What should be done if the investigation reveals human error?

Should a thorough incident investigation identify human factors as contributing causes of the incident, then this fact should be pointed out, irrespective of the involved individual(s), management, supervisors, and/or the workforce. Failure to point out human failings that contributed to an incident or focus on human factors alone will not only downgrade the quality of the investigation, but it may lead to recurrence. It is advised to make recommendations regarding the different ways to address human errors. However, even though disciplinary actions are also part of ways to deal with some human errors, in particular of deliberate rule-breaking type, the OHS investigation team within the limits of the UN Agency's code of conduct may recommend specific disciplinary action. Disciplinary steps should be taken within the UN Agency's code of conduct by the relevant authorities of the organization.

8.14 How should follow-up be done?

Management is responsible for acting on the recommendations of the investigation report. The health and safety committee or representative, if present, can monitor the progress of these actions. Follow-up actions include:

- (a) Review the report to ensure alignment with UN Agency's recognized standards.
- (b) Respond to the recommendations in the report by explaining what can and cannot be done (and why or why not).
- (c) Monitor to ensure that the scheduled actions have been completed.
- (d) Check the condition of injured worker(s) and progress of recovery and return to work as applicable.
- (e) Educate and train other workers at risk.
- (f) Re-orient worker(s) on their return to work.
- (g) Closure of incident once action plan has been executed.

09 INCIDENT CAUSATION (INVESTIGATION) MODELS

This guideline recommends three main incident investigation models for consideration:

- (a) The Root Cause Analysis (RCA) Model
- (b) The James Reason Accident Causation Model
- (c) Simple Causative Model

Although there are several tools for conducting the RCA, three of the most common ones are discussed in this guide.

9.1 Root Cause Analysis Model

9.1.1 What is Root Cause Analysis?

A root cause is the most basic underlying issue that led to the incident or non-conformance. Root Cause Analysis (RCA) is a structured methodology that uses different tools and techniques to identify the root cause and answer three critical questions:

- (a) What happened?
- (b) Why did it happen?
- (c) How do we prevent it from happening again?

Identifying and eliminating the root cause of an incident or non-conformance should permanently prevent re-occurrence.

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9.1.2 How do you conduct a Root Cause Analysis?

- (a) Define the problem - determine exactly what the problem is and how it affects the operations of the Organization.
- (b) Gather information, data and evidence.
- (c) Identify all issues and events that contributed to the problem - brainstorm and make a list of all potential causes and how they may have resulted in the incident or non-conformance.
- (d) Determine root causes.
- (e) Identify recommendations for eliminating or mitigating the reoccurrence of the incident or non-conformance.
- (f) Implement the identified solutions.

9.1.3 Some Common Tools for Conducting Root Cause Analysis

Several effective methods exist for analysing and determining the root cause of an incident or a non-conformance. Three of the commonly applied methods include:

- (a) The 5-Whys (Why-tree) method of root cause analysis is done by repeatedly asking the question “Why” (five is a good rule of thumb), to peel away the layers of symptoms which can lead to the root cause of a problem. Very often, the apparent reason for an incident will lead you to another question. Although this technique is called “5-Whys,” you may find that you might need to ask the question fewer or more times than five before you find the root cause of the incident or non-conformance.
- (b) A fishbone or Ishakawa diagram is used to analyse more complex problems to find their root cause. It identifies and sorts possible causes into various categories, which are then enhanced with additional information related to that cause. This continues until a root cause is determined.
- (c) A Pareto Analysis follows the principle that 80% of all outcomes (i.e., incidents or non-conformances) can be attributed to only 20% of causes. This 80/20 rule charts the most common causes of issues in a histogram in descending order along with a line graph showing their cumulative totals. This simple quantitative visualization helps you identify which issues cause the most incidents.

Illustration of the “Why-tree” or “5-Whys”

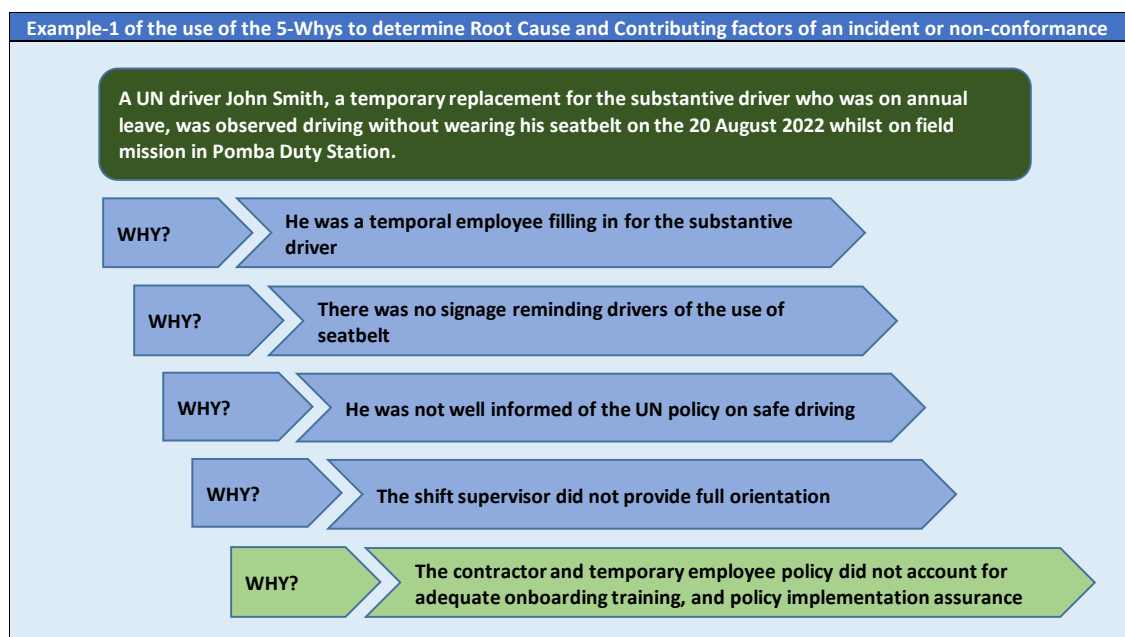


Figure-3

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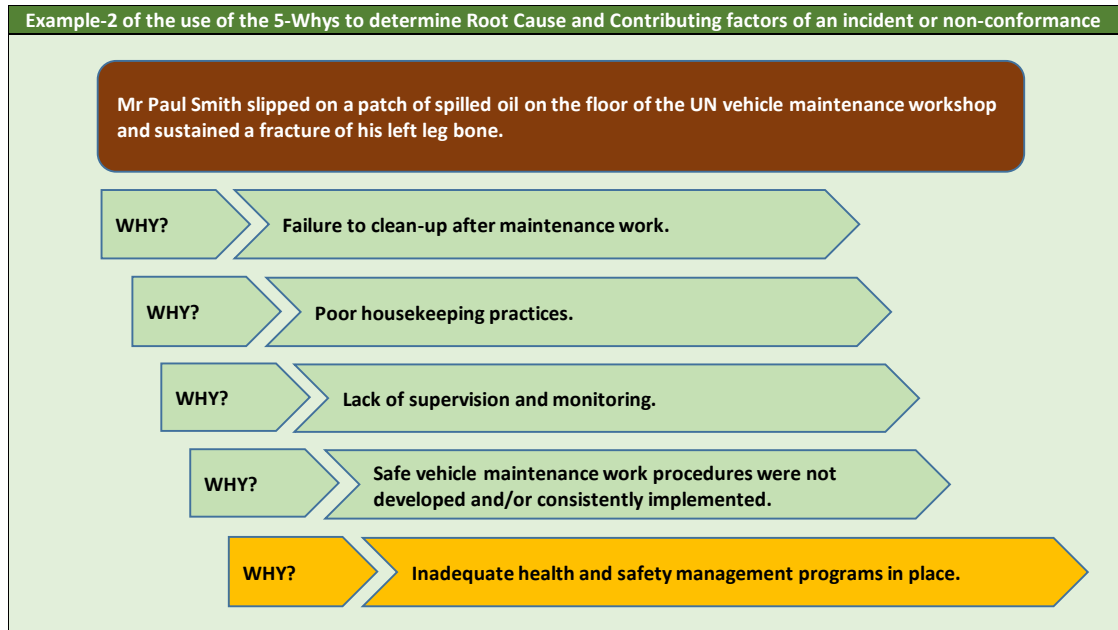


Figure-4

In incidents where there may be more than one root causes, the chart in annex 6 may be employed in the analysis.

9.2 James Reason's Accident Causation (Investigation) Model

9.2.1 This model can be used as a constructive tool to identify underlying cause(s) and contributing factors of an incident.

Reason's framework is a useful model for investigating high, major and extreme category incidents. The framework further shows that:

- (a) For hazards to cause an accident there must be absence or failure of defences.
- (b) To effectively prevent incidents, the control defences or barriers are to be;
 - multiple and complementary in their control effectiveness
 - designed and implemented in a way that the weaknesses in each control barrier do not align

Defences preventing incidents may fail due to a combination of:

- (a) **Latent conditions** inherent in the Organizational Factors and/or Local Workplace Factors. Latent conditions may be due to: policy and work procedure development and implementation issues, uncontrolled work environment, scheduling problems, inadequate training, weak resourcing, etc.;
- (b) **Active failures** are usually errors and violations at individual levels, which contribute to an incident.

According Reason's model, mostly, **Latent conditions** cause or contribute to **Active failures**. The incident causation and investigation pathways are shown below, as modelled by James Reason.

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James Reason’s Accident Causation (Investigation) Model

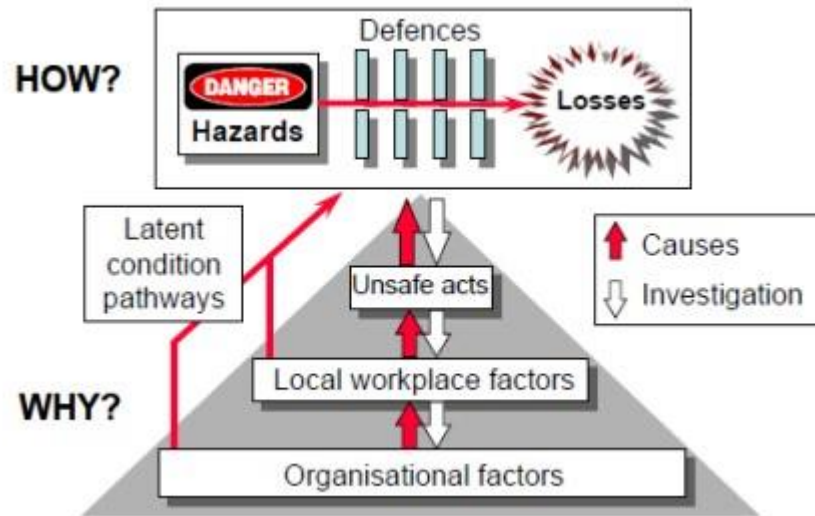


Figure-5: Credit to AngloGold Ashanti

9.2.2 Find a quick guide in annex 3 on “*HOW and WHY* did the incident occur,” and in annex 4 on “*some likely recommended actions to target.*”

9.3 Simple Causative (Investigation) Model

A more simplified or modified method may be employed to undertake the analysis of the incident. In the investigation of the events leading up to an incident, there will be a number of basic factors to consider that are important in determining causation. The basic factors comprise of elements which must exist to enable the sequence to continue, and hence the damage to occur. These elements contribute to all incidents. In conducting an effective incident investigation, it is essential to look for each of these components and not to look for any single cause:

- (a) **Design Factors** – poor systems design may result in exposure to hazards such as unguarded dangerous parts of machinery, ineffective safety devices or inadequate ventilation.
- (b) **Environmental Factors** – The production system environment has a direct effect on safety behavior. How people function in the work environment depends on what they experience in it. The environmental factors may be both physical and psychosocial.
- (c) **Behavioral Factors** – behavioral factors can result in exposure to hazards. Examples of behavioral factors are the misuse of safeguards, the improper use of tools and equipment, ignoring cautionary notices, failure to wear personal protective equipment, horseplay or poor standards of housekeeping.

The reasons that lie behind the disregard for accepted safe systems of work and safety practices, procedures or rules are to be fully examined.

The Incident Cause Analysis Method (ICAM) template in annex 7 may be employed.

10 MANAGEMENT REVIEW & CLOSURE

10.1 Review

Once the investigation is completed, a designated Senior Manager or OHS Manager should review it to ensure all steps have been followed and the outcome is of good quality.

The designated Senior Manager or OHS Manager may review and recommend classification changes to the investigation team / head of concerned department, and then, if necessary, escalate to the Head of Agency and be accountable for the relevant notifications internally and to external agencies.

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The OHS manager and an executive level manager will review all High, Major and Extreme Potential Incidents investigated.

For all Significant Incidents and High Potential Incidents, an incident follow-up review date shall be set for one week post the longest action due date for the team to review the progress and effectiveness of implemented actions.

10.2 Closure

An OHS professional or manager shall verify actions completed prior to submission for event closure. Events are not to be closed until all actions assigned are completed and verified.

The Manager shall close an event only if satisfied with the level of investigation, and convinced that the controls in place are at a level able to prevent or reduce the likelihood of incident re-occurrence.

Should the Manager not be satisfied, they will advise on expected further actions.

On closure, the event will move from Review to Closed.

11 ELECTRONIC INCIDENT REPORTING PLATFORMS

A number of effective digital applications or software can be used for OHS incident management in the workplace. An effective digital solution is user-friendly and enables: easy incident reporting from anywhere, seamless analyses and reviews, as well as further risk management actions.

Workstream 3 of the OHS Forum recommends that individual agencies consult their ICT services to decide on the digital technology that meets their requirements.

In no specific preferential order, the list **11.1 through 11.10** provides some of the solutions on the market that may support individual agencies in deploying and maintaining an incident management program within their Organization. Almost all the applications listed below provide modules for managing Occupational Environment, Health, Safety and Quality (EHSQ) management programs.

	Software Company	UN Organizations using the application	Link to the website
11.1	CORITY / EarthMed	UNS, UNHCR, WFP, FAO, IFAD	Website link
11.2	KPA EHS Software		Website link
11.3	INTELEX		Website link
11.4	EHSInsight		Website link
11.5	SAP EHS Management		Website link
11.6	Enablon EHS management software		Website link
11.7	ISOMETRIX		Website link
11.8	Vector Solutions		Website link
11.9	Walters Kluwer		Website link
11.10	OSH-RS Mobile/Web Application	UNDP / UNGSC	Website link

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12 INCIDENT VISIBILITY, TRENDS AND ANALYTICS

- 12.1 The Organization should compile and analyse incident database. An OHS Incident database that has been well classified and analysed over time provides reliable predictive EHS indicators for preventing future incidents, supporting in maintaining safer workplaces, and for making better business decisions.
- 12.2 The Birds triangle, as illustrated in figure-6 below, provides insight into the relationship between different OHS incidents. If unsafe acts and near misses builds up unchecked and unaddressed, it means a major incident or fatality is looming.

Birds triangle illustration of incident classification relationships

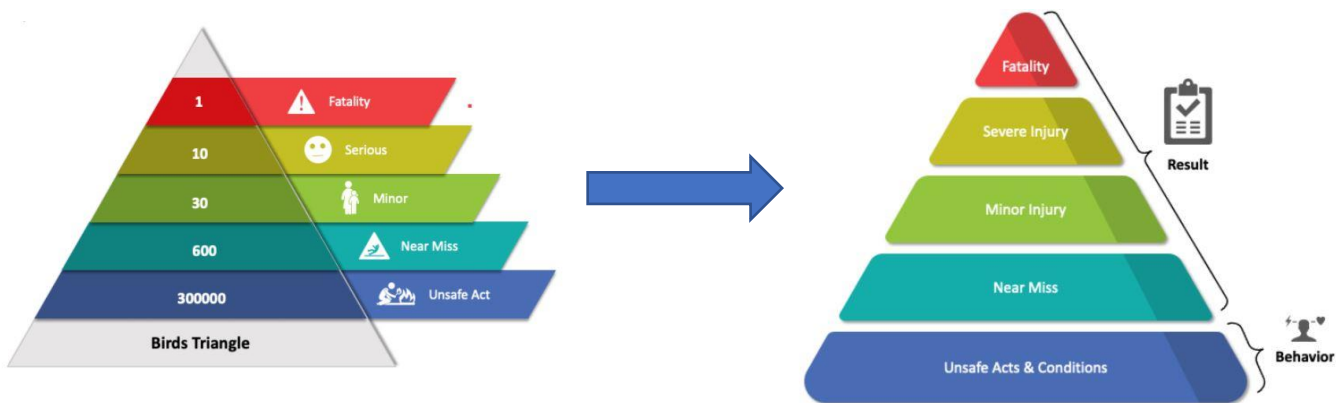


Figure-6

Credit to Sketchbubble.com

13 COMMUNICATION AND LESSONS SHARING

- 13.1 The key learning points from the incident and its management must also be shared with site personnel (as appropriate) and within the organization, if common interests exist.
- 13.2 The sharing of lessons learnt do not need to include the names of the personnel involved, but rather the relevant content of the incident. The OHS Department shall ensure that all incidents and the lesson learned shall be discussed during relevant OHS meetings.
- 13.3 The OHS Manager or focal point shall select incidents with high significance from sister Agencies and shall communicate control actions and lessons learned to all employees. Such communication should be done in a format and mode agreed upon in the organization.

13 ROLES AND RESPONSIBILITIES

The guideline recommends below as the roles and authorities that may be used in the incident management workflow of the chosen electronic platform.

13.1 Incident Reporter:	An individual or group of personnel who identify and reports an incident or a hazard. All personnel and contractors are encouraged to report incidents and hazards in the workplace.
13.2 Incident Creator / Notifier:	An individual who reports the incident through the process defined by the organization, which may include platforms such as the UN Agency's chosen electronic incident management software, and ensures that relevant notification in line with the requirements of annex-1 is done

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13.3 Incident Investigators:	The constituted team that carries out the investigation of the incident based on the magnitude.
13.4 Incident Reviewer:	Members of this group have the authority to review the notified and investigated incident to ensure all elements have been duly completed.
13.5 Action Manager:	The action manager has the responsibility to ensure that the actions recommended have been implemented and the incident is closed.

