ORGANISATION DE L'AVIATION CIVILE INTERNATIONALE

INTERNATIONAL CIVIL AVIATION ORGANIZATION

Internal Audit Report
on
Medical Services

IA/2021/08

Office of Internal Oversight

ACRONYMS

ADB	Bureau of Administration and Services
AI	Administrative Instructions
CEB	UN System Chief Executives Board for Coordination (CEB)
EFAP	Employee and Family Assistance Programme
FIN	Finance Branch
HIPAA	Health Insurance Portability and Accountability Act
ICAO	International Civil Aviation Organization
LEB	Legal Affairs and External Relations Bureau
OIO	Office of Internal Oversight
OSG	Office of the Secretary General
OSH	Occupational Safety and Health
SEA	Staff Employment and Administration Section

CONTENTS

EXECUTIVE SUMMARY

1. As part of its annual work plan for 2021 (C-WP/15114), the Office of Internal Oversight (OIO) carried out an audit of medical services. The objectives of this audit were to assess the adequacy of human and financial resources of the ICAO medical clinic and implementation of relevant policies, procedures, and guidelines for effective and timely delivery of occupational safety and health services to ICAO staff, members of delegations, and staff of other UN Organizations based in Montreal.

2. The ICAO medical clinic was established for the use of ICAO staff members and members of delegations. Its primary purpose is to provide first aid; medical examinations required for employment and pension fund purposes; inoculations/vaccinations in connection with official travel; authorization of sick leave; and medical care in connection with sudden illnesses/accidents, etc. **However, the absence of a documented strategy and instructions on occupational safety and health has led to a lack of clarity in the mandate of the medical clinic. As opposed to existing UN practice, since 2011, the medical consultant doctors hired by ICAO have been providing family physician services to staff members, their dependents, retirees and members of delegations. The medical consultant doctors were remunerated by both the Organization as well as the RAMQ[1] in exchange for providing primary health care and first referral services.** The ICAO medical clinic needs a complete review of its current structure and services for assessing whether it is providing high quality occupational safety and health services as its primary purpose of establishment. The current practice of ICAO medical clinic serving as a private medical clinic providing general practitioner clinical services needs to be discontinued providing that transitory measures are taken to cater for any gaps that may occur in the provision of general practitioner services presently used by many staff members, delegations and their family members .

3. **There are no administrative instructions on occupational safety and health (OSH) in ICAO and no defined parameters or key performance indicators on OSH to assess and report on the performance of the ICAO medical clinic. Practices of ICAO medical clinic are also not in alignment with UN best practices.** Internal controls related to authorizing sick leave were found to be significantly weak and sick leave beyond 20 days is not independently reviewed by the medical clinic in most cases, which is mandatory in all UN organizations. The digitization of all medical records is incomplete despite engaging services of an external agency.

4. Staff members are entitled to subscribe to the local RAMQ arrangements and ICAO pays the local government for this service. 4.26% of gross salary is deposited with the local authorities for the RAMQ subscription of staff members (a total of CAD 12.43 million in 2017-2020[2]). The CIGNA medical insurance provided to staff members is in addition to the RAMQ coverage and costed CAD 6.26 million to the Organization in the period 2017-2020. **The practice of subscribing to two insurance coverages does not exist in other UN organizations and hence a review is required to ensure alignment with UN good practice aiming at provision of cost efficient, high quality health services to the Organization.**

5. The average number of sick days per staff member per year is 8.4 days. ICAO would benefit from benchmarking with other UN organizations including a root cause analysis to identify and address the staff absenteeism and related issues for improving overall human resource management The lack of procedural guidance and effective controls in resolving workplace conflicts increases the risk of misuse of sick leave entitlement and also deteriorates the working environment. In few cases, special leave with full pay was granted to sick staff members which was not in line with ICAO Rules and procedures.

[1] Régie de l'assurance maladie du Québec (RAMQ)
[2] CAD 2.98 million in 2017, CAD 3.08 million in 2018, CAD 3.17 million in 2019 and CAD 3.20 million in 2020

6. As part of this audit, OIO conducted a survey of United Nations and other international organizations for provision of medical services. **10 out of 15 respondent organizations (66%) which have medical service units, do not provide family physician and first referral services.** The remaining five (34%) organizations provide family physician or first referral services only in respect of staff posted in difficult geographical locations where access to medical services is not available. 14 out of 15 respondent organizations (93%) issue sick absence certificates only up to three/five days duration as opposed to the practice of ICAO medical clinic, which has been issuing medical certificates to staff members for prolonged periods of sickness.