14 OCCUPATIONAL HEALTH AND WORK-RELATED MENTAL HEALTH INCIDENTS

14.1 Occupational Health Incidents

Occupational health incidents may be categorised into, or emerge from;

- (a) Newly recognized reportable or significant health hazard
- (b) Occupational hygiene exposure monitoring or assessment finding
- (c) Newly diagnosed occupational disease or work-related disease

Sections 3.14 and 3.15 of this guideline provide the definition and the difference between “*occupational disease*” and “*work-related disease*.”

(a) Newly recognized reportable or significant health hazard

Reporting of certain health hazards may be required by local OHS legislation of the duty station’s host country, e.g. asbestos exposure, hazardous chemical substance, ionizing radiation, etc. Refer to annex-5 for classes and examples of commonly encountered occupational health hazards.

All newly recognised reportable or significant health hazards, not documented in the organization’s risk register and controlled through the organization’s established risk management process, are to be investigated, eliminated or adequately controlled to protect personnel’s health. This should be done using the principles of OHS incident management and the hierarchy of OHS hazard control.

(b) Occupational hygiene exposure monitoring or assessment finding

Depending on the type of industry, the OHS risk profile of the organization, and the OHS programs of the UN Agency, certain health hazard monitoring and/or planned occupational hygiene assessments may need to be carried out.

An OHS incident would be considered to have occurred if occupational hygiene monitoring or assessment finds a new significant hazard or overexposure of personnel to a recognized hazard, above the standard permissible or occupational exposure limit (PEL / OEL) subscribed to by the UN Agency or as required by the national OHS regulation. Such OHS incident should activate the UN Agency’s incident management process. Example, when personnel noise exposure reaches or exceeds 85 decibels (dBA) averaged over 8 working hours (TWA), or for radiation workers, when the annual total effective dose equivalent (TEDE) exposure for the whole body reaches or exceeds 5,000 mrem (5 rem). This would constitute an OHS incident, which would need to be investigated, the root cause determined and remedial action implemented to forestall recurrence. The health of the individual would need to be monitored, in line with standard occupational medicine practice, to ensure that such exposure does not lead to work related disease.

The [ILO recommends](#) the most widely used occupational or permissible exposure limits (OEL / PEL), also called threshold limit values (TLVs) issued and periodically reviewed by the American Conference of Governmental Industrial Hygienists (ACGIH). In a country where such standard limits do not exist, the ACGIH promulgated limits may be used to assess the effectiveness of health hazard exposure controls. The ACGIH limits for virtually all classes of health hazards may be [obtained here](#) at a small fee.

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(c) Newly diagnosed occupational disease or work related disease

A diagnosed occupational disease or work related disease constitute an OHS incident, which indicates that a hazard control defence has failed or malfunctioned. This is normally diagnosed through the employee medical surveillance program, or at a hospital by a physician who establishes a scientific link between workplace hazard exposure and the disease. An example is a worker diagnosed with Noise Induced Hearing Loss (NIHL) after working for many years in a high noise zone.

Diagnosis of work related disease or an occupational disease should call for incident investigation to understand the root cause, including defences that may have failed, as well as the effectiveness of the existing medical surveillance program.

Organizations, as part of their risk management program, are to determine all health hazards to which employees are exposed, to control the hazards adequately, and to implement a system of medical surveillance. Absence of a well planned and implemented occupational health program constitutes a risk for the organization.

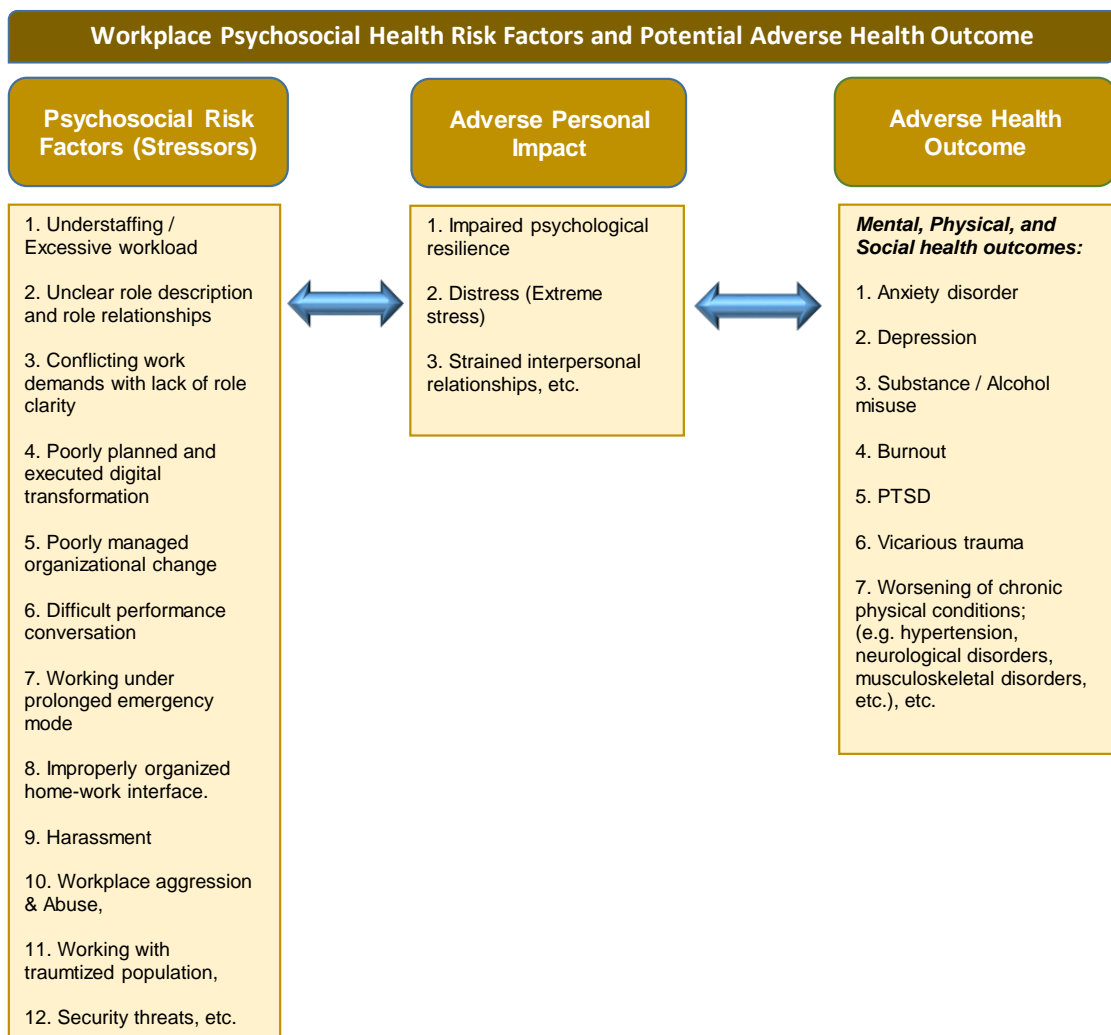
14.2 Managing workplace psycho-social risks

ISO 45003:2021 provides guidelines for managing psychosocial risks within occupational health and safety (OH&S) management system based on ISO 45001-2018 standard. It enables organizations to prevent work-related injury and ill health of their workers and other interested parties, and to promote personnel mental well-being at work.

Organizations are faced with stress risk factors (stressors) in the workplace, which if not well managed may lead to distress (stress level exceeding the individual's coping abilities), and sometimes, eventually leading to: mental, physical and social adverse health symptoms, such as: burnout, insomnia, substance abuse, hazardous/harmful drinking, and worsening of chronic physical diseases or mental health conditions such as an anxiety disorder, depression, etc.

Psycho-social risks can impact on the mental health of personnel, and lead to mental health incidents, which is when psycho-social risks have an adverse effect on the mental health of personnel. Where psycho-social risks have an adverse effect on the mental health of personnel, interventions may be focussed on the stressor, impact or the adverse health outcome (see figure-6 below). Under the guidance of a professional psychologist/counsellor and/or OHS expert, the scoping may include only part of the elements shown in figure-6 or all of them. The primary goal is to understand; *what happened, why it happened, how it happened, and to come up with actions to minimize impact and prevent re-occurrence of the impact on the mental health of the personnel impacted.*

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Adapted from; [Hassard, J., Cox T. \(26 January 2015\), OSH-Wiki & \[EU-OSHA\]\(#\)](#)

Figure-7
Recognition, reporting and management of work-related mental health incidents

The stigma associated with mental health today requires that incidents resulting from psycho-social risk factors be managed with the utmost respect for confidentiality and privacy. In implementing incident management principles to prevent re-occurrence of the impact of psycho-social risks, and ultimately promoting decent and conducive work environment, confidentiality and privacy requirements are imperative.

Some factors to consider when designing the management of psycho-social risks may include;

- (a) The detection, reporting, investigating, and reviewing of work-related mental health incidents must be protected and done in strict confidence. Access right must be given to only specifically trained professionals in the medical and counselling units who have health confidentiality agreement with personnel.
- (b) Personnel are to be educated to understand the confidentiality controls applied, and their effectiveness to build trust and promote collaboration.
- (c) Work-related mental health incident management software must be designed with the necessary protection features to ensure utmost confidentiality and privacy rights.

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15 OHS INCIDENT MANAGEMENT IN THE CONTEXT OF HOME-BASED (REMOTE) WORKPLACE

The workplace has evolved beyond the traditional office locations to now include working from home, within or outside of the duty station. Personnel working from remote locations, with the organization's approval, may encounter hazards that could result in incidents. The organization should establish a risk-based process to determine which hazards and incidents would be considered as service incurred, in the context of the new working modalities, and building on the ILO definition stated under 3.13. The lack of managerial oversight on accommodations not provided for personnel would, however, limit the employer's ability to effectively control OHS hazards and reduce risks in private home-based or remote workplaces of personnel. The process below is recommended as a general guide for individual agencies to consider when redefining the scope of their occupational health and safety incident determinants, in light of the expanded work environment.

15.1 OHS Risk Assessment of home-based (remote) work environment

A Workplace Risk Assessment and Control (WRAC) should be carried out, now including remote working modalities to generate a revised OHS risk register of the organization. The new risk register must now include potential hazards and their risks in remote working environment that may harm employees during defined working hours or recognized flexibility limits. The OHS Forum recommends the inclusion of input from the organization's human resources experts, the policy office, and the legal counsel, etc. in the finalization of the risk assessment. The workplace risk assessment should be a dynamic process, taking into account relevant current information and data. Additionally, the risk assessment should take into consideration the specific vulnerabilities of certain groups of workers, such as pregnant women, personnel with babies and young kids, people with disabilities, and those with chronic medical conditions.

15.2 Redefining Service Incurred Injury, Illness, and death in the context of the new working modalities

The outcome of the risk assessment should inform a possible redefinition of liability for OHS incidents in the entire workplace, including office and remote work environments.

15.3 Incident reporting, investigation, and implementation of lessons learned

Employees should be trained and encouraged to report incidents (including near misses) whilst performing duties under authorized remote working modality. Such incidents should be managed under the same principles as outlined in this guideline with the goal of continually improving the workplace health and safety conditions.

15.4 Some likely Challenges/Hazards encountered under home-based (remote) working conditions and suggested control measures

	Hazards / Challenges		Potential adverse events	Recommended Controls	
People	1	Feeling of isolation (barriers to building rapport and community)	Mental, Social and Physical health & safety issues.	1	Promote inclusive and caring culture that increases social interaction within the team
	2	Reduced team cohesion		2	Allow for flexibility, including childcare
	3	Work and personal life interface challenges		3	Use one-on-one catch-ups to guard against demoralization
	4	Loss of in-presence team interaction		4	Set clear direction; lead rather than micromanage
	5	Inappropriate home-based workstation	Reduced productivity	5	Provide information on available psychological and social services, including provisions at work to address harassment and bullying.
	6	Violence and harassment (including cyberbullying)		6	Ergonomic workstation assessment program
	7	Difficulty disconnecting from work			

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Structure	1	Amplification in the lack of clarity		1	Set clear objectives and KPIs
	2	Difficulty in navigating organization		2	Establish clear delegation of authority and decision-making structures.
	3	Inefficiencies in decision making		3	Define and embrace new routines and new norms
	4	Disturbed office-based flows and rhythms			
Process	1	Unaligned priorities		1	Select the right and familiar digital channel for communication
	2	Inefficient use of digital communication tools		2	Provide opportunities for training and learning to adapt to the new realities
	3	Challenges in ownership of content and progress			
Technology	1	Limited access to co-creation and process management tools		1	Ensure fast stable and secure internet connections
	2	Unfamiliar digital tools, platforms, and processes		2	Provide access to VPN
Physical (Home-based workplace)	1	Hazards associated with home-based physical environment not under the control of the organization's facility services, such as; <ul style="list-style-type: none"> (a) Slip and trip hazards, (b) Fire or electrical hazards, (c) Uncontrolled room temperature, (d) Poor indoor air quality, (e) Lack of ventilation (natural or mechanical), (f) Ergonomics, Lighting, etc. 		1	Clear communication of OHS risks in home-based workstations and support facilities available to control the hazards, lower their risks and prevent harm. This may include systematic and periodic education on measures to control common health and safety hazards at home.

The measures to control identified hazards and their risks should be planned and implemented following the principles of the “hierarchy of hazard controls,” including: *elimination, substitution, engineering controls, administrative controls* and finally, *personal protective equipment (PPEs)* usage. Implemented hazard controls should be reviewed and maintained periodically to ensure they are working as intended.

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15 ANNEXES

Annex 1

Requirements and time frame for notification, investigating and reporting the incidents and hazards

Assess			Notify				Investigate			Report	
Potential Impact Level	OHS or Financial Loss	Environmental Damage	Who by	Who to	How	When	Who	Type	How	By When	
EXTREME	Multiple Fatality or >\$20 million loss	Extreme environmental effect with impairment of ecosystem function. Long-term, widespread effects on a significant area	Direct Supervisor, Dept. Manager, UNRC Country Rep Director	Dept. Manager OHS / HSEQ, UNRC, DG / President of the Agency, Executive Director of the Agency, Regulatory Compliance Office.	In-person or Phone Call or Prescribed forms or manner.	Immediately, and not exceeding 24 Hrs after informing the regulatory compliance office	Appointed by Head of Agency or Designate	Recommended Team Composition: Led by Snr Mgt. Rep., Members- RC / UNCT Rep., OHS / HSEQ / Safety Officer Independent Technical Specialist, Concerned Employees, ERT / Med Officer	As per the Incident Management Group Procedure and site Incident Reporting Investigation Procedure Utilising any of the models below; (a) James Reason's Model (b) Root Cause Analysis (c) The 5-Whys / The Why-Tree (d) Basic Model (annex-4)	Preliminary Findings /Interim Report, and then Final Report to; DG / President of UN Agency & Regulatory Agency	Within 20 working days or as defined by regulatory body.
	Fatality/ multiple disablement/ occupational disease cases or \$5m – \$20 million loss	Serious environmental effect with some impairment of ecosystem function. Relatively widespread, medium-long term impact.	Occupational Health and Safety / Health, Safety, Environment, and Quality (OHS / HSEQ) Department							Preliminary Findings /Interim Report, and then Final Report to; DG / President of UN Agency & Regulatory Agency	Within requested timeframe advised by regulatory body or Within 20 working days.
Where the incident has resulted in an actual impact as described above			UN RC or Snr. Manager.	DG / President of UN Agency or Delegated Snr Manager	Personally or Videocon.	Within 24 Hrs					

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Annex 2

Incident Level Definitions

		Actual Impact Level	Health & Safety loss	Environmental damage	Financial loss (USD)	Reputational damage	Legal & regulatory issue	Social & community damage
Involve Corporate ERM Office	Notification within 24 Hrs	Extreme	Multiple fatalities	Extreme environmental effect with impairment of ecosystem function. Long-term widespread effects on significant area	>20m	Extreme international public / media outcry/ Damaging NGO campaign. Social / legal licence to operate severely threatened.	Loss of host Government's permit to operate in-country. Significant fine / imprisonment.	Extreme widespread social impact. Irreparable damage to highly valued cultural heritage.
		Major	Fatality multiple disablement / occupational disease	Serious environmental effect with some impairment of ecosystem function. Relatively widespread	5m – 20m	Serious adverse national media / public / NGO attention. Social / legal license to operate questioned	Major breach of regulation / major litigation	Persistent social issues. Serious damage to / infringement to valued cultural heritage.
		High	Permanent disability	Significant effect on biological or physical environment not affecting ecosystem function. Significant short-medium term widespread impact.	1m – 5m	Concerted attention from media & / or heightened community concern.	Serious breach of regulation with report to authority.	Ongoing social issues. High damage to valued cultural heritage.
	Notification within 48 Hrs	Moderate	Temporary disability	Moderate effect on biological or physical environment. Moderate, short-medium term damage to minimal low significance area.	100,000 – 1m	Moderate, adverse local public media attention / complaints	Minor legal issue / non-compliance / breach of regulation.	Moderate medium-term social impact on local population. Moderate damage to heritage.
		Minor	Medical treatment case	No lasting effect / low level impact on biological or physical environment. Minor damage to small significance area.	10,000 – 100,000	Public concert restricted to local complaints. On-going regulator scrutiny / attention.	No legal issue / but breach of company guidelines	Low- level social or cultural impact. Minor repairable damage to commonplace structures.
		Insignificant	No injury	Negligible	<10,000	Negligible		

Annex 3

HOW and WHY did the incident occur?

INCIDENT MANAGEMENT (INCIDENT INVESTIGATION)		QUICK GUIDE	
HOW and WHY did the incident occur? From the description of what happened, what were the absent or failed controls, what were the contributing factors to the incident and which Safety Guiding Principles failed, the team will be able to find the underling and contributing causes.			
Absent / Failed defences (barrier analysis)		Contributing factors (events & conditions, behaviours analysis, change analysis, why tree)	
Group	Organisational culture; Management decisions; Working hours / rosters; Resourcing – people / equipment / infrastructure / supervision; Management systems;	Individual factors	Actions – what someone did or did not do (act or omission) (ed.) Unfit for work, not using PPE, not following the procedure, not doing a SLAM / JHA, taking a short cut, improvising, horseplay, task assignment / task execution. <i>(from change analysis and behaviour analysis)</i>
Technical	Guarding / barricades / delineation; Alarms & warning systems; Access equipment; Safety equipment; Design; PPE.	Workplace factors	Conditions (from events and conditions chart, change analysis) – (e.g.) wet / hot / cold / windy; uneven surface; confined / congested / restricted; lighting / noise / dust; time pressure / deadline; housekeeping; availability of tools / equipment; visibility; work above / below; access & egress.
Administrative	Procedures; Training; Signage / Labelling; Inspections; JHA / SLAM / Take5 (not used, not effective).	Organisational factors	Management system failures / underlying root causes (from why tree or 5-whys)
People / Individual	Competency; Behaviours (enabled / difficult / impossible to do right thing?); Values; Accountability.	Which safety guiding principle(s) failed? Please tick ✓	We set clear accountabilities for health and safety
			We understand and manage hazards and risks
			We engage our workforce in all aspects of their work
			We support the actions of our team members by providing the necessary resources to complete their work
			We have relentless and broad commitment to Safety
			We develop a learning culture where we remain open to new possibilities

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Annex 4

Some likely recommended actions to target.

Recommended Actions to Target		Responsible manager	By who	By when
Organisational actions	Provide safe systems of work			
	Organizational structure, formal appointments, accountabilities, authorisations, training programs / information management			
	Review managements systems: Risk & change mgt / preventative maintenance / fleet management / Business Process Framework / Contractor Management / Emergency management / chemical management / Fitness-for-Work & fatigue management / procurement & supply etc.			
	Cultural Climate Survey; Communication & consultation			
Workplace actions	(Provide competent people, fit-for-purpose equipment and processes, as well as well-controlled environment to enable safe work)			
	Design / guarding / barricading / delineation / signage			
	Safety equipment & PPE			
	Planning & scheduling, adequate resourcing			
	Housekeeping			
Individual actions	(Corrective actions that enable the right behaviours)			
	Training / Mentoring / Coaching			
	Individual accountabilities and KPIs			
	Fair treatment process			

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Annex 5

Occupational Health Hazard Categorization				
Physical	Biological	Chemical	Ergonomic	Psychosocial
Work environment factors that has the potential to cause harm with or without physical contact	Biological agents which have the ability cause diseases	Occupational hazards that involve a wide variety of chemicals, which when exposed can cause acute or long-term detrimental health effects.	Physical workplace conditions that may pose risk of injury to the musculoskeletal system.	Workplace stressors (psychological risk factors) that may cause distress and adverse mental, physical, and/or social health events.
<ol style="list-style-type: none"> 1. High Noise Levels 2. Radiation (including UV radiation) 3. Vibration 4. Illumination (Poor lighting) 5. Extremes of Temperature (Heat or Cold Stress) 6. Shift work disrupting circadian rhythm, 7. Healthcare system of country of duty station, etc. 	<ol style="list-style-type: none"> 1. Blood borne pathogens (e.g. HIV, Hepatitis B and C) 2. COVID-19 viruses (SARS-CoV-2) 3. Influenza viruses 4. Legionnaires bacteria - from infected water-based aerosols (poorly maintained air conditioning or abandoned shower) 5. Other infectious agents (Salmonella, Cholera bacteria, etc.) 6. Insect bites and stings (e.g. Mosquitoes, Bees, etc.) 7. Animal and Human bites (e.g. Dogs, Snakes, etc.) 8. Anthrax 9. Toxins from Snakes, Spiders, Scorpions, etc. 	<ol style="list-style-type: none"> 1. Pneumoconiosis dust (e.g. Silica dust, Asbestos fibres, Coal dust, etc.) 2. Cotton dust 3. Poor indoor air-quality 4. Carcinogens (e.g. benzene, vinyl chloride, etc.) 5. Occupational Asthmagens (e.g. latex, wood dust, pesticides, etc.) 6. Chemical sensitizers (e.g. cereal flours, isocyanate, anhydrides, etc.) 7. Diesel Particulate Matter (DPM) - Diesel exhaust fumes 8. Volatile Organic Compounds (VOCs), etc. 	<ol style="list-style-type: none"> 1. Inappropriately designed workstation - office or remote workstation / home 2. Repetitive strain motion 3. Awkward postures 4. Prolonged use of Computer Display Screen Equipment 5. Manual handling 6. Contact stress, etc. 7. Prolonged sitting, etc. 	<ol style="list-style-type: none"> 1. Understaffing / Excessive workload 2. Unclear role description and role relationships 3. Conflicting work demands with lack of role clarity 4. Poorly planned and executed digital transformation 5. Poorly managed organizational change 6. Difficult performance conversation 7. Working under prolonged emergency mode 8. Improperly organized home-work interface. 9. Harassment 10. Workplace aggression & Abuse, 11. Working with traumatized population, 12. Security threats, etc.

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Annex 6

Worksheet for “Why-tree” or “5-Whys”

Define the Problem:				
	Cause 1	Cause 2	Cause 3	Cause 4
1				
	↓WHY	↓WHY	↓WHY	↓WHY
2				
	↓WHY	↓WHY	↓WHY	↓WHY
3				
	↓WHY	↓WHY	↓WHY	↓WHY
4				
	↓WHY	↓WHY	↓WHY	↓WHY
5				
	↓WHY	↓WHY	↓WHY	↓WHY
CORRECTIVE ACTION(S):			RESPONSIBLE PERSON	DUE DATE
5-Whys team members:				

Annex 7.

**INCIDENT CAUSATIVE ANALYSIS METHOD – ICAM
Incident Investigation Form**

Business unit / department (where incident occurred)		Incident number	
Date of incident		Reported by	
Date of report		Responsible Manager	
Name of person completing report		Position of person completing report	
Area Supervisor		Name of Involved or Witnesses	
Name of Involved		Name of Involved or Witnesses	
Name of Involved		Name of Involved or Witnesses	
Name of Involved or Witnesses		Name of Involved or Witnesses	
Incident Type			
<input type="checkbox"/> Electrical		<input type="checkbox"/> Ignition of Gas or Dust	
<input type="checkbox"/> Entrapment		<input type="checkbox"/> Impoundment	
<input type="checkbox"/> Exploding vessels under pressure		<input type="checkbox"/> Inundation	
<input type="checkbox"/> Explosives and Breaking Agents		<input type="checkbox"/> Machinery	
<input type="checkbox"/> Falling, Rolling, or Sliding Rock or Material of any Kind		<input type="checkbox"/> Non-Powered Haulage	
<input type="checkbox"/> Fall of Face, Rib , Side or High Wall		<input type="checkbox"/> Powered Haulage	
<input type="checkbox"/> Fall of Roof or Back		<input type="checkbox"/> Slip or Fall of Person	
<input type="checkbox"/> Fire		<input type="checkbox"/> Stepping or Kneeling on Object	
<input type="checkbox"/> Handling Material		<input type="checkbox"/> Striking or Bumping	
<input type="checkbox"/> Hand Tools		<input type="checkbox"/> Chemical Hazard	
<input type="checkbox"/> Hoisting		<input type="checkbox"/> Environmental	
<input type="checkbox"/> Other		Blank	
Incident Classification			
<input type="checkbox"/> Near Miss		<input type="checkbox"/> C -Fatality	
<input type="checkbox"/> Dangerous Occurrence		<input type="checkbox"/> D1 – Security Incident	

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<input type="checkbox"/> A1 – First Aid Injury	<input type="checkbox"/> D2 – Property Damage / Fire
<input type="checkbox"/> A2 – Medical Treated Injury	<input type="checkbox"/> E1 –Level 1 Environmental Incident
<input type="checkbox"/> A3 – Restricted Work Injury	<input type="checkbox"/> E2 – Level 2 Environmental Incident
<input type="checkbox"/> B1 – LTI Total Disability	<input type="checkbox"/> E3 – Level 3 Environmental Incident
<input type="checkbox"/> B2 – LTI Partial Disability	<input type="checkbox"/> E4 – Level 4 Environmental Incident
<input type="checkbox"/> B3 – LTI Temporary Disability	<input type="checkbox"/> E5 – Level 5 Environmental Incident

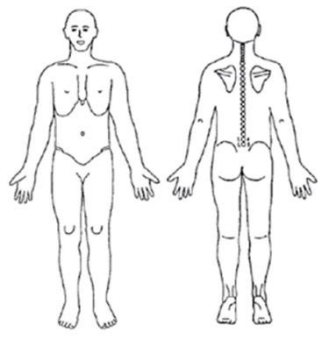
Injury Details

(for more than 1 injured person, a separate investigation form must be filled out and attached)

Full name of Injured person:

Body part: N/A

(Select One Option from List Below)

<ul style="list-style-type: none"> • Back (L/M/U) • Ear/s (L/R) • Eye/s (L/R) • Head-Other • Hips & Legs <ul style="list-style-type: none"> - Hip (L/R) - Leg (L/R) - Legs both - Thigh (L/R) - Knee (L/R) - Shin (L/R) - Calf (L/R) - Ankle (L/R) • Face 	<ul style="list-style-type: none"> • Feet & Toes <ul style="list-style-type: none"> - Foot (L/R) - Foot both - Toes (1-5)(L/R) • General • Hands/Fingers <ul style="list-style-type: none"> - Hand (L/R) - Thumb (L/RP) - Finger (1-5)LR - Both • Internal Organs • Mouth • Multiple • Neck • Nose 	<ul style="list-style-type: none"> • Shoulder & Arm <ul style="list-style-type: none"> - Shoulder (L/R) - Arm (L/R) - Elbow (L/R) - Wrist (L/R) - Upper Arm (L/R) • Respiratory • Trunk <ul style="list-style-type: none"> - Chest - Genitals - Rib (L/R) - Abdomen (L/M/U) - Groin - Buttocks • Unknown 	
--	--	---	---

Nature of injury

(Select one Below)

<ul style="list-style-type: none"> • Graze • Amputation • Burn • Chemical Burn • Contusion (bruise) • Crush 	<ul style="list-style-type: none"> • Cut • Dermatitis • Dislocation • Electric Shock • Eye disorders • Foreign Body 	<ul style="list-style-type: none"> • Foreign body in eye, ear or nose • Fracture • Hearing • Heat Exhaustion • Hernia 	<ul style="list-style-type: none"> • Inter-cranial (Head) • Internal • Open wound • Poisoning • Scald 	<ul style="list-style-type: none"> • Sprain/strain • Superficial • Tear • Other (specify)
---	---	--	--	---

Mechanism of injury

(Select one Below)

<ul style="list-style-type: none"> • Bites <ul style="list-style-type: none"> - Insect/Spider - Snake • Caught in/between • Dismounting • Electricity Contact 	<ul style="list-style-type: none"> • Exposure to: <ul style="list-style-type: none"> - Chemical Subs. - Heat/cold - Mech. Vibration - Mental Stress - Radiation 	<ul style="list-style-type: none"> • Fall from Height • Hit-moving objects • Hitting Objects • Jumped Down • Multiple mechanism 	<ul style="list-style-type: none"> • Other muscular stress • Repetitive movement • Sounds (Expos) <ul style="list-style-type: none"> - Sharp/sudden - Long term - Blast 	<ul style="list-style-type: none"> • Trip/Fall same level • Vehicle Accident • Unspecified mechanism
--	--	--	--	---

Object causing injury:

Injury Outcome	<input type="checkbox"/> Return to full duties	<input type="checkbox"/> Return with Restricted Duties	<input type="checkbox"/> Return in Different Position	<input type="checkbox"/> Not able to return to work
Treatment Provider	<input type="checkbox"/> On Site First Aid	<input type="checkbox"/> Onsite Clinic	<input type="checkbox"/> Offsite Hospital:	

Treatment Provided:

Equipment Damage Details

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<input type="checkbox"/> Personal Equipment		<input type="checkbox"/> Non-Personal Equipment		<input type="checkbox"/> Company Equipment		<input type="checkbox"/> Leased Equipment	
<input type="checkbox"/> Building		Damage Details:					
<input type="checkbox"/> Product							
<input type="checkbox"/> Plant (Mobile)							
<input type="checkbox"/> Plant (Fixed)							
<input type="checkbox"/> Other							
Est. Cost							
Blank							
Environmental Damage Details							
<input type="checkbox"/> Hazardous Chemical		<input type="checkbox"/> Non-Hazardous Chemical		<input type="checkbox"/> Onsite		<input type="checkbox"/> During Transport	
Uncontrolled release of		Environmental Damage Details:					
<input type="checkbox"/> liquid							
<input type="checkbox"/> gas							
<input type="checkbox"/> solid							
Est. Cost							
Incident Description: (include details of actions leading to incident, details of environmental release – volume, characteristics etc.) Use sketches as appropriate (Number of attachments 1, 2 3 – circle as appropriate)							
<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>							
INCIDENT TIMELINES/ TIME SERIES EVENT CHART							
Pre-Incident Timelines:							
Actual Incident Timelines:							
Post- Incident Timelines:							

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Sketch or Photo of Incident					
<p>Absent or Failed Defences - Identify the defense factors that allowed the outcome. Defences are those factors that are designed to detect and protect the overall system from the results of human or technical failures, that is, they are the "last minute" protection measures designed to avoid or mitigate and outcome. Check question: Does the item describe the equipment, work process, control measure, detection system, and procedure or attribute which normally prevents this Event or limits the consequences? (Tick only if applicable)</p>					
DF1	Awareness – hazard identification	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF12	Control and recovery – bypass valves / circuits	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF2	Awareness – communication	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF13	Control and recovery – emergency shutdown	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF3	Awareness – competency / knowledge	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF14	Protection and Containment - PPE	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF4	Awareness – supervision	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF15	Protection and Containment – fire fighting	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF5	Awareness – work instruction / procedure	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF16	Protection and Containment – spill response	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF6	Detection – visual warning systems	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF17	Protection and Containment – bunding / barricading / exclusion zones	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF7	Detection – aural warning systems	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF18	Escape and Rescue – safe access/egress	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF8	Detection – speed / movement detectors	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF19	Escape and Rescue – emergency planning / response	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF9	Detection – vigilance / fatigue	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF20	Escape and Rescue – emergency communication	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF10	Detection – gas / substance	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	DF21	Other	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure
DF11	Control and recovery – procedures	<input type="checkbox"/> Absent <input type="checkbox"/> Some Failure <input type="checkbox"/> Complete Failure	---		
BARRIER ANALYSIS					
	Type of defense/ Control Barriers. (PEEPO)	Control Barriers (failed/Absent)	How did they (Control Barriers) perform?	Why did the control barriers fail?	Outcome of failed barrier

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(Tick only if applicable)					
TE1	Task planning / preparation / manning	<input checked="" type="checkbox"/> Some <input type="checkbox"/> Significant	HF1	Complacency / motivation / desensitization to hazard	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE2	Hazard Analysis / JHA/ Take 5	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF2	Drugs / alcohol influence	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE3	Procedures to work availability and suitability	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF3	Familiarity with task	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE4	Permit to work availability and suitability	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF4	Fatigue	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE5	Abnormal operational situation / condition	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF5	Situational awareness	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE6	Tools / equipment condition / availability	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF6	Time / productivity pressures	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE7	Materials availability and suitability	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF7	Peer pressure / supervisory example	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE8	Equipment integrity	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF8	Physical capability	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE9	House keeping	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF9	Mental capability	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE10	Weather conditions	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF10	Physical stress	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE11	Congestion / restriction / access	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF11	Mental stress	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE12	Routine / non routine	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF12	Confidence level	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE13	Fire and / or explosion hazard	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF13	Secondary goals	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE14	Lighting	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF14	Personal issue	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE15	Equipment / material temperature / conditions	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF15	Distraction / pre-occupation	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE16	Noise	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF16	Experience / knowledge / Skill for task	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE17	Ventilation	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF17	Competency	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE18	Gas , dust or fumes	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF18	Behavioural beliefs	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE19	Radiation	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF19	Personality / attitude	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE20	Chemical	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF20	Poor communications	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE21	Wildlife	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF21	Poor shift patterns & overtime working	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE22	Surface gradient	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF22	Passive tolerance of violations	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE23	Reduced / restricted visibility	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF23	Perceived license to bend rules	<input type="checkbox"/> Some <input type="checkbox"/> Significant
TE24	Other factor	<input type="checkbox"/> Some <input type="checkbox"/> Significant	HF24	Change of routine	<input type="checkbox"/> Some <input type="checkbox"/> Significant
---			HF25	Reliance on undocumented knowledge	<input type="checkbox"/> Some <input type="checkbox"/> Significant
			HF26	Other Human Factors	<input type="checkbox"/> Some <input type="checkbox"/> Significant

Occupational Health and Safety Incident Management Guideline.

Organisational Factors - Identify the Organisational Factors that contributed to the Event. These are the underlying organisational factors which produce the task/environmental conditions that affect performance in the workplace. These may include fallible management decisions, processes and practices.
 Check question: Does this item identify a standard Organisational Factor present before the Event and which resulted in the task/ environmental conditions or allowed those conditions to go unaddressed?
 (Tick only if applicable)

HW	Hardware	<input type="checkbox"/> Contributing	MM	Maintenance Management	<input type="checkbox"/> Contributing
TR	Training	<input type="checkbox"/> Contributing	DE	Design	<input type="checkbox"/> Contributing
OR	Organisation	<input type="checkbox"/> Contributing	RM	Risk management	<input type="checkbox"/> Contributing
CO	Communication	<input type="checkbox"/> Contributing	MC	Management of Change	<input type="checkbox"/> Contributing
IG	Incompatible Goals	<input type="checkbox"/> Contributing	CM	Contractor Management	<input type="checkbox"/> Contributing
PR	Procedures	<input type="checkbox"/> Contributing	-	-	-

Code	Based on the above event facts, identify the absent / failed defences that contributed to the event – give reasons.