7. Based on the results of the audit, OIO has given an overall rating of '**Major Improvement Needed**'. This report has made ten recommendations including nine high priority recommendations. These include recommendations on developing administrative instructions on occupational safety and health, review of the current practice of two medical coverages, discontinuation of family physician services to dependents and members of delegations, development of procedural guidance on independent review of sickness certificates, assessment of staff resources, setting a limit on the number of days of sick leave that can be granted by the medical clinic, root cause analysis of long term staff absenteeism, review of special leave with full pay, and digitization of medical records. All recommendations in the report have been accepted by the Management. Management comments and proposed actions to implement the recommendations are detailed in the Management Action Plan at Annex 5.

8. OIO wishes to thank management and staff for their assistance and cooperation during the audit.

RESULTS OF THE AUDIT

Background

9. The ICAO medical clinic was established to ensure prompt access to occupational safety and health services so as to enable the Organization to fulfil its duty with regard to the health care of staff members. The health services include medical examinations and consultations, official travel clearance as may be required, inoculations/vaccinations, preventive health care, etc.

10. There is no earmarked budget for the ICAO medical clinic. Expenses of the medical clinic are paid out of the SEA (Staff Employment and Administration) and staff welfare allotment. The ICAO medical clinic is generally run by two part-time consultant medical doctors[3], one full-time nurse and one receptionist hired on a consultancy contract.

11. The ICAO medical clinic provides services to staff members and consultants at ICAO Headquarters, and members of delegations, as well as staff from other international organizations located in Montreal. In addition, until this practice was stopped recently, the ICAO medical clinic was providing medical services to dependents of staff members and to retirees.

12. The activities of the ICAO medical clinic are overseen by the SEA Section to ensure that medical services are delivered and resources, supplies etc. are provided to the clinic.

Audit Objectives and Scope

13. The objectives of this audit were to assess:

    a. the adequacy and implementation of relevant policies, procedures, and guidelines for the effective and timely delivery of occupational safety and health services to ICAO staff, members of delegations, and staff of other UN Organizations based in Montreal;

    b. the adequacy of human and financial resources for provision of medical services in ICAO.

14. The scope of the audit included assessment of the practices of the ICAO medical clinic with regard to compliance with relevant policies and procedures and UN good practice; access to and maintenance of medical records; and implementation of medical clearance procedures. Sick leave data for the period 2017-2020 was analyzed to study the extent of compliance of sick leave procedures and the role of the medical clinic in certifying sick leave.

15. A benchmarking survey was conducted to gather information on medical services in UN common system organizations and other international organizations. OIO also held discussions with senior medical staff of the United Nations Offices in New York and Nairobi to assess the extent of alignment of ICAO's medical clinic procedures and practices with those adopted by the United Nations. Electronic surveys were also conducted to gather feedback from staff members and members of delegations on the quality of medical services provided by the ICAO medical clinic.

16. OIO neither requested nor accessed confidential medical information of any staff member during the course of this audit.

[3] There was only one medical doctor working on three half-days in the period December 2020 – August 2021.

Audit Findings and Recommendations

Governance of occupational safety and health services

The ICAO medical clinic deviated from its primary role of providing occupational safety and health services

17. The terms of reference for hiring ICAO medical doctors on a consultancy contract includes activities such as medical examination/clearances at the pre-employment stage, medical consultations in connection with extended or repetitive sick leave absences, disability pension cases, immunizations, and aspects related to medical administration including preventative health care, etc. However, until November 2020, these activities were treated as secondary and instead medical doctors hired by ICAO were providing family physician services to staff members, their dependents, retirees and members of delegations. This was a significant deviation by ICAO medical clinic from its mandate.