Immediate Causes: Individual Failures

Immediate causes may be defined as substandard acts or conditions that lead directly to the accident. These might be removal of a machine guard, employee error, and non-use of personal protective equipment, lack of concentration, stress, fatigue and poor housekeeping.

Underlying Causes: Work Place Failures

Things that lie behind the immediate causes. These may include: Failure to adequately supervise workers, poor maintenance, inadequate training, inadequate workplace inspection, poor supervision, incomplete risk assessments, and unsatisfactory safe systems of work. etc

Root Causes: Organizational Failures

Root causes may be defined as inadequacies in the Health, Safety and Environmental (HSE) management system that allow the immediate and the underlying causes to arise unchecked, leading to the accidents. These may include: Lack of policy or procedure, unrealistic demands or expectations placed on employees, Lack of resources for effective maintenance, , inadequate selection and placement of employees,

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Occupational Health and Safety Incident Management Guideline.

Report Sign off			
Position	Name	Signature	Date
Lead Investigator			
Head of Department			
Area Supervisor			
HSE Representative			
Employee Representative			
Involved Persons			
Final Sign off			
Managing Director			

Annex 5

Further recommendation on establishing a UN system-wide Occupational Safety and Health (OSH) capability at field duty stations

Background

1. As provided in its 2021-2022 Action Plan and endorsed by the High-Level Committee on Management (HLCM), the OHS Forum is expected:

“To promote the holistic integration of OHS risk management across all relevant UN-system departments (HR, Medical, Security, etc.) and particularly into the work of Resident Coordinators and UN Country Teams, in particular:

 - To clarify the role of UNCT/OMT/SMT in dealing with non-security related OHS issues at country level.
 - To consider whether the job description of Heads of country/field offices should include an accountability line for OHS and propose relevant text if confirmed.
 - To develop an effective and proactive communications strategy to advance OHS risk management, targeting a broad internal audience, including senior managers and UN Resident Coordinators, OHS focal points and field personnel.”
2. In addition to these deliverables for which Workstream 4 is responsible under the lead of Dr Mike Rowell, DHMOSH, the HLCM, at its 41st session on 25 March 2021, *“Requested the OHS Forum, in coordination with the Inter-Agency Security Management Network (IASMN), to discuss and identify options for suitable mechanisms for the system-wide governance of safety-related subjects, and to come back to HLCM with recommendations, building on and avoiding overlap with existing system-wide mechanisms”*.
3. Following the HLCM’s endorsement of the initial recommendation jointly made by DCO and the OHS Forum to address this assignment, DCO wrote to the Resident Coordinators on 19 May 2022 to encourage them to establish a local OSH Committee. A template of the Terms of Reference for the Committee was provided. This constitutes the first element of the accountability and governance framework at field duty stations.
4. As requested by the HLCM, consultations with relevant stakeholders continued to take place with the view of making further recommendations on the accountability framework and sustainable funding of the OSH capacity at country level. The result of these consultations and the suggestions on the way forward are provided below with the proposed framework of accountability for RCs and UNCTs.
5. Considering the temporary nature of the OHS Forum and other evolving aspects, the framework of accountability for RCs and UNCTs will be updated in due course.

Occupational Safety and Health Framework of Accountability for Resident Coordinators and UN Country Teams

I) Background

Scope

This Occupational; Safety and Health (OSH) Accountability Framework defines the responsibilities and accountabilities of Resident Coordinators (RCs) and other United Nations officials and personnel in the context of UN Country Teams (UNCTs) for coordinated OSH measures. Its primary focus is on field-based duty stations and describes only the support functions of Headquarters duty stations¹.

The determination of the need for, and scope of, coordinated and/or joint OSH actions by the UNCT in response to OSH hazards is to be made by RCs and UNCTs based on local risk assessments and the technical advice and recommendations provided by the local OSH Committee.

The Framework is based on the following key considerations:

- The primary responsibility for the workplace safety and health of all personnel employed by United Nations system organizations rests within each UN system organization respectively as per UN staff regulations and rules and entity-specific regulations and rules.
- OSH is a line management responsibility shared between the employers (UN entities) and the employees (each individual belonging the UN entity's personnel), and for an effective duty station approach is a shared responsibility between UN entities regardless of their sizes and institutional investments towards OSH.
- UN-wide coordinated actions and joint planning are most effective when UN entities in a location are faced with similar OSH hazards, as determined by a local OSH risk assessment. Individual entities remain responsible for implementing mitigation plans for OSH hazards in accordance with their own risk appetite or when the hazard is specific to their workplace.

Definitions

Occupational Safety and Health (OSH) / Occupational Health and Safety (OHS): Interchangeable terms that refer to a multi-disciplinary set of measures with the broad aim of preventing work-related illness and injury by addressing workplace hazards.

Workplace: A place under the control of the organization where a person needs to be or to go for work purposes (may include the home environment in defined circumstances).

Hazard: Any source with the potential to cause harm, or hazardous situations with the potential for exposure leading to injury and ill health.

¹ An updated version of the Framework for headquarters duty stations and peace operations settings will be developed in due course.

Incident: An event arising out of, or in the course of, work that could or does result in injury and ill health.

Injury and ill-health: An abnormal condition or disorder in the physical, mental, or cognitive condition of a person.

Principles

RCs, UNCTs and OSH Committees in carrying forward their responsibilities as defined in this framework shall be guided by the **“Vision Statement and Core Principles for a healthier, safer and more respectful UN workplace”** (as endorsed by the HLCM at its 38th session in October 2019).

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

The Core Principles for a healthier, safer, and more respectful UN workplace are:

- 1. Risk awareness and transparency**
Organizations are proactive in providing information and remains open to engagement, input, and feedback from UN personnel.
- 2. Safe and healthy living and working environment**
Shared engagement and responsibility of the Organization and personnel to promote and sustain security, safety, health, and well-being of personnel as far as it is reasonably practicable.
- 3. Inclusion and respect for dignity**
Organizations treat personnel in good faith, with due consideration for individual circumstances, respecting and preserving dignity and diversity.
- 4. Caring for consequences of risk**
Caring for those who have been adversely affected or impacted by hazardous events associated with their work with the United Nations.
- 5. Accountability at all levels**
Creating a just culture that supports effective leadership and individual accountability.

I) Governance, Accountabilities and Coordination Mechanisms

1. HLCM-OHS Forum

In October 2019, the HLCM established the Occupational Health & Safety (OHS) Forum chaired by the World Health Organization (WHO) and composed of experts nominated by the HLCM members. The OHS Forum serves as a multidisciplinary UN-system-wide technical body, and it intends to support agency heads fulfilling their obligations towards workplace safety and health in a manner that evolves in parallel with the risks and the contexts in which their organizations work.

The OHS Forum supports the implementation of health and safety measures in UN system entities by providing a central mechanism for coordination, collaboration, and information sharing. It also conducts global surveys highlighting the status of implementation, key successes and challenges, and recommendations for future development.

The OHS Forum will provide support to the implementation of this framework ad interim and until a dedicated mechanism responsible for UN-wide coordination of OSH management systems is established and operationalized.

2. Development Coordination Office (DCO)

As the UN entity responsible for management and oversight of the Resident Coordinator System, DCO will support disseminating guidance, determining the frequency of reporting, and collating information provided from RCs' about UNCT OSH outputs and performance indicators. This information will then be provided to an appropriate OSH body (such as the OHS Forum) for further analysis. This analysis will then be provided to the HLCM for review regarding the progress of the system-wide OSH performance.

3. Resident Coordinators (RC's)

The RC holds the responsibility for a collective approach to OSH by UN Country Team members in that duty station. Specifically, the RC is responsible for:

- Convening and leading a country-level coordination mechanism focused exclusively on OSH matters (the OSH Committee).
- Ensuring that OSH matters as identified by the OSH Committee feature on the agenda of the UNCT and are addressed, and implemented, as appropriate.
- Coordinating a UNCT collective approach to OSH risk management.
- Documenting UNCT-level OSH activities and good practices on an annual basis.

In countries where there is no RC or that are not covered by RC's, a representative of a resident agency should be nominated by the UNCT to coordinate the collective approach to OSH in country.

4. UN Country Team (UNCT)

At the country-level, heads of country offices of each entity are responsible for the workplace health and safety of their personnel in that duty station, and for aligning any OSH activities with their own entity's OSH policies. They are also accountable to the RC and the rest of the UNCT to ensure that recommendations of the local OSH Committee that are endorsed by the wider UNCT are implemented as appropriate.

The heads of country offices of each entity (or their authorized representative as OSH Focal Point) participate in the local OSH Committees to develop a common approach to the workplace environment which provides reasonable safety and health to all UN employees.

5. Security Management Team (SMT)

The SMT manages the security risks and crises as the field-based interagency operational coordination body in support of the Designated Official in country. As the SMT also has fire safety and road safety in their mandate, the SMT and OSH Committee should jointly maintain a holistic view and approach to issues that cut across safety and security matters.

6. Operations Management Team (OMT)

The OMT provides guidance, recommendations, and management support to the UNCT on operational matters, including on matters with an impact on the safety and health of staff. Given this relationship, OSH Committees are responsible for report to RC's/UNCT on the health and safety implications of operations, and OMT's on the operational implications of OSH risk management plans. Given the OMT is a more established structure, it may be appropriate initially for OMTs to serve as a mechanism by which the OSH Committee can report to the RC/UNCT.

7. Local OSH Committee

The local OSH Committee is a technical body responsible to support the RC and all heads of country offices at the duty station. It provides a forum for addressing a range of OSH issues, spanning from COVID-19 and other infectious diseases matters, mandatory vaccinations and return to work premises, pollution, ecological disasters as well as other traditional health and safety concerns around general, equipment and environmental safety.

The tasks of the OSH Committee are defined in its Terms of Reference and are specific to each duty station but include receiving or identifying safety and health concerns in the workplace, assessing hazards through a standard risk management process, and proposing mitigation measures that are consistent with sound OSH practice and existing UN OSH policies. (Annex 1 - Sample TOR of OSH Committee).

The OSH Committee is responsible to conduct an ongoing OSH risk assessment through a combination of job hazard analyses (for specific tasks and locations), accident, injury, and illness data, and by consideration of the local environment. Based on this broad assessment they are to establish risk levels for key hazards and recommend to the RC/UNCT the most appropriate prevention and mitigation measures. The decision on what risks to address or what mitigation measures to introduce

is for the RC to coordinate and the heads of country offices of each entity to decide according to its own OSH policies, operational needs and risk appetite.

Although the OSH committee may be responsible for the development of key communication products on OSH initiatives and for monitoring, **entities themselves** are responsible for implementing OSH risk mitigation measures.

8. Supervisors/Managers

Safety and health is a line management responsibility, flowing from top management to all staff at every level. All supervisors are responsible for the management of OSH issues in their areas of responsibility. Supervisors shall ensure that all personnel under their supervision are briefed on the entity's OSH policy and provided access to training on prevention and management of work-related hazards, injuries, and illnesses in the workplace. Supervisors with additional OSH responsibility such as workshop heads, medical personnel, agency risk managers, security officers, OSH focal points, fleet managers, safety officers and guesthouse managers are responsible for using the OSH tools available to them to assess risk in their area of responsibility and escalate this to their supervisors or the OSH Committee when further action is warranted. When invited to be a member of the OSH Committee all supervisors should actively participate and help implement solutions within their area of responsibility.

9. UN Clinic Health Managers

Given the lack of professional Safety Officers or Occupational Safety and Health staff in many field locations, technical expertise to support OSH may be provided by those medical staff in UN Clinics who have an occupational health background and access to occupational health resources.

The Head of Service (HOS) of each UN Clinic is responsible for ensuring that injuries, illnesses, and exposures that present to the Clinic for assessment or treatment are correctly recorded in the medical record system, including by linking these presentations to known incidents in the Safety Module or by initiating a safety record in the Safety Module. Where feasible and appropriate, this may also include notification to other safety management systems used by entities not enrolled in the Clinics internal OSH record management system. HOS are also responsible for ensuring that de-identified OSH data is made available to the local OSH Committee for review, either annually or as needed, to provide an evidence base for decision making on OSH matters.

HOS are responsible for ensuring that occupational health matters are managed effectively. This includes routine occupational health preventive measures such as employment, travel and other workplace clearances, safe return to work programs, ergonomics, and infectious disease hazards in the duty station (such as malaria),

In the absence of access to advice by professional Safety Officers, HOS are expected to provide leadership in all aspects of OSH, including principles around safety inspections and basic risk management, utilizing primarily occupational health knowledge skills and experience.

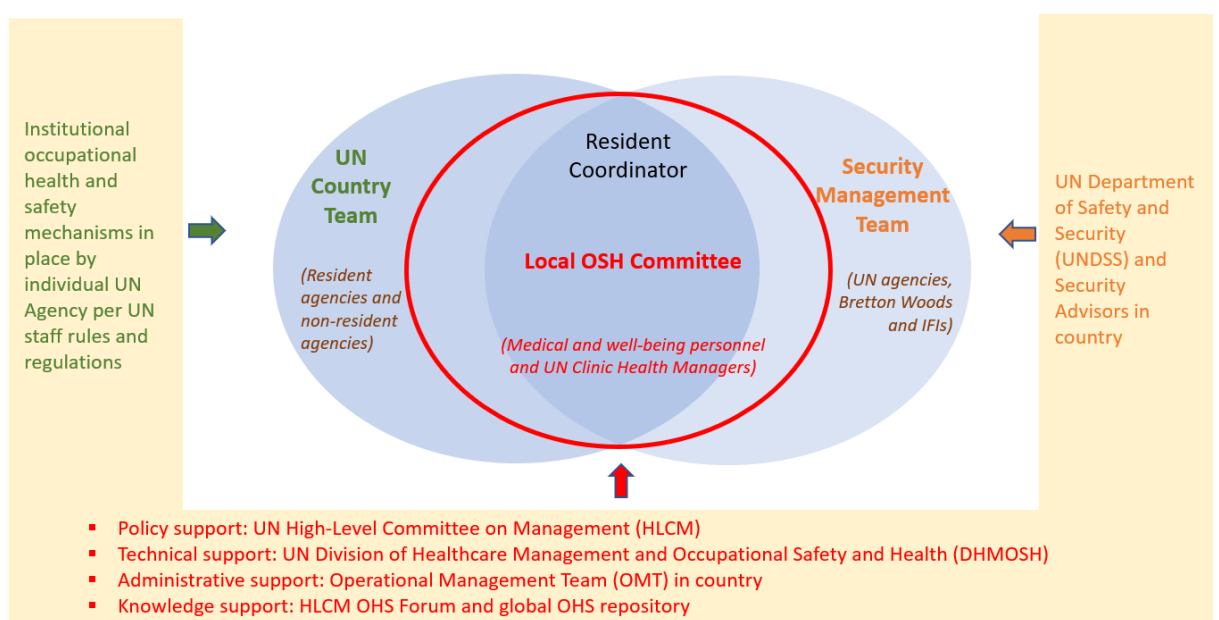
10. UN personnel

Under the UN staff regulations and rules and entity-specific regulations and rules, each employee is responsible for their own actions that may impact the health and safety of others.

All UN personnel are responsible for adhering to the OSH measures in their workplace and reporting any accidents, hazards or potential hazards through available channels.

All UN personnel are responsible for respecting the confidentiality of any information concerning affected individuals.

Figure 1: Local coordination mechanisms and accountabilities



III) Support

The mechanisms for accessing specialist OSH advice are particular to each duty station and entity, however, they should be identified by each local OSH Committee for it to effectively manage OSH risks in the duty station.

IV) Financial arrangement of OSH coordination at country-level

The mechanisms for funding specialist OSH advice or to implement OSH risk mitigation plans are particular to each duty station. These financial arrangements should be agreed by UNCTs with the coordination of the RC.

Common categories of activities and expenses for occupational health and safety may include:

- Personnel – professional Safety Officer / OSH Officer (full time, part time, shared regional resource).
- Travel budget if OSH officer is a regional resource.
- Test equipment according to hazard profile – light meters, sound meters, particulate collection and measurement equipment, etc.
- Access to OSH incident recording software, preferably linked to medical records system.
- Office equipment and delivery of training resources.

Budget preparation and endorsement

The local OSH budget is a funding mechanism to enable the planning and execution of local OSH activities. The budget should be developed by the local OSH committee on an annual basis based on the annually updated health risk assessment at the duty station level and then endorsed by the RC/UNCT as for other shared resource budgets.

Cost-sharing formula

Costs of the planned local OSH activities are shared among the entities present in the duty station that are benefitting from common health and well-being services provided on the UN premises or by the local OSH budget.

Entity share of the local OSH budget should be based on the actual presence of personnel per entity in the duty station and any additional criteria or formulas negotiated and agreed upon locally at the time of discussions on the annual local OSH budget.

Designation of “Administering Agency”

The local OSH committee shall discuss and designate an operational entity as the “Administering Agency” to provide administrative support to the implementation of the local OSH budget on behalf of the OSH committee. The Administering Agency’s administrative support includes the preparation of the billing and invoices that need to be submitted to UN entities present in the duty station for their payment.

The statements of account, billing and invoices as prepared by the Administering Agency shall be signed by the Resident Coordinator on behalf of the local OSH committee. The Resident Coordinator’s Office will not serve as the Administering Agency.

Figure 2: Key component of local OSH committee budget planning



V. Monitoring and reporting

To ensure the integration of OHS risk management into the work of RC's and UNCT's, effective monitoring, reporting and feedback measures are required.

Local measures

The OSH Committee shall meet regularly to discuss the implementation status of OSH actions and prepare a summary on the implementation once a year; the summary shall be submitted to the RC's, and good practices identified in the summary shall be submitted by the RC to the global repository upon DCO request.

The OSH Committee, or the local OSH expert shall update the local OSH risk assessments in a periodicity that was recommended by the previous OSH assessment or by changes in the local environment.

Central measures

An appropriate body, such as the OHS Forum, may undertake further analysis of the local OSH assessments and annual summaries of OSH actions, and make recommendations for further improvement of the system-wide OSH capability.