18. **Between 2011 and 2020, the medical doctors were acting as family physicians and were remunerated by both the Organization as well as the local health system (RAMQ[4]) for providing primary health care and first referral services.** The medical clinic was proactively registering staff members as well as their dependents for family physician services rather than advising staff members to register with a general practitioner outside of ICAO. **The medical doctors registered 1,037[5] persons as their patients for which they were remunerated by the RAMQ[6].** In the period 2018-2020, a total of 4,778 medical appointments were made with the medical doctors of ICAO. Considering the minimum RAMQ payment of CAD 50 for each consultation, this amounts to a payment of about CAD 238,900 between the doctors employed during the period 2018-2020. Clearly, this practice was neither covered by the terms of reference of their engagement nor allowed by ICAO rules and procedures. In addition, ICAO paid remuneration of about CAD 114,000 per year to the doctors.

19. The benchmarking survey with the UN and other International Organizations as well as individual interviews with the UN doctors located in New York and Nairobi in the UN common system organizations indicated that no medical doctor is allowed to charge a fee for any consultations either from the patient or indirectly from local health authorities. Doctors are paid solely by the organization and not by local government in any form. In the case of ICAO, the medical doctors were obtaining remuneration from the Quebec Government and also remunerated by ICAO as consultants. This double charging has led to a situation where the ICAO medical doctors may have gained remuneration beyond what was allowed by ICAO Rules and Procedures. This practice has stopped from November 2020 with the departure of lead consultant doctor.

20. This practice was carried out in a private capacity by the doctors since the Quebec authorities paid them directly for providing medical services to all registered RAMQ patients. Since a large number of staff members, dependents and retirees are private RAMQ patients of the ICAO medical doctors, the ICAO medical clinic was being used as a private clinic by the doctors. Thus, the services provided by the doctors were not fully in line with the Terms of Reference of their contract with ICAO.

21. Anonymous feedback from the staff survey also indicated that the doctors were not serving or were even refusing to see those who were not RAMQ patients unless they paid cash fees directly to the medical doctors. OIO was informed that ICAO has no details regarding the remuneration received from the RAMQ or any cash fees charged by doctors who were otherwise hired by ICAO

[4] Régie de l'assurance maladie du Québec (RAMQ)
[5] 396 staff members, 394 dependents of staff members, 122 members of delegations, 44 employees of other organisations based at Montreal, 38 consultants, and 43 uncategorized
[6] Family physicians base rate varies between CAD 50-120 per consultation.

and operated from ICAO premises. Non compliance with ICAO financial rules and procedures and the lack of adequate management controls over the functioning of the medical service led to a weak control environment where associated operational and administrative risks were high. OIO confirmed from Finance branch that any cash collected by the medical doctors was never deposited into the ICAO treasury.

22. Although no formal approval was found, it is unclear who authorized this practice to continue for about 10 years up until November 2020 when all staff members were advised to register with a doctor outside of ICAO. Since this is a significant change and it will take considerable time to register with a RAMQ doctor outside of ICAO because of current waiting times, the first referral services will continue to be provided by the ICAO medical clinic sparingly and only as a temporary measure. **The family physician / first referral services need to be phased out after a transitional phase.**

23. **The ICAO medical clinic needs a complete review of its current structure and services with a view to ensuring that it is providing high quality occupational safety and health services as its primary purpose.**

No administrative instructions on occupational safety and health

24. There are no comprehensive set of documented instructions on occupational safety and health (OSH) in ICAO with defined parameters or key performance indicators on OSH to assess and report on the performance of the ICAO medical clinic. The functions of the medical clinic are not formally defined in any document. The terms of reference for hiring medical doctors is the only document which broadly mentions the role of the medical clinic.

25. The absence of a documented strategy or instructions on occupational safety and health has led to a lack of clarity in the mandate of the medical clinic; non-alignment with standard practices of the United Nations; and an incorrect perception amongst staff members that medical services including family physician and first referral services are to be provided by the Organization.

26. Effective occupational safety and health management requires the development of comprehensive instructions which contribute to preventative health care, the minimization of work-related hazards and risks and the promotion of health at work. Such a policy broadly captures the organizational procedures and arrangements necessary to ensure a safe and healthy place of work.

27. The activities defined by these instructions have to be cost-effective and aimed at achieving a safe and healthy working environment whilst at the same time reducing financial losses and liabilities due to absenteeism and sickness.

Recommendation 1	**Administrative Instructions on Occupational Safety and Health (OSH)**
Priority	**High**

ADB should develop Administrative Instructions on occupational safety and health for the Organization which, inter alia should identify the primary objectives, roles and responsibilities, and activities of the medical clinic covering all aspects of occupational safety and health in line with the practice adopted by UN common system organizations.

Closing criteria:

Development of formal administrative instructions on occupational safety and health and its dissemination to all staff members.

Lack of alignment with the practices in UN common system organizations

28. Since 2011, the primary focus of the ICAO medical clinic has been to provide family physician services, which is not in alignment with UN practices adopted by UN common system organizations. The OIO benchmarking survey showed that the medical doctors employed by other UN common system organizations are not allowed to provide family physician services to staff members or their dependents. The ICAO medical clinic should focus on occupational safety and health including issues related to stress, ergonomics, mental health, rehabilitation, preventive health care, vaccinations, travel consultations, crisis management, work place injuries, first aid (defibrillators), etc.; rather than clinical medical services which are to be provided by general practitioners outside of the Organization.

29. The provision of medical services to dependents of staff members has also led to a diversion of organizational resources. The UN medical facilities deal solely with occupational safety and health services in the workplace and since dependent family members are in no such occupational settings, they are not eligible to receive services from the medical clinics.

30. ICAO provides services including first referral and clinical services to members of delegations. In other UN organizations, such services are not provided except as a courtesy service whenever there is an emergency e.g. a minor injury in the workplace, without charging any cost.

Recommendation 2	**Discontinuation of family physician services to staff members, members of delegations and their dependents**
Priority	**High**

ADB, under the direction of the Council and in coordination with relevant ICAO units, should draw up a plan to transform the ICAO medical clinic into a medical service provider focusing on Occupational Safety and Health (OSH) services of high quality in line with UN good practice. Since the discontinuation of the current practice of providing family physician services to staff members, Council delegations and their dependents may lead to difficulties because of long waiting times in registering with an outside family physician, transitional measures should be adopted to facilitate for a smooth transition.

Closing criteria:

Development of a plan to ensure that the ICAO medical clinic focuses on occupational safety and health, and discontinuation of family physician services.

31. The ICAO medical clinic has also provided medical services to retirees. The medical clinic should not be providing such services to separated staff as they are not in the occupational setting. It is not the responsibility of the Organization to provide any medical services to separated staff members. None of the UN common system organizations and other international organizations provide medical services to retirees or separated staff members. This practice was stopped by ICAO in 2019[7].

32. All other UN medical services do not issue any sick absence certificates; except for short durations up to a maximum of three days. In ICAO, sick absence certificates of any duration are issued by the medical doctors in their capacity as family physicians of staff members. This has led to a situation of "conflict of interest" as the doctor issuing the certificate cannot undertake an independent secondary review of sickness certificates. There were cases where sick leave certificates were issued for several months, which in other UN common system organizations, would have required an independent medical review before approval. ICAO's Staff Rule 106.2 on

[7] Staff Notice 5775 dated 13 November 2019

sick leave does not provide any guidance about the maximum duration of sick leave certificates which can be issued by the ICAO medical clinic.

Recommendation 3	**Maximum limit of sick leave days that can be certified by the medical clinic**
Priority	**High**

ADB should review and update Staff Rule 106.2 on sick leave and set a maximum limit on the number of sick leave days which the medical clinic can certify and issue sickness certificates. This should be implemented to ensure alignment with UN practice so that no conflicts of interest arise when the medical clinic performs secondary independent reviews of prolonged and recurrent sickness cases.

Closing criteria:

Review and update of Staff Rule 106.2 and setting a maximum limit on the number of days for which the ICAO medical clinic can certify and issue sickness certificates.

33. In OIO's benchmarking survey on medical services, in 9 out of 15 respondent organizations (60%), there are no requirements for medical doctors of UN organizations to be registered with the local health authorities, as they do not and ought not to practice outside the perimeters of the Organization. Since the doctors provide occupational health and safety services and not clinical services, they can be qualified doctors of other countries without the need for registration within the host country. In the case of ICAO, the current requirement for a doctor to be registered with the local health system will not be necessary if ICAO medical clinic is deregistered from RAMQ and the mandate of the clinic is aligned with UN System good practice to include only the occupational safety and health aspects.