Annex 1

Occupational Safety and Health Committee – (Duty Station) Terms of Reference

1. United Nations (UN) personnel are its greatest asset, and the UN has a duty to undertake all reasonably practicable actions to prevent occupational accidents, illnesses and exposures, and to enhance personnel health and wellbeing. The UN's ability to deliver its mandate is inextricably linked to the safety and health of its workforce, and managing workplace safety and health is part of the UN's duty of care to its personnel and to those affected by its work.
2. The UN's Occupational Safety and Health (OSH) policies and the achievement of its OSH objectives in (duty station) (DS) are implemented through a consultative process between personnel and management within the DS OSH Committee.
3. The (DS) OSH Committee is to address all workplace hazards, including COVID, to (insert relevant oversight body such as Country Team).

Mandate

4. The (DS) OSH Committee's mandate is to advise the Country Team members on all aspects of occupational safety and health in (DS). This applies to:
 - a. All personnel of (DS) based United Nations Departments/Offices, Agencies, Funds and Programmes (AFPs) (hereafter *UN personnel*).
 - b. Visitors, delegates and other persons in office locations of members of the country team and UN occupied floors of commercial properties (hereafter *UN workplaces*).
5. This mandate includes receiving or identifying safety and health concerns in the workplace, assessing hazards through a standard risk management process, and proposing mitigation measures that are consistent with sound OSH practice, existing UN OSH policy, and each organization's duty of care.
6. Senior management of each entity retains the responsibility for overall workplace safety and health. This includes for aligning with existing organizational OSH policies, establishing new OSH policies and approaches in the (DS), and for implementing OSH risk mitigation measures. Each entity may delegate certain tasks to the OSH Committee where appropriate (see tasks).

Objectives

7. The objectives of the (DS) OSH Committee are to:
 - a. Provide a mechanism by which safety and health issues affecting the (DS) based workforce and (DS) workplaces can be raised and addressed.
 - b. Provide a resource for advice on safety and health matters for senior management, personnel and managers at all other levels in each entity.

- c. Promote the development of a culture of risk-based safety and health awareness in UN personnel and workplaces.

Composition

- 8. The (DS) OSH Committee is a multidisciplinary technical and advisory body. Its work is to be conducted in a co-operative, non-adversarial atmosphere. It shall include representatives authorized to contribute on behalf of the following:

The suggestions below are indicative only.

- Technical expertise is to be sought, and in particular representation should include any discrete area of work where injuries, illnesses or exposure to hazards is high.
- The Chair should be a regular member of senior Country Team meetings – not an occasional invitee – so that routine issues in the Country Team can be brought directly to the OSH Committee, and so that matters raised in the OSH Committee can be routinely represented in Country team meetings
- The Committee is not a staff management committee that requires equal representation of staff representatives and management, although all committees should include staff representation

- a. Chair appointed by Resident Coordinator
 - b. Representatives of each UN entity
 - c. Representatives of staff associations
 - d. Human resources
 - e. Occupational health or medical staff
 - f. Occupational safety
 - g. Facilities or Commercial Activities Services
 - h. Warehousing
 - i. Motor pool / transport
 - j. Catering
 - k. Security
 - l. Communications
- 9. The Staff Association representative and each of the technical representatives are required to coordinate with and represent any equivalent body in other entities locally i.e., one representative from UNDP transport coordinate with other entities transport staff where appropriate.

Tasks

- 10. The (DS) OSH Committee is to:
 - a. Review requests from the Country Team on all aspects of organizational health and safety management and provide them with recommendations on OSH risk and OSH prevention and control measures.
 - b. Receive input from personnel and managers on occupational safety and health concerns and mitigation measures.
 - c. Develop broadcasts, articles, guides or other related communications materials to assist personnel and managers at all levels to understand and implement safety and health policies or approaches adopted by the Country Team or the requesting organization.

- d. Develop measures to promote a culture of safe work practices and environments, improve access to OSH policies, instructions and training, and facilitate measures to report incidents, accidents and near-misses.
11. Note that day-to-day management of OSH matters, and the provision of workplace risk assessments, job hazard analyses or other OSH advice is the responsibility of each entity's OSH local or HQ OSH services. Where appropriate the (DS) OSH Committee may request via member entities for OSH services or advice that the OSH Committee cannot provide.

Meetings

12. The (DS) OSH Committee is to meet at least quarterly, and quorum requires (insert).

Confidentiality

13. Members of the (DS) OSH Committees have a strict requirement to maintain confidentiality where personnel raise safety and health concerns that involve individuals. Where health impacts are relevant, individual health status of personnel are to be anonymized prior to being presented to the (DS) OSH Committee.

Annex 6

The Impact of COVID-19 on the Mental Health and Well-being of UN Personnel: Recommendations, implementable actions and good practices

Background

1. The UN System Workplace Mental Health and Well-being Strategy Implementation Board in partnership with the UN Medical Directors, UN Staff and Stress Counsellors Group and the OHS forum submitted a report for the HLCM 43rd session in April 2022. This was submitted as part of the Progress Report by the OHS Forum, CEB/2022/HLCM/4, annex 5, title: *Analysis and Recommendations around the Impact of COVID-19 on the Mental Health and Well-being of UN Personnel*. The report was developed based on analysis of survey data collected from a number of UN surveys and consisted of preliminary recommendations based on the data and indicating that further details of the recommendations would be presented at the HLCM 44th session.
2. The ensuing report focuses on implementable actions in UN organizations, adaptable to local needs and good practice examples from both UN and external organizations. Additionally, system-wide activities are also recommended to minimise the duplication of effort and resources.

Recommendations

3. The analysis and recommendations (see Annex I and Annex II) are structured around the following key areas:
 - a) Workplace factors;
 - b) Role of Managers and Leaders;
 - c) Psycho-social support; and
 - d) Groups of personnel who experienced an increased impact (for example, gender, age, employment status).
4. These recommendations are in-line with key pillars of the current 2018-2023 UN System Workplace Mental Health and Well-being Strategy.¹ The findings provide an opportunity to expand on priority actions from the strategy based on current data and needs. If approved, these recommendations could be added to the Implementation Guide for the mentioned Mental Health and Well-being Strategy. This links to a separate paper being presented to HLCM (CEB/2022/HLCM/14/Annex 7) regarding the current UN System Workplace Mental Health and Well-being Strategy plus 2024 and beyond.

¹ <https://www.un.org/en/healthy-workforce/files/Strategy%20-%20full.pdf>

Proposed actions for the HLCM

5. The HLCM is invited to:
 - a) Endorse the recommendations submitted by the working group of the UN Mental Health Strategy Implementation Board (MHSIB) containing recommendations, implementable actions and good practices;
 - b) Agree to take action to implement where appropriate;
 - c) Lead by example and take the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme;”²
 - d) Consider contributing to the costs of the activities of the remaining 15-months of the Strategy, as outlined in Annex II to document CEB/2022/HLCM/14/Annex 7:
 - Request a the MHSIB to present a progress report at the HLCM 45th and 46th sessions;
 - Support the upcoming activities of World Mental Health Day;
 - Commit to use the Implementation Guide and Scorecard.

² <https://www.unssc.org/courses/workplace-mental-health-and-well-being-lead-and-learn>

Annex I
Summary of Recommendations

Area	Recommendation
1 Workplace factors	<p>Short-term recommendations UN Organizations are encouraged to develop frameworks, policies, and practices to enable healthy working practices. This could include:</p> <ul style="list-style-type: none"> ▪ Encourage disconnecting time and ensure that harmonious work/life balance is maintained ▪ Explore remote work modalities ▪ Encourage flexibility on how personnel undertake their role and working hours within policy limits ▪ Allow job control and autonomy where possible. <p>These arrangements are best agreed at a team or duty station level to allow for local circumstances.</p>
	<p>Medium - Long-term recommendations It is recommended that psycho-social risk assessments are undertaken, in partnership with UN counsellors, to develop an understanding of contextualized risks and the development of a mitigation plan.</p>
2 Role of managers and leaders	<p>Short-term recommendations</p> <ol style="list-style-type: none"> 1. Senior leaders to communicate the importance of workplace culture on mental health and well-being and provide simple, implementable ideas. 2. All managers and leaders are encouraged to undertake the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme.”
	<p>Medium - Long-term recommendations</p> <ol style="list-style-type: none"> 1. Roll out resources that have been developed in all UN organizations. This includes the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme,” podcasts and the “mental health and well-being dialogue;” 2. Develop additional tools and (training) resources: for leaders and managers as well as human resources professionals; on workplace culture and creating a positive working environment; on prevention; and on stigma reduction; and 3. Incorporate mental health and well-being into leadership frameworks, performance requirements, strategic plans, recruitment and induction plans.
3 Psycho-social support	<p>Short-term recommendations UN organizations are encouraged to:</p>

Area	Recommendation
	<ol style="list-style-type: none"> 1. undertake a robust communications effort to ensure staff are aware of existing internal and external mental health support services; 2. undertake an audit of psychosocial services available through internal counsellors, insurance providers and other services. A template can be provided to assist with this process; and 3. use mechanisms that closely track usage and impact of their internal psycho-social support systems. <p>Medium - Long-term recommendations UN organizations are encouraged to utilize the minimum requirements and quality standards of professional support mechanisms outlined in the United Nations Staff/Stress Counsellors Group’s (UNSSCG) paper on “Guidance on Professional Standards for UN Counsellors” to track compliance of staff counsellors. A template can be provided to assist with this process.</p>
<p>4 Groups of personnel who experienced an increased impact</p>	<p>UN organizations are encouraged to:</p> <ol style="list-style-type: none"> 1. focus on having an inclusive workplace environment and enhancing autonomy to ensure all personnel are not discriminated against and can balance competing needs; and 2. in partnership with UN counsellors, identify and implement innovative ways to provide informational and emotional support to the families of staff members, which then decreases the likelihood of mental health issues in the staff member. Psychosocial wellbeing of staff is directly related to the wellbeing of dependents, which has been identified in several of the studies mentioned in this report.

Annex II Recommendations in Detail

1 Workplace Factors: Short-term recommendations

Key Area	Job control, autonomy, flexibility
Recommendations	<p>UN Organizations are encouraged to develop frameworks, policies and practices to enable healthy working practices. This could include:</p> <ul style="list-style-type: none"> ▪ disconnecting time and ensure that harmonious work/life balance is maintained ▪ explore remote work modalities ▪ encouraging flexibility on how personnel undertake their role and working hours within policy limits ▪ allowing job control and autonomy where possible. <p>These arrangements are best agreed at a team or duty station level and allow for local circumstances.</p>
Who benefits	All personnel
Responsible functional groups	IT, HR, Managers
Action	<p>As much as is practical, personnel should be given autonomy about how they do their work and how they organize their working day. An organization, duty station, team, and job role specific approach to the enhancement of job control and autonomy is encouraged to ensure an appropriate contextual approach. Autonomy is related to when, how and where work is undertaken. Flexible working arrangements should be encouraged, supported by policy and high-level management. This was noted as a key issue from survey results and is supported by the evidence. Examples of how this could be done is allowing team level decisions in work schedules, encouraging managers to have conversations with their teams and direct reports about how they work best as a means to signify care, enhance autonomy, and strengthen trust. By involving employees in deciding which type of flexibility they need, UN Organizations may be able to identify alternative work designs to further develop the workforce.</p> <p>Evidence-based educational material can be developed at a system-wide level to support this action.</p>
Timeline	Recommend action is taken by UN organizations by the end of 2023. System-wide resources could be developed to assist the implementation of this action at minimal cost.
Cost	None anticipated at an organizational level with possible cost savings due to productivity benefits.
Implementation	<p>Appropriate policies and educational materials would support the implementation of this recommendation.</p> <p>Policies should clearly outline the responsibilities of organizations, managers and personnel and focus on allowing maximal flexibility within the confines of organizations requirements. Flexible work arrangements will depend on the work function and there is a need for a measured approach. The risk of isolation and other psycho-social factors should also be considered.</p>

	<p>Managers should be provided with information about how to encourage autonomy and flexibility while focusing on deliverables. Managers should be aware of how to set clear expectations, such as:</p> <ul style="list-style-type: none"> ▪ The quantity of work that should be done ▪ The channels employees should be available ▪ When attendance is mandatory for meetings, whether virtually or in-person ▪ Providing clearer objectives and goals (decreasing ambiguity) ▪ Focusing on results and deliverables rather than where, when or how it is achieved.
Good practice	<p>External:</p> <ul style="list-style-type: none"> ▪ For more than a decade Unilever has been offering employees the opportunity to work anytime, anywhere, as long as they meet business needs. ▪ Google is planning a hybrid work week where employees will work from the office about three days a week, and two days "wherever they work best," according to a company memo. ▪ Microsoft is empowering their employees to make decisions regarding where they work and during what hours. The remote work policy is no longer defining those things for the employees, rather, it serves as guidance to help employees make the best decisions they can regarding their own work schedules. <p>Internal:</p> <p>Many UN Organizations have implemented flexible working arrangements. Further analysis is required to determine what good practice looks like within UN Organizations.</p>

1 Workplace Factors: Medium – long term recommendations

Key Area	Psycho-social risk assessments
Recommendation	It is recommended that psycho-social risk assessments are undertaken in partnership with UN Counsellors to develop an understanding of contextualized risks and the development of a mitigation plan. This is aligned with other recommendations from the OHS forum.
Who benefits	All personnel
Responsible functional groups	HR, Counselling, IT
Action	Piloting psycho-social risk assessments in one duty station using internal resources to reduce costs and build internal competencies is recommended. These risk assessments would highlight workplace risk factors at a local level and allow for tailored actions to be put in place to minimize these risks. Well established methodologies exist within organizations to conduct workplace risk assessments that result in actionable

	<p>outcomes including workflow, delegation of tasks, utilization of staff skills, areas for improvement of skills, workplace culture etc. that can be implemented using internal resources which would reduce costs and build internal competencies. A group of facilitators – staff members from various departments with relevant expertise – will conduct these assessments in collaboration with the relevant office.</p> <p>Psycho-social risk assessments conducted from a country perspective may provide interventions that are too vague, therefore, an agency specific approach is recommended. By offering a systemic and holistic intervention programme customised to each office, colleagues can be supported within their context, not as isolated cases. Through an agency specific approach, the agency can capitalize on its internal expertise for facilitation.</p> <p>As an instrument, the Copenhagen Psychosocial Questionnaire (COPSOQ) is recommended due to its psychometric properties. The COPSOQ can provide a detailed picture of where the gaps are, thus allowing for a context specific suite of interventions that support the team with what they identified as needs.</p>
Timeline	<p>12-month pilot, potential timeline:</p> <ul style="list-style-type: none"> ▪ 1st month: interviews and first assessment, review results and develop plan ▪ 4th month: workshops as required by interventions ▪ 6th month: mid-assessment to measure impact of intervention; review and adjust plan ▪ 8th month: workshops as required by interventions ▪ 12th month: final post-intervention assessment, plan for continued improvement, final report
Cost	<p>COPSOQ access is free.</p> <p>Time will be required by internal resources to undertake the assessment, collect the data and make recommendations. The use of internal resources to pilot will lead to reduced costs and benefits through strengthening internal competencies. It is expected that a one-year time commitment will be required by the facilitators of the assessment and intervention.</p> <p>Resources may be required to enact any recommendations.</p>
Implementation	<ol style="list-style-type: none"> 1. The Country Office will determine upfront ‘what success looks like’. A pre-assessment phase will inform the facilitators which assessment instrument is best suited to the problems faced by the office 2. The assessment phase will provide a baseline, as well as provide direction for the interventions required. Results of the initial assessment should be presented to the team, and they should be included in the interpretation of the results and help to define interventions. 3. An intervention plan will be developed and implemented by the Country Office and facilitators based on initial assessment. 4. Improvement can be assessed by using the same measures used during the initial assessment at a defined point in time to gauge the degree of change. A mid-assessment can be conducted to measure impact of the interventions so far, which can guide the team and facilitators to review and adjust the intervention plan. 5. A final post-intervention assessment can take place, resulting in a final report and the drafting of a plan for continued improvement.

Good practice	<p>UNDP has been undertaking psycho-social risk assessments at team or country office level and making recommendations based on the assessments.</p> <p>Since 2021 the WHO EURO workforce has participated in a survey covering all the areas of the WHO healthy workplace framework, including a psycho-social risk assessment. The questionnaire is based on internationally validated instruments (e.g. COPSOQ), and the results are available at the Unit level. The intention is to support managers to discuss with their team what they can do themselves, as a team, to address the risk factors identified in their Unit. These discussions can also identify the actions the Organization can take to support the team. Additionally, the results of this survey are guiding the recommendations of the Committee for Health, Safety and Wellbeing to the Regional Director regarding staff health and wellbeing. With this initiative, EURO is now addressing mental health in the workplace at the individual, team, and organizational level with primary, secondary, and tertiary interventions.</p> <p>The UN Department for Safety and Security (DSS) Critical incident Stress management Section (CISMS) has developed an Information and Data Management (IDM) Platform that has a battery of validated instruments in English, French and Spanish, and have the expertise to analyse these. The use of the IDM Platform and the expertise for data analysis can be utilised by UN system organizations.</p>
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2 Role of Managers and Leaders: Short-term recommendation

Key Area	Communication and training
Recommendations	<ol style="list-style-type: none"> 1. Senior leaders to communicate the importance of workplace culture on mental health and well-being and provide simple, implementable ideas. 2. All managers and leaders encouraged to undertake the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme.”
Population	All UN Leaders and Managers
Functional groups	Heads of Entities, other senior leaders, human resources
Action	<ol style="list-style-type: none"> 1. Senior leaders to communicate their commitment to mental health and well-being, the importance of workplace culture on mental health and well-being and provide simple, implementable ideas to support this. Template communications can be provided that can be adapted for this purpose. 2. Managers and leaders are encouraged to undertake the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme” and communicate that they have done this. This programme could be incorporated into performance plans. <p>This online learning programme is a tool to develop UN leaders and managers’ knowledge, skills, and accountability, to support the mental health and well-being of personnel. The four modules of the programme are:</p> <ol style="list-style-type: none"> a) Mental health and well-being in the workplace b) Personal well-being and thriving as a manager

Key Area	Communication and training
	<ul style="list-style-type: none"> c) Supporting a colleague experiencing poor mental health d) Addressing stigma related to mental health problems
Timeline	By end of 2023
Cost	None anticipated. The development of the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme” is being offered free to all UN personnel. Managers and leaders would need to spend approximately eight non-concurrent hours by the end of 2023 to complete the Programme.
Implementation	<ol style="list-style-type: none"> 1. Senior leaders could share messages through broadcasts, events emphasizing the importance of mental health and well-being and communicating what action they are taking to support personnel. Messages could focus on stigma reduction, personal experience and actions being undertaken to create a healthy workplace. The Healthy Workforce United Nations website link could be shared and the resources on the site used to assist with messaging. 2. UN Organizations are encouraged to develop a roll-out plan for the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme.” This could be undertaken in a number of ways: <ul style="list-style-type: none"> ▪ Designate a focal point for the roll-out of the programme and working group with key stakeholders (for example, human resources, learning managers, counsellors), and provide term of reference to support the designated focal points, as well as training; ▪ Adopt a cascading approach, with senior leaders undertaking the programme and communicating with direct reports what they learned; and/or ▪ Ensure performance plans and reviews include learning and capacity building about mental health and wellbeing in the workplace. 3. To monitor progress, the following can be tracked: <ul style="list-style-type: none"> ▪ Senior leaders have communicated messages; ▪ Collect percentages of senior staff completing the Lead and Learn programme; and ▪ Performance review (system) includes objectives for managers on mental health and wellbeing and creating a healthy workplace
Good practice	Good practice in this area requires a proactive approach from UN Organizations and the development of a roll out plan. Early examples of this can be found at UNDP, IAEA and DSS within the UN Secretariat who have sent regular communication encouraging participation on the programme.

2 Role of Managers and Leaders: Medium – Long-term recommendation

Key area	Training and implementation
Recommendation	<ol style="list-style-type: none"> 1. Roll out the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme” and the “mental health and well-being dialogue” in UN organizations;

Key area	Training and implementation
	<ol style="list-style-type: none"> 2. Develop and roll-out additional tools and (training) resources for leaders and managers as well as human resources professionals and on workplace culture and creating a positive working environment, stigma and prevention; and 3. Incorporate mental health and well-being into leadership frameworks, performance requirements, strategic plans, recruitment and induction plans.
Population	Leaders and managers
Functional groups	HR, Counselling, Learning, Communications
Action	<ol style="list-style-type: none"> 1. The “mental health and well-being dialogue” is rolled out in UN Organizations. The main objective of this dialogue is to start and normalize the conversation about mental health and well-being in the workplace. The dialogue is envisaged to enable participants to: <ol style="list-style-type: none"> a) describe some factors at work that can impact mental health and well-being; b) note some simple actions they can take to support each other as a team; and c) find support resources. <p>At a UN organization level, each organization to develop an implementation plan to roll-out the “mental health and well-being dialogue,” supported by system-wide resources. Materials include a facilitator’ guide and powerpoint slides which will be provided free of charge to all UN Organizations. These have been piloted across a range of settings and amendments made in response to this.</p> <p>At a system-wide level a support mechanism needs to be developed for the roll-out of the mental health and well-being dialogue. This would ensure that support and resources are in place for managers delivering the dialogues. This would include:</p> <ul style="list-style-type: none"> • Project lead to provide support and advice roll out approaches and plans • Well-structured and designed training sessions for counsellors • A platform and a community of practice to exchange expertise and good practices. 2. Develop additional tools and (training) resources: for leaders and managers as well as human resources professionals; on workplace culture and creating a positive working environment; on prevention; and on stigma reduction; and 3. Incorporate mental health and well-being into leadership frameworks, performance requirements, strategic plans, recruitment and induction plans: leadership frameworks, performance processes, induction programmes, recruitment processes, to be reviewed with a view to promoting mental health and well-being and ensuring people with a mental health condition are not discriminated against.
Timeline	By end 2023
Cost	Roll-out of the “mental health and well-being dialogue:” while an individual UN organization approach could be taken for this, there are benefits for a UN system-wide support structure which would include development of a learning module how to deliver the ‘mental health and well-being dialogue’ and the development of a community of practice. Cost for this would be approximately US\$60,000.

Key area	Training and implementation
	<p>Development and rolling-out of additional tools and (training) resources: for leaders and managers as well as human resources professionals; on workplace culture and creating a positive working environment; on prevention; and on stigma reduction. Including project management costs and translation into the six UN official languages approximate cost is US\$100,000.</p>
Implementation	<ol style="list-style-type: none"> 1. UN Organizations to communicate about available resources on mental health and well-being and provide links to the Healthy Workforce United Nations website or include on internal intranet sites. 2. UN Organizations to develop an implementation plan to roll-out the mental health and well-being dialogue, supported by system-wide resources. This could be undertaken in a number of ways: <ul style="list-style-type: none"> ▪ Develop internal, tailored roll-out plan considering context and resources. ▪ Ensure support mechanisms are in place including counsellors attending train-the-trainer sessions held at a system-wide level ▪ Link with community of practice ▪ Roll out from senior levels and cascading throughout the organization ▪ Provide managers with the tools and ask them to complete the dialogue within a given timeframe. ▪ Roll out at different duty stations at different times. 3. Mental health and well-being are incorporated in human resources policies, practices and procedures. <ul style="list-style-type: none"> ▪ Review leadership frameworks, performance review practices and induction programme and consider mental health and well-being could be incorporated. ▪ Review recruitment practices to ensure those with mental health conditions have equal access 4. To track completion: <ul style="list-style-type: none"> ▪ Additional resources for leaders and managers are developed and made available to all UN personnel ▪ A support system for the mental health and well-being dialogue roll-out and implementation is developed at a system-wide level ▪ Number of mental health and well-being dialogues conducted. ▪ Mental health and well-being incorporated into leadership frameworks, performance reviews and induction programmes.
Good practice	<p>This recommendation focusses of the development of new resources and as such good practice will be established and conveyed in future HLCM reports.</p>

3 Psycho-social Recommendations: Short-term recommendations

Key Area	Psychosocial services
Recommendations	<p>UN Organizations are encouraged to:</p> <ol style="list-style-type: none"> 1. undertake a robust communications effort to ensure staff are aware of existing internal and external mental health support services. 2. undertake an audit of psychosocial services available through internal counsellors, insurance providers and other services. A template can be provided to assist with this process; and. 3. use mechanisms that closely track usage and impact of their internal psycho-social support systems.
Who benefits	All personnel
Responsible functional groups	HR, Counselling, Communications
Action	<p>An internal audit within each agency is recommended to inform the proposed robust communications drive which will enhance awareness of available support services. This audit is intended to count the number of counsellors in the agency, and to collect the terms of reference (TOR) for each counsellor. The TORs can then be used to keep track of specific services offered.</p> <p>It is important to recognize that the impact of internal psycho-social support systems is difficult to measure outside of a research facility. Thus, measuring impact is dependent on correlates and indicators including demand for the service, creation of positions, and cross-functional committee seats. Strategic plans could also be an indicator of impact through tracking the desired outcomes of the service. There is great utility in tracking the usage of internal support systems. To better track usage, it is recommended to distinguish between the types of consultations provided. It is suggested to discriminate between i) initial contact only, ii) clinical contact requiring individualized serviced support, iii) managerial contact requiring customized serviced support, and iv) seminars.</p>
Timeline	Monthly monitoring ongoing basis
Cost	Time taken to undertake required tasks, such as mapping psycho-social resources, developing communication messages and put in place structures to track service usage.
Implementation	<p>To track psychosocial services available to inform a communications drive:</p> <ol style="list-style-type: none"> 1. Count of number of counsellors in agency 2. Collection of TORs for counsellors of each agency to track services offered 3. Identification of physical locations of counsellors 4. Count number of cost shared UN counsellors available for personnel. <p>To measure the impact, the following could be tracked:</p> <ol style="list-style-type: none"> 5. Cross-functional committee seats mental health services participate in

Key Area	Psychosocial services
	<p>6. Strategic plan desired outcomes</p> <p>7. Are services provided to family members? Which services?</p> <p>To measure the usage, the following should be tracked monthly:</p> <p>8. Number of consultations</p> <p>9. Who the consultations were with, divided into following groups:</p> <p style="padding-left: 20px;">i) initial contact, ii) clinical contact requiring serviced support, iii) managerial contact, iv) seminars.</p> <p>10. Reason for consultation (e.g., workshops, team support, advice, inter-collegial conflict, conflict related to supervisor, un-collegial work environment etc.).</p>
Good practice	<p>WFP measures the impact of their communication through monitoring:</p> <ul style="list-style-type: none"> ▪ Number of attendees of webinars ▪ Number of downloads of Wellbeing app <p>UNDP:</p> <ul style="list-style-type: none"> ▪ Internal all-staff communications email from Headquarters listing available resources of psychosocial support and upcoming events as well as sharing relevant resources individually as a follow up on incoming inquiries, and with HR focal points on upcoming events ▪ Wellbeing site via SharePoint with available resources, contact information and upcoming events schedule ▪ Yammer Wellbeing café page, with available resources, useful tips, and upcoming events ▪ Interagency Wellbeing app ▪ Feedback surveys post-event and post-individual counselling <p>IAEA:</p> <ul style="list-style-type: none"> ▪ Creation and promotion of Staff Wellbeing Portal ▪ Continuous campaigns and events announced through the intranet, accessible to all Vienna-based-organizations ▪ Utilization of world mental health month and other UN days, e.g., autism awareness day etc. to create visibility and awareness ▪ Regular cooperation with other departments ▪ Comprehensive statistical records of usage and impact of internal psycho-social support systems being kept and reported annually

Key Area	Psychosocial services
	<p>External example: RAND National Defence Research Institute tracking of:</p> <ul style="list-style-type: none"> ▪ Reasons for seeking counselling ▪ Satisfaction with speed of being connected to counsellor ▪ Satisfaction with confidentiality of personal and family information held by program

3 Psycho-social Recommendations: Medium – long-term recommendations:

Domain	Psycho-social support
Key Area	Psychosocial services
Recommendation	UN Organizations are encouraged to adopt the minimum requirements and quality standards of professional support mechanisms outlined in the United Nations Staff/Stress Counsellors Group’s (UNSSCG) paper on “Guidance on Professional Standards for UN Counsellors” to track compliance of staff counsellors. A template can be provided to assist with this process.
Who benefits	All personnel
Responsible functional groups	HR, Wellness, Counselling
Action	<p>UN Organizations to ensure agreed UNSSG standards are implemented.</p> <p>Minimum requirements and quality standards of professional support mechanisms have been outlined in the United Nations Staff/Stress Counsellors Group’s (UNSSCG) paper on Guidance on Professional Standards for UN Counsellors. This paper outlines guidance for professional standards to ensure the protection of staff, and that counsellors are competent to practice and work to the highest ethical standards. Within this paper, UN agencies are held accountable for their own adoption and implementation of the guidance, with support offered by UNSSCG. Thus, agencies are requested to utilize the guidance to track compliance of staff counsellors.</p> <p>Additional guidance can be found in the UN System Workplace Mental Health and Well-being Implementation Guide (see Annex II in CEB/2022/HLCM/14/Annex 7).</p>
Timeline	To be included in annual reviews.
Cost	Time would be required to ensure compliance measures are met and structures put in place to review this.
Implementation	<p>Track the compliance of the staff counsellors with professional standards as set out by UNSSCG:</p> <ol style="list-style-type: none"> 1. System level and experience: <ul style="list-style-type: none"> ▪ The counsellor must have a minimum of five years of experience 2. Malpractice and/or Violations of Professional Standards as stated in the license: <ul style="list-style-type: none"> ▪ The counsellor must have no currently pending allegations of violation of ethical standards or malpractice suits ▪ The counsellor must have no history of licensure, registration, or certification suspensions or revocations

Domain	Psycho-social support
	<p>3. Educational qualifications:</p> <ul style="list-style-type: none"> ▪ The counsellor must have an Advanced/Postgraduate University Degree or equivalent in psychology, counselling, psychology, clinical psychology, psychiatry (medical or nursing), marriage and family therapy, or social work with evidence of training in mental health counselling ▪ The counsellor who does not possess a license, certification, or professional membership must provide an official transcript documenting extensive course work including courses on theory, skills, and ethics plus face-to-face client work, with evidence of supervised client hours while in a student status <p>4. Licensure, Certification and Registered Membership:</p> <ul style="list-style-type: none"> ▪ The counsellor possesses an active license or certification or demonstrates registered membership in a legitimate professional organization in the field most relevant to their degree, including psychiatry (medicine or nursing), psychology, counselling, marriage and family therapy, and social work. ▪ The counsellor already working in the UN system who does not possess licensure or certification, or registration with a professional organization for reasons related to residency is working to obtain licensure, certification, or membership in a professional organization no later than April 1, 2023. <p>5. Continuing Professional Development:</p> <ul style="list-style-type: none"> ▪ The counsellor demonstrates that they are continually updating their professional expertise as part of the licensure and licensure renewal procedure. ▪ Human Resources of the counsellors' respective agencies assume responsibility for ensuring that staff maintain and update their licenses.
Good practice	<p>WFP:</p> <ul style="list-style-type: none"> • Embedded UNSSCG guidelines into Terms of Reference and staff counsellor profiles <p>IAEA:</p> <ul style="list-style-type: none"> • Auditing available psychosocial services: Annual report in progress <p>CISMU:</p> <ul style="list-style-type: none"> • Provides technical guidance and ensures professional standards of practice for staff/stress counsellor recruited in DPO/DPPA mission, and UN country offices. • Conducts a standard certification training for UN counsellors and External Mental Health Professionals. • Conducts regular regional training sessions for the counsellors in each region.

4 Groups of personnel who experience an increased impact

Recommendation	<p>UN organizations are encouraged to:</p> <ol style="list-style-type: none"> 1. focus on having an inclusive workplace environment and enhancing autonomy to ensure all personnel are not discriminated against and can balance competing needs. 2. in partnership with UN counsellors, could identify and implement innovative ways to provide informational and emotional support to the families of staff members, which then decreases the likelihood of mental health issues in the staff member. Psychosocial wellbeing of staff is directly related to the well-being of dependents which has been identified in several of the studies mentioned in this report.
Who benefits	All personnel
Responsible functional groups	HR, Well-being, Counselling, Diversity and Inclusion teams
Action	<p>In the report presented at the April 2022 HLCM meeting it was noted that some groups experienced a greater impact on their mental health and well-being. The data identified a number of groups of personnel as being at greater risk of poor mental health. This was related to gender, age, employment status, family situation, pre-existing mental health condition, or being a personnel victim of domestic abuse. Whilst there may be opportunities to consider targeted interventions for these groups, generally the principles laid out in the earlier recommendations would be beneficial for all and reduce the impact of challenges faced. We thus recommend that UN Organizations acknowledge that personnel exist within complex systems with unique circumstances exacerbated by the pandemic. If we focus on having an inclusive workplace and increasing autonomy personnel, we can reduce discrimination and increase the level of autonomy personnel will be more likely to be able to manage competing demands.</p>
Timeline	NA
Cost	Resources would be required to provide to support family members. Costs would vary dependent on the type of support made available.
Implementation	<p>Workplace factors: increasing autonomy allows personnel to better manage the challenges of balancing workload and care giving responsibilities as they are more able to consider best how to undertake their competing priorities. This could reduce some of the extra challenge that personnel face with care giving duties. <u>If we focus on having an inclusive environment and reduce discrimination, this will have a positive impact for those who are more likely to experience circumstances leading to poorer health outcomes.</u></p> <p>Leaders should consider how additional circumstances and burdens can be considered when introducing policies related to flexibility and work-life harmony.</p> <p>Leaders and managers: Training leaders and managers to create a workplace environment that promotes good mental health and well-being ensures that irrelevant of the issues that are being faced they are more likely to be supportive, allow increased autonomy, and refer someone to help where needed. Personnel experiencing long-covid will be able to have accommodations made where needed. For example, the Lead and Learn programme gives managers increased skills to notice if a staff member is experiencing challenges and how to support them through</p>

	<p>this. Managers will be more likely to create an environment personnel feel able to disclose if they are not ok. Personnel experiencing long-covid will be able to have accommodations made where needed.</p> <p>The following should be considered:</p> <ul style="list-style-type: none"> ▪ Do managers require additional training on how to identify personnel circumstances that require support? ▪ Do managers require additional training on how to support personnel based on their circumstances? ▪ Do managers require additional support programmes? ▪ Do managers regularly communicate with staff about programs, policies and accommodations available? <p>Psycho-social support: Through ensuring effective psycho-social support mechanisms, all personnel will be able to access quality support for their circumstances.</p> <p>The following should be considered:</p> <ul style="list-style-type: none"> ▪ Are our current support services sensitive to individual circumstances? ▪ What training do our psycho-social service providers need to ensure they can meet the need? ▪ Programmes to support counsellors ▪ Programmes to provide familial support <p>In implementing recommendations related to workplace factors, the role of leaders and managers and psycho-social support these issues should be considered.</p>
Good practice	<p>WHO:</p> <ul style="list-style-type: none"> ▪ Online support <u>groups for personnel who experienced an increased impact</u>: offered online support groups with limited places in order to increase interaction and provide a safe place for people to share concerns, challenges, and best practices (i.e., How to support aging parents from distance, parenting best practices during COVID-19, Long covid-19 support groups) ▪ Individual online counselling, and monthly online all-staff Seminars on various psychosocial topics <p>IAEA:</p> <ul style="list-style-type: none"> ▪ Creating an inclusive environment: Dignity and Inclusion Campaign, all VBOs together: Ongoing webinar series on inclusion-related monthly subjects to raise awareness and create a VIC-wide culture of inclusivity, respect, and dignity. ▪ Providing support to family members/dependants: family members and dependants are eligible to approach the staff counsellor just like staff members; provided with assessment and tailored external referral ▪ Website with comprehensive information on what constitutes abuse and where to get help ▪ Close cooperating with internship programme, gender focal point, and other relevant partners. ▪ In development: information material targeted at risk groups.

Annex III
Compliance tracking template

Agency / Fund / Program	
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Service Line	Professional Speciality Group	Licensure Status	Certification Status	Professional Organizational Membership	Actively seeking licensure or certification	Supervision Plan required?
Staff Counsellors						
Stress Counsellors						
Staff Welfare Officers						
Other (please identify)						

Annex 7

2018-2023 UN System Workplace Mental Health and Well-being Strategy + 2024 and beyond

Progress Report

Background

1. The United Nations System Workplace Mental Health and Well-Being Strategy¹ is a comprehensive approach to address the needs of United Nations personnel and improve organizational capacities to protect and promote good mental health and prevent poor mental health. It was endorsed by the heads of management of all UN system organizations, and it applies to the whole of the UN system. The Strategy is for all personnel, across diverse roles, contexts and environments, from deep-field missions to Headquarters.
2. Launched by the Secretary General in October 2018,² the UN System Workplace Mental Health and Well-being Strategy aimed to:
 - a) Create a workplace that enhances mental and physical health and well-being;
 - b) Develop, deliver and evaluate high-quality psychosocial services everywhere that UN staff work;
 - c) Welcome and support staff who live with mental health challenges; and
 - d) Ensure sustainable funding for mental health and well-being services.
3. A multi-agency, multi-disciplinary Implementation Board was established and a P5 Global Lead was appointed to support the implementation of the strategy.

Progress

4. In the 3.5 years since the Strategy's launch, the UN has dealt with a myriad of political, social and health issues that have threatened the mental health and well-being of our personnel. Work commenced on implementing the strategy in 2019, with initial actions taken for most priority actions identified in the Strategy.
5. The pandemic upended work and home lives, impacting on mental health and well-being across the globe. In March 2020 it was agreed to suspend the workplan of the implementation board to focus on immediate needs. This included:
 - a) providing resources that can be adapted by UN Organizations to address current and emerging mental health and wellbeing issues arising due to the COVID-19 outbreak;
 - b) minimizing duplication of resources by providing tools that could be shared across the UN System;
 - c) ensuring equitable access to quality psychosocial support through online tele-counselling and reviewing insurance products;
 - d) communication and engagement activities; and
 - e) establishing a domestic abuse taskforce

¹ <https://www.un.org/en/healthy-workforce/files/Strategy%20-%20full.pdf>

² <https://www.un.org/sg/en/content/sg/speeches/2018-10-16/un-system-workplace-mental-health-and-well-being-strategy-remarks>

6. Over this period the Implementation Board, supported by the Global Lead along with a small team worked diligently to shore up support for UN personnel and their families.
7. Additional activities since the launch of the strategy include:
- a) **Establishment of the Implementation Board:** A system wide, multi-disciplinary body charged with leading and monitoring the implementation of the UN System Workplace Mental Health and Well-being Strategy.
 - b) **Development and roll out of the ‘Lead and Learn’ program:**³ A robust educational tool that is free to all users within the UN system. Fully funded by the UN Secretariat.
 - c) **Creation of the Implementation Guide and Scorecard:** A tool aimed at assisting UN Organizations to implement the strategy and monitor progress towards achieving common standard ‘good practices’. The Implementation Guide and Scorecard contain agreed upon programs and standards that the UN system can work towards. This common approach will allow UN Organizations to share good practices and use economies of scale for products such as well-being apps, insurance provisions and communications materials.
 - d) **Communication with personnel:** Tools including a website,⁴ online events, World Mental Health Month activities, podcasts, factsheets, interviews and board communications all played a part in letting personnel know their needs were being heard.
 - e) **Stigma reduction:** Communications and engagement activities were undertaken to reduce stigma and relevant information was developed for the mental health matters website including a language guide was developed. Events were held with personnel sharing their experiences with mental health issues. A stigma reduction module was developed for the Workplace Mental Health Lead and Learn Programme.
8. To date the implementation of the UN System Strategy has been mainly funded with voluntary contributions in cash and personnel as well as other in-kind types. Currently there are limited resources to complete the remaining priorities during the next 15 months. Annex I presents a summary of the finances since the launch of the Strategy through 30 September 2022 and Annex II presents a summary of the resources required from October 2022 through 31 December 2023.

³ <https://www.unssc.org/courses/workplace-mental-health-and-well-being-lead-and-learn>

⁴ <https://www.un.org/en/healthy-workforce/files/Strategy%20-%20full.pdf>

Next steps

9. The current strategy will conclude until the end of 2023. Over the next 15 months the Implementation Board will continue with the agreed 2022-23 workplan. Some of the focusses of this plan focusses on includes:

- a) The next phase of the Led and Learn roll out:
 - this phase focuses on individual organizations promoting the Lead and Learn program (as opposed to at the system wide level)
 - organizational integration of the Lead and Learn program through respective senior leadership promotion, inclusion in workplans, and the use of communication tools to advocate for participation
- b) A system-wide pilot of the Mental Health and Well-being Scorecard (see Annexes III and IV) to assist UN organizations to:
 - map current programs and priorities against identified good practices;
 - use of the Scorecard for 'snapshot reporting' to create historical data trends which can be used to identify impact of resourcing and prioritize future funding allocation;
 - identify common materials which can be shared through MHS platforms to minimize duplicate efforts; and
 - use of the information gathered to inform the next Mental Health and Well-being Strategy 2024- and beyond.
- c) Distribution and data analysis of the next UN Health Survey:
 - building on the already established partner network to combine the data from UN Organizations and continue to advocated for the robust reporting (over 22,000 personnel) from the last UN Health Survey
 - Distribution and data analysis of the next UN Health Survey
- d) Undertake communication and engagement activities such as events, World Mental Health Day activities and setting up online communication tools.
- e) Identification of resources needed to complete the remaining of the 2022-2023 workplan

10. As reflected in the last UN Health Survey, there is a continued trend of workplace stress within the UN which is now magnified by the effects of COVID and its resulting economic and social impacts. As we work collectively towards the future of work, the efforts of the Strategy Implementation Board and our implementing partners will become even more critical to ensuring the mental health and well-being of UN personnel. Our focus is on continuing to provide the tools to educate staff (Lead and Learn), helping to identify opportunities for early intervention (surveys), and assisting UN organizations to avoid duplication and work towards agreed best practices (Implementation Guide and Scorecard). We know that more work is needed to ensure we are creating a healthy working environment, giving leaders and managers the tools they need, reducing stigma and ensuring we are supporting personnel with mental health issues. We need to ensure all UN Organizations are taking action and that we are measuring progress against benchmarks. We also need to focus on those who are experiencing a greater impact, based on gender, age and race. The report on the impact of COVID-19 on the impact a number of key issues that have arisen that need to be addressed.

11. As we approach the end of the currently Strategy, it is of utmost importance to start as early as possible to consider actions and priorities required for 2024 and beyond as the work cannot stop. The Strategy Implementation Board has begun such work with a view of presenting a final proposal to HCLM at its 46th Session. The work will involve:

- Engaging stakeholders: meetings to identify the various needs and limitations for UN Organizations for delivering on a new strategy;
- Reaching consensus on ‘what has worked and what has not’ in the last strategy; and
- Taking into account:
 - the new realities COVID has created in the aspects of the definition of the ‘workplace’ and how this effects the mental health and well-being of UN personnel
 - the WHO guidance to be launched on 28 September 2022
 - the WHO-ILO Policy Paper to be launched on 28 September 2022
 - the Joint Inspection Unit (JIU) evaluation of mental health and well-being policies and practices in the UN System organizations scheduled to be released in the Spring of 2023
- Arriving to a full funding proposal and a sustainable resourcing model for 2024 and beyond will be presented at the 45th session of the HLCM.

12. Finally, and in the words of the Strategy Implementation Board and supporting stakeholders, the aim is to make...

“The UN system an inclusive, sustainable work environment where mental health and well-being is embedded in our organizational culture and systems where each and every one belongs, is valued, nurtured and thrives, ensuring an efficient workforce delivering on our promise of a better world.”

Proposed actions for the HLCM

13. The HLCM is invited to:

- a) Support the upcoming activities of World Mental Health Day; and
- b) Commit to use the Implementation Guide and Scorecard.;
- c) Consider contributing to the costs of the activities of the remaining 15-months of the Strategy, as outlined in Annex II.

Annex I
UN System Workplace Mental Health and Well-being Strategy
Implementation Board
Finances October 2018 to 30 September 2022

To date the implementation of the UN System Strategy has been mainly funded with voluntary contributions in cash and personnel as well as other in-kind types.

Total Contributions in Cash as of 30 September 2022	
Organization	Amount
UN Cares	\$ 20,000
UN Secretariat	\$ 192,000
ILO	\$ 10,000
WHO	\$ 10,000
WIPO	\$ 20,000
UNDP	\$ 100,000
UNICEF	\$ 30,000
Total:	\$ 382,000

Total Funds used as of 30 September 2022	
Activity	Amount
Communication and engagement related activities	\$ 45,000
Commissioning of reports (Mapping psychosocial support, stigma)	\$ 18,000
Development of tools and resources (for example website):	\$ 60,000
Development of the UN online “Workplace Mental Health and Well-being: Lead and Learn Programme”	\$ 140,000
Development of Implementation Guide and Scorecard	\$ 36,000
Data analysis	\$ 5,000
In-person Board meetings	\$ 16,000
Total:	\$ 325,000

Currently available funds: \$57,000 which are committed to:

- Consultant to assist with Systemwide activities, primarily rolling out the implementation and monitoring progress; and
- Translation of resources

Total Contributions in Personnel as of 30 September 2022	
Organization	Position
UN Secretariat	P5 Global Lead (since January 2019 to date)
	P3 TJO (six months: March to September 2022)
	JPO (at 50% of time, six months March to September 2022)
	G6 (33 months: May 2019 to January 2022)
ICSC	loan of a P4 for ad hoc tasks
UNHCR	loan of a P5 for 6 months
WFP	loan of consultant to assist with report writing

It is important to note that many UN Organizations have provided support on the Implementation Board, in working groups and by leading projects. In addition UNSSCG, UNMD, CISMS, Ombudsmen and Mediators, and the three Staff Federations have provided support in the form of expert advice, presenting at and organizing events and being advocates.

Total Contributions in Kind as of 30 September 2022	
Organization	Type
UN Secretariat	Chair and oversight of Implementation Board
	Ad hoc programme and administrative support
	Recruitment and support of 12 interns
	Translation of materials
IAEA	sharing of tools developed
ILO	sharing of managers and leaders resources
IOM	sharing of tools developed
UNICEF	sharing of tools developed
UNSSC	support for Implementation Board 2022 retreat

Annex II
UN System Workplace Mental Health and Well-being Strategy
Implementation Board
Finances for 1 October 2022 to 31 December 2023

Below are the cash and personnel resource requirements for which voluntary contributions are being sought.

Required Cash	
October 2022 through December 2023	
Activity	Amount
Communication and engagement related activities (events, speakers, travel, etc.)	\$ 30,000
Development of tools and (training) resources (including project management and translation): a) for leaders and managers as well as human resources professionals; b) on workplace culture and creating a positive working environment; c) on prevention; and d) on stigma reduction.	\$ 100,000
Data analysis	\$ 5,000
Evaluation and reporting	\$ 15,000
Preparation of the strategy proposal for 2024 and beyond a) Project management; b) Stakeholder engagement; c) Data analysis; d) Translation into the six official UN languages; e) Launch; and f) Communications campaign	\$ 100,000
Roll-out of the Implementation Guide and Scorecard in UN organizations	\$ 30,000
Roll-out of the "mental health and well-being dialogue" in UN organizations	\$ 60,000
Website maintenance	\$ 5,000
In-person Board meetings	\$ 10,000
Total:	\$ 355,000

Required Personnel as of 30 September 2022	
Role	Comments
Global Lead P-5	Funded by UN Secretariat.
Programme Officer: To oversee the implementation of resources development, relevant projects and working groups.	Unfunded. Options: <ol style="list-style-type: none"> 1. UNVs based in Nairobi (one-year cost US\$60,000 per UNV for a total of US\$240,000); 2. Organizations temporarily release staff on non-reimbursable loan to work virtually for a limited time period with the Global Lead. The staff member could be from the GS, NO or P category and would work from their current duty station. This could present an excellent opportunity to give staff the opportunity to work on a system-wide project and gain new skills without needing to travel to New York. It would be expected that the home agency would continue to pay the staff members salary over this period; 3. Organizations provide resources to fund temporary staff positions
Communications Officer: To oversee relevant communication activities, including events, stakeholder engagement	
Monitoring and Evaluation Officer: To monitor progress and oversee evaluation activities	
Administrative Officer: To provide administrative support	

Annex III

UN System Workplace Mental Health and Well-being Strategy Implementation Guide

INTRODUCTION

The United Nations System Workplace Mental Health and Well-being Strategy (hereafter, 'The Strategy') aims to increase the effectiveness of the United Nations by optimizing the psychological health of its personnel. As a supporting document to The Strategy, this Implementation Guide (hereafter, 'The Guide') serves to assist UN organizations to mainstream psychosocial health and well-being into the culture of the United Nations. The Strategy's focus on creating a healthy workplace is underpinned by specific administrative and process related indicators which will facilitate this change.

Recognizing that this is a *workplace* mental health and well-being document, these initiatives focus on the workplace and the individual's interaction with their workplace. This includes a focus on preventative measures, investment in mental health and well-being programmes, education to reduce stigma, and ensuring that there is equal access to quality psychosocial support as directed in The Strategy.

While The Guide focuses on collecting data for Priority Actions (as outlined in The Strategy), other activities may also form part of an overall Action Plan depending on the needs of your organization. Recognizing that not every Priority Action is equally applicable to every United Nations entity, these indicators are not meant to compare groups, but instead create benchmarks the Agencies, Funds and Programs can use to measure progress.

GOVERNANCE

In 2015 the High-level Committee on Management (HLCM) endorsed the Occupational Safety and Health Framework, recognizing the need for the systematization of the management of occupational health risks. Concurrently, HLCM developed a body of work on duty of care for staff in high-risk duty stations. One of the recommendations was for an overarching policy framework for psychosocial health. However, based on the results from the 2015 UN-Wide Health Survey, it was clear that the need for improved psychosocial health was not limited to high-risk duty stations, and should be a priority for all UN personnel. This realization produced the strategy document *A Healthy Workforce for A Better World* developed by a multi-agency, multi-disciplinary working group. The document outlined the United Nations System Mental Health and Well-being Strategy and was adopted by the HLCM in September 2018, launched in October 2018 with work commencing in 2019.

As a follow up to the Mental Health and Well-being Strategy, the Chief Executive Board for Coordination (CEB) published a 'High Level Implementation Plan and Budget' which underlined the interagency nature of the work. Special attention was given to the 'complexity' versus the 'complicated' nature of the implementation model and listed the core requirement of the approach 'to be cognizant of [the] complexity of UN system of agencies and recognition of agency autonomy and a desire to pro-actively implement what is 'right for their agency'. UN Agencies, defined as 'partner agencies' were tasked with implementing a co-creative process, along with joint investment and governance of a shared resource fund, utilization, and outcomes. This governance is currently maintained through the Mental Health Strategy Implementation Board where 'members have strategic oversight and [provide] support via a hybrid approach to successful and practical operational implementation of [the strategy] across the UN family of agencies...'⁵

⁵ [Implementation Board TORs](#)

THE ROLE OF THE ORGANIZATION

Structuring the workplace, working conditions and workplace culture to put people first can have a significant impact on the mental health and well-being of personnel. According to the World Health Organization, many organizational factors influence the mental health of employees. These issues include poor communication and management practices, limited participation in decision-making, long or inflexible working hours and lack of team cohesion. Bullying and psychological harassment are well-known causes of work-related stress and related mental health problems.⁶

Comparison studies have shown that the reported levels of symptoms consistent with mental health conditions are higher in the UN (at approximately 50%) than in the general population.⁷ Successive Staff Well-being Surveys have highlighted that the longer people work for the United Nations the more likely they are to have negative mental health outcomes. Anxiety, depression, post-traumatic stress, and hazardous drinking negatively impacts the quality of life of thousands of UN employees and costs the Organization millions of dollars every year.⁸

Despite current investment, there is an opportunity for improvement within the UN organizational mental health and well-being approach. The Guide asks UN partners to influence change in four main areas as taken from The Strategy:

1. Create a workplace that enhances mental and physical health and well-being.
2. Develop, deliver, and continuously evaluate mental health and well-being services in all duty stations.
3. Welcome and support staff who live with mental health challenges.
4. Ensure sustainable funding for mental health and well-being services.

These thematic areas will serve as a foundation to achieve the overall goal of *increasing staff member resilience, productivity, and engagement*.⁹ Actions need to be taken to ensure the UN is creating an environment that enables good mental health and well-being, facilitates the ability of personnel to improve their resilience and ensures targeted quality intervention is available for those seeking help.

To further these efforts, organizations will be asked to develop a Workplace Mental Health and Well-being Action Plan, based on principles found in The Strategy. Keeping in mind that the size and resources of entities vary, partners will be asked to tailor their plans to fit their specific needs and available funding. For some organizations, The Guide will serve as a first step, while for others it is an opportunity to review their existing plans.

DEVELOPING A MENTAL HEALTH AND WELL-BEING ACTION PLAN

A Workplace Mental Health and Well-being Plan refers to a coordinated and comprehensive set of strategies which include programs, policies, benefits, environmental supports, and links to resources designed to meet the mental health and well-being needs of all personnel.¹⁰

The systematic process of building a Workplace Mental Health and Well-being Plan emphasizes four main steps:

⁶ [WHO Mental Health in the Workplace](#), 22 Jan 2019

⁷ A Healthy Workforce for A Better World, pg. 8

⁸ A Healthy Workforce for A Better World, pg. 8

⁹ A Healthy Workforce for A Better World, 01 Outcome Measure, pg.10

¹⁰ <https://www.cdc.gov/workplacehealthpromotion/model/index.html>

- Step 1 – Workplace Assessment
 Step 2 – Planning
 Step 3 – Implementing
 Step 4 – Determine Impact through Evaluation



Step 1- Workplace Assessment

In the first step, data is collected to assist organizations to decide where to focus resources. There are three data collection levels to consider which cover the key areas of people, programs, and initial funding. Ideally, assessment team members should include people with lived experience.

- Interpersonal – elements of personnel's workplace network which includes relationships with managers and coworkers.
- Organizational – elements of the workplace structure, culture, practices and policies such as benefits, health promotion programs, work organization, and leadership and management support for workplace well-being initiatives
- Environmental – elements of the physical workplace such as facilities and settings where employees work as well as access and opportunities for health promotion provided by the surrounding duty station.

Data sources for this assessment may include, but are not limited to: psychosocial assessment tool, sick leave data, use of EAP or counseling services by topic, job satisfaction surveys, UN-Wide Health Survey, internal data collection methods (surveys, questionnaires, personnel inputs)

Step 2- Planning

During this phase resources are identified based on the priorities identified in step one. These resources may include:

- Senior leadership- individuals who will serve as a role models, communication leaders and champions within management.
- A workplace coordinator or working group to oversee the plan.
- Dedicating the financial resources necessary to execute the plan.
- Creating a communications strategy to inform all personnel about priorities, resources, and how to join the effort.

Examples of Planning Group TORs can be found on the UN Healthy Workforce website

Step 3 – Implementing the Plan

It is important for Mental Health and Well-being Plans to contain a combination of individual and organizational level interventions. These may include:

1. Mental Health and Well-being programs– opportunities available to personnel to begin, change or maintain behaviors supportive of their mental health and well-being goals. This may include access to counseling services- either internal or external- educational programing, online well-being tools, and training opportunities such as the Lead and Learn Program.
2. Mental Health and Well-being related policies– formal or informal written statements that are designed to protect or promote the mental health and well-being of personnel. Supportive policies affect large groups of personnel simultaneously and make adopting healthy behaviors easier. Examples may include return-to-work policies for those coming back after experiencing a mental health condition, SOP's for reasonable accommodations, and policies that allow for greater autonomy for workload management, telecommuting, and work-life harmony.

Step 4 – Determine Impact through Evaluation

The evaluation stage of the project is important for two reasons. First, it allows for information to be gathered on ways in which the plan can be improved over time. Second, the evaluation is a way to define the value of the plan to senior management.

There are 6 key areas for inclusion in your evaluation which are reflected in the Scorecard provided. These areas are based on the Priority Actions outlined in the Mental Health and Well-being Strategy. The following areas can be used in all stages of the project including to inform initial data collection, assist with creating the plan and finally implementation and evaluation.

PRIORITY ACTION 1 – Psychosocial support

Resource and distribute psychosocial support and mental health services to enable all United Nations staff who need it, especially those at higher risk, to have universal and equitable access to these services within 18 months of endorsement.

Psychosocial support is defined by The Strategy as services which are;

1. *appropriate*, ‘this includes access to advice, psychosocial support and mental health treatments which are responsive to [an individual’s] personal characteristics’¹¹ and take into consideration cultural, linguistic, and social factors.
2. *accessible* and allows staff members to ‘engage with services regardless of where they are working’.¹²
3. *achieve* the goal of return-to-work where ‘staff takes part in the return-to-work programmes that are coordinated and integrated across professional groups.’¹³

Action Plan (potential items for inclusion in initial assessment/ planning):

- Review of currently available service delivery options (internal counsellors, external access, peer support specialists, etc.) (Tool provided)
- Review of return-to-work policies through a mental health and well-being perspective.
- Review practices in place to facilitate reasonable accommodation for personnel with a mental health condition (educating managers, informing staff of their rights, case management in place).
- Assess wait times for access to mental health professional through internal resources or an external provider

Reporting –indicators listed in Scorecard

PRIORITY ACTION 2- Stigma Reduction

Implement stigma reduction and health promotion approaches over the five-year period, to strengthen the knowledge, skills and behavior of all United Nations staff members with regard to staying psychologically fit and healthy and to ensure that concerns about stigma, anticipated and/or experienced, are not a barrier to achieving good mental health and well-being.

Stigma can be influenced at three levels: organizational, managerial, and individual.

1. At an *organizational level*, issues such as the use of appropriate language, policies to assist those seeking help, and parity in the support of those with physical and mental health diagnosis should be supported.
2. At a *managerial level*, training to recognize and discuss mental health and well-being challenges both in individual and team settings is important. Additionally, managing the processes around return-to-work is a vital role for managers, both with other departments and within their own teams.
3. At an *individual level*, people should know not only *where* to access mental health and wellness services, but also recognize any internal or external stigma that might be preventing them from seeking help.

¹¹ A Healthy Workforce for A Better World, pg. 17

¹² A Healthy Workforce for A Better World, pg. 17

¹³ A Healthy Workforce for A Better World, pg. 17

Cultural, social, and institutional contexts influence the way staff members experience and perceive stress and mental health issues. This culturally influenced, anticipated and perceived stigma, are common and contribute to fear of acknowledging one's mental health issue and subsequently seeking mental health care. This delayed, or no-care, outcome is associated with lower self-esteem and compromised engagement in employment.¹⁴ The sooner people get help the better the outcome for them, and for the organization.

Action Plan (potential items for inclusion in initial assessment/ planning):

- Review of currently available stigma reduction tools such as language guides, educational material for individuals and managers, communications materials.
- Review of return-to-work policies through a mental health and well-being perspective with an emphasis on perceived or actual stigma people may experience.
- Assess if practices are in place for those who are experiencing stigma to be able to seek help through official (reporting) or unofficial (counseling) channels.
- Check current levels of perceived or actual stigma using the UN-Health Survey or other organizationally pertinent surveys.

Reporting - indicators listed in Scorecard

PRIORITY ACTION 3 and 4 - A Healthy Workplace (Prevention and Well-being)

Initiate a suite of prevention interventions, informed by best practice and shown to influence positively the protective factors associated with good mental health and well-being, as well as avert or minimize harm from known risk factors, directly and indirectly for the staff member, and/or from the environment in which they work. Establish a workplace well-being programme, with an agreed charter, practical support, training and recognition awards for teams and managers that enables the achievement of respectful, resilient, psychologically safe and healthy United Nations workplaces over a five-year timescale.

Workplace prevention and well-being interventions differ from most interventions as they are organizationally based, not individually based. While the result will ultimately be measured by improvements for the individual, the delivery methods differ.

To support prevention and well-being in the workplace, organizations need to consider *how we work* and *the environment* in which we work- all resulting in the individuals *experience* of the workplace.

Organizations will be asked to identify the most prevalent *workplace* risk factors and the most prevalent *workforce* risk factors. While these two concepts are closely related, they differ in that workplace factors are organizationally driven, while workforce factors are individual behaviors based on the perceived wants, needs or constraints of the workplace.

United Nations personnel report *workplace* risk factors around 3 main topics: lack of time, lack of resources and lack of control over job/ career. *Workforce* stressors are often the behavioral results of the primary stressors listed above and can be modified with coping strategies supported by the organization and managers. These stressors include; working outside core hours, feeling obligated to be online/available 24/7 and wanting to improve work life balance.

¹⁴

<https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1271-3#Sec2>

Workplace and workforce stressors are often closely linked. Improvement in one area can lead to gains in the other and often advancement can be made simultaneously. One way these gains can be made is through educational programs for both managers and staff on the well-being benefits of clear expectations and boundaries in the work/ life harmonization arena. Additional educational areas may include managing stress (work related or otherwise), healthy communication styles, and timely and open conversations career plans and goals.

Action Plan (potential items for inclusion in initial assessment/ planning):

- Psychosocial Risk Assessment and eventual mitigation plan
- Implementation of recommendations from the Future of Work report.
- Review work policies to ensure staff have autonomy and flexibility within policy limits (tele-commuting, right to disconnect, workload management, work-life harmony, etc.)
- Potential creation of a well-being working group

Reporting - indicators listed in Scorecard

PRIORITY ACTION 5 – Insurance

Complete a review of United Nations Health Insurance provision, and United Nations social protection schemes (for disability and compensation) within two years, to achieve equity of coverage for mental health, and ensure that provision is adequate, acceptable and appropriate.

Quality health insurance is necessary for organizations and individuals to optimize their psychological health. Adequate networks, acceptable levels of coverage and appropriate delivery mechanisms, empower personnel to seek help when needed. While insurance coverage related to physical illness is well understood, reaching mental health parity can be a challenge. When organizations have inadequate coverage for mental health care, they effectively discriminate against the people who need that assistance.

This discrimination is unintentional. It is often buried in the fine print of second opinions, session caps, language barriers and out of pocket costs. Couple this with a mental health challenge and the opportunity for a cost-saving early intervention may be lost. This is why it is imperative that the UN System review, simplify, and standardize their health insurance schemes as related to mental health, well-being, and disability.

Based on a review done by the United Nations Health Insurance Working Group and a survey of Employer Health Benefits Survey by the Kaiser Family Foundation, the following actions have been established for review in your organization's Action Plan.

Action Plan (items for inclusion in initial assessment/ planning):

- Decide on contract modalities that will receive mental health coverage
- Review of your organization's existing insurance provisions for mental health and social protection. (Tool provided)
- Identify gaps in coverage and/or access and take steps to reach basic minimum standards
- Create insurance review working groups with membership including those with lived experience

Reporting - indicators listed in Scorecard

PRIORITY ACTION 6 – Quality Control

Create systems to enable and oversee the safety and quality of psychosocial support programmes.

As outlined in the United Nations Staff Stress Counsellor Group (UNSSCG) report “Guidance on Professional Standards for UN Counsellors” the United Nations has a commitment to ensuring the quality and ongoing professional development of those who support the psychosocial needs of UN personnel. “Minimum standards for counsellors are vital to ensure the protection of staff and that those employed as counsellors are competent to practice and work to the highest ethical standards.”¹⁵

Due to the variety of cultural competencies needed by the United Nations, not all counsellors are trained in countries with national licensing and/or accreditation boards. As a result, the United Nations Staff/ Stress Counsellors Group has outlined internal standards that will help ensure the quality of providers. The standards can be found discussed in detail via the UNSSCG document “Guidance on Professional Standards for UN Counsellors”.

To summarize,

1. Licensure/ certification is preferred
2. Professional organization membership is accepted under certain circumstances
3. An alternate track is required where the abovementioned tracks are not available

In addition to ensuring providers have the competency to practice effectively and ethically, ongoing education is needed to ensure the programmes being implemented meet international standards. As per the UNSSCG Guidelines this requires a minimum of 20 hours of mental health related ongoing education annually. To ensure the maintenance of these standards an ongoing assessment should be included in a pre-existing structure such as annual performance reviews.

Action Plan (items for inclusion in initial assessment/ planning):

- Review of psychosocial support personnel and their existing licensure/ accreditation/ organizational membership status. This may include personnel from professional specialty groups which are employed as counsellors.¹⁶
- Identify deficits in professional status’ and ensure managers have created plans with the staff member to reach basic minimum standards as outlined in UNSSCG Guidance document.

Reporting - indicators listed in Scorecard

¹⁵ UNSSCG Guidance on Professional Standards for UN Counsellors, v.1.5

¹⁶ UNSSCG Guidance on Professional Standards for UN Counsellors, v.1.5

Annex IV
UN System Workplace Mental Health and Well-being Strategy
Implementation Scorecard

Priority Action 1

Resource and distribute psychosocial support and mental health services to enable all United Nations staff who need it, especially those at higher risk, to have universal and equitable access to these services within 18 months of endorsement.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Complete mapping of currently available psychosocial services (internal and external)	Complete mapping of currently available psychosocial services (internal and external)	Complete mapping of currently available psychosocial services (internal and external)
Psychosocial counseling available (All personnel can access psychosocial service within 72 hours of request regardless of duty station)	Psychosocial counseling available (All personnel can access psychosocial service within 72 hours of request regardless of duty station)	Psychological counseling available (All personnel can access psychosocial service within 72 hours of request regardless of duty station)
Facilitation for external referrals when needed	Facilitation for external referrals when needed	Facilitation for external referrals when needed
	Communication with personnel on how to access webinar, podcasts, counseling and all other programming related to psychosocial support	Communication with personnel on how to access webinar, podcasts, counseling and all other programming related to psychosocial support
	Support in case of critical incident and crisis management	Support in case of critical incident and crisis management
		Pro-active counseling support for staff in unstable/ high risk environment
		Family Liaison Officer available to address the well-being needs of the families of staff
		Psychosocial support available to non-staff personnel

Priority Action 2

Implement stigma reduction and health promotion approaches over the five-year period, to strengthen the knowledge, skills and behavior of all United Nations staff members with regard to staying psychologically fit and healthy and to ensure that concerns about stigma, anticipated and/or experienced, are not a barrier to achieving good mental health and well-being.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Establish a stigma reduction working group	Establish a stigma reduction working group	Establish a stigma reduction working group
Consultation with managers and human resources professionals in supporting staff with mental health issues	Consultation with managers and human resources professionals in supporting staff with mental health issues	Consultation with managers and human resources professionals in supporting staff with mental health issues
	Target is established and met for reduction in perceived stigma reporting	Target is established and met for reduction in perceived stigma reporting
	Organization is taking action such as holding events and/or rolling out educational tools (Lead and Learn)	Organization is taking action such as holding events and/or rolling out educational tools (Lead and Learn)
	SOP or policy on return-to-work arrangements after time off when experiencing a mental health condition	SOP or policy on return-to-work arrangements after time off when experiencing a mental health condition
	Input is being sought from personnel who have experienced a mental health condition in planning appropriate actions	Input is being sought from personnel who have experienced a mental health condition in planning appropriate actions.
		Programs addressing chronic mental health conditions as reported by personnel are established
		Leadership has taken an active role in communication about stigma

Priority Action 3

Initiate a suite of prevention interventions, informed by best practice and shown to influence positively the protective factors associated with good mental health and well-being, as well as avert or minimize harm from known risk factors, directly and indirectly for the staff member, and/or from the environment in which they work.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Organizations complete a psycho-social risk assessment	Workplace risks identified and plan developed to mitigate	Workplace risks identified and action taken to mitigate
Well-being missions are undertaken (missions to	Well-being missions are undertaken (missions to	Well-being missions are undertaken (missions to

Approaches Requirement	Meets Requirement	Exceeds Requirement
promote well-being through staff and office level interventions)	promote well-being through staff and office level interventions)	promote well-being through staff and office level interventions)
	Review, and improve where needed, policies surrounding staff autonomy in the areas of workload management, work hours, telecommuting and work-life harmony	Review, and improve where needed, policies surrounding staff autonomy in the areas of workload management, work hours, telecommuting and work-life harmony
	SOP or policy on adjusting work arrangements due to mental health conditions are in place and enacted	SOP or policy on adjusting work arrangements due to mental health conditions are in place and enacted
		Pre-deployment psychosocial resilience counseling and briefing Post-deployment psychosocial resilience counseling and briefing
		Suicide prevention programs developed and communicated to all personnel
		Demonstration of innovative approaches to creating healthy workplaces with personnel actively encouraged to share ideas which are then implemented
		Personnel who require work adjustments are supported with a case manager

Priority Action 4

Establish a workplace well-being programme, with an agreed charter, practical support, training and recognition awards for teams and managers that enables the achievement of respectful, resilient, psychologically safe and healthy United Nations workplaces over a five-year timescale.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Establish a well-being working group (may be combine with stigma reduction group).	Establish a well-being working group (may be combine with stigma reduction group).	Establish a well-being working group (may be combine with stigma reduction group).
Training and education in mental health and psychosocial wellbeing	Training and education in mental health and psychosocial wellbeing	Training and education in mental health and psychosocial wellbeing

Approaches Requirement	Meets Requirement	Exceeds Requirement
	Access to online/ technology – based staff well-being resources (e.g., webpage, webinars, apps)	Access to online/ technology – based staff well-being resources (e.g., webpage, webinars, apps)
	Leaders communicate the importance of a healthy work environment and demonstrate commitment to this	Leaders communicate the importance of a healthy work environment and demonstrate commitment to this
		Support for conflict resolution (reconciliation, conflict coaching, mediation)
		Healthy workplace program in place with senior leadership taking an active role, system wide activities and formal recognition for innovative programming

Priority Action 5

Complete a review of United Nations Health Insurance provision, and United Nations social protection schemes (for disability and compensation) within two years, to achieve equity of coverage for mental health, and ensure that provision is adequate, acceptable and appropriate.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Assess/ review current insurance carriers for mental health coverage	Assess/ review current insurance carriers for mental health coverage	Assess/ review current insurance carriers for mental health coverage
Identify standards of care for mental health coverage that all agency insurance companies must meet.	Identify standards of care for mental health coverage that all agency insurance companies must meet	Identify standards of care for mental health coverage that all agency insurance companies must meet
Identify personnel types to be covered by health insurance (mental health care).	Identify personnel types to be covered by health insurance (mental health care)	Identify personnel types to be covered by health insurance (mental health care)
	SOP or policy on decision on disability status due to mental health condition	SOP or policy on decision on disability status due to mental health condition
	SOP or policy on granting extended sick leave due to mental health condition	SOP or policy on granting extended sick leave due to mental health condition
		UN organizations provide case management for personnel with mental health conditions

Priority Action 6

Create systems to enable and oversee the safety and quality of psychosocial support programmes by the end of year one.

Approaches Requirement	Meets Requirement	Exceeds Requirement
Establishment of lead psychosocial staff with responsibility for oversight of psychosocial programmes	Establishment of lead psychosocial staff with responsibility for oversight of psychosocial programmes	Establishment of lead psychosocial staff with responsibility for oversight of psychosocial programmes
Complete a review of the organization's psychosocial support personnel and their existing licensure/ accreditation/ organizational membership status.	Complete a review of the organization's psychosocial support personnel and their existing licensure/ accreditation/ organizational membership status	Complete a review of the organization's psychosocial support personnel and their existing licensure/ accreditation/ organizational membership status
	Clinical supervision for staff counselors	Clinical supervision for staff counselors
		Identify deficits in professional status' and ensure line-managers have created plans with the staff member to reach basic minimum standards as outlined in UNSSCG guidance document
		Ensure a feedback mechanism exists for client input and review