34. There are certain peculiarities in ICAO compared to other UN organizations as all staff members subscribe to the local health system RAMQ arrangements and ICAO pays the Quebec government for this service. ***ICAO's Understanding[8] with Government of Quebec states that "ICAO undertakes to respect the provisions of the Loi sur la Régie de l'assurance maladie du Québec (RAMQ) relating to the employer's contribution on the salary, in accordance with said law, paid by ICAO to all its officials, except for that portion of the payment which is attributable to after-service benefits.***". Accordingly, 4.26% of the gross salary of staff members is deposited with the local authorities for the RAMQ subscription of staff members (a total of CAD 12.43 million in 2017-2020). It is worthwhile mentioning here that international organizations in Quebec are not obliged to subscribe to the local health system and pay the contribution to the health services fund unless they agree to pay for it[9].

35. In addition to RAMQ coverage, staff members are provided with CIGNA medical insurance. A proportion[10] of the CIGNA medical insurance premium is paid by the Organization (CAD 6.26 million in 2017-2020). The financial costs to ICAO for the two coverages of medical insurance is as follows:

[8] Article 16, Understanding between ICAO and the Government of Quebec concerning the immunities, exemptions and courtesy privileges extended to the Organization, to its officials, to Member States and to members of a permanent representation to the Organization, dated 26 June 2018

[9] Revenu Quebec **Guide for Employers – Source Deductions and Contributions 2021 ,** pages 57 & 58

[10] ICAO pays 35% of the premium for IP staff members and 50% for GS staff members at Headquarters for Class 1 coverage. For staff in the regional offices, the ICAO share is 50% and 75% for IP and GS staff respectively.

Year	100% share paid by ICAO for RAMQ subscription of staff members (CAD in millions)	ICAO share for CIGNA medical coverage (IP staff) (CAD in millions)	ICAO share for CIGNA medical coverage (GS staff) (CAD in millions)
2017	2.98	0.75	0.74
2018	3.08	0.81	0.74
2019	3.17	0.85	0.76
2020	3.20	0.84	0.77
Total	CAD 12.43 million	CAD 3.25 million	CAD 3.01 million

36. This practice of subscribing to two medical insurance coverages does not exist in other UN organizations and it may not be cost beneficial to ICAO. The IMO (International Maritime Organization) is one exception but only pays the local health system for those staff members who are ordinarily resident in the host country.

Recommendation 4	Assessment of the existing provision of two medical coverage
Priority	High

ADB in close cooperation with LEB and FIN,

a. should review ICAO's existing practice of paying for RAMQ subscription as well as CIGNA medical insurance for staff members. The review should *inter alia* include an assessment of existing legal provisions, a cost benefit analysis of the existing practice, and available realistic options for the Organization.

b. explore ways of reducing the cost of contributions to RAMQ including renegotiating the terms of the Understanding with the Government of Quebec in this regard with a view to improving access and delivery of high quality healthcare services while reducing the associated costs.

Closing criteria:

a. Conduct a cost benefit analysis of ICAO's existing practice of paying for RAMQ subscription in respect of all staff members in addition to the CIGNA medical insurance.

b. Based on the results of the cost benefit analysis, review the provisions of the existing Understanding and if necessary, negotiate with the Government of Quebec regarding payment of the contribution to the health services. Such negotiation should also include further ways of reducing costs and improving access and delivery of high quality healthcare services with particular attention to the prompt assignment of a family doctor to ICAO international personnel.

Procedural guidance

Need for procedural guidance on secondary review of prolonged sickness cases

37. In ICAO, rules do not specify the maximum cumulative duration of sick leave beyond which a staff member must submit a medical report and the need to undergo a secondary review. As a consequence, HR is unable to stringently enforce the practice of secondary reviews in all cases of frequent and long-term sickness.

38. In all UN organizations, there are mandatory requirements for a secondary review by the internal medical services unit of all sickness cases beyond 10/20 days in an annual cycle. Staff members must submit a medical report issued by their treating doctor to ICAO medical doctors to facilitate a secondary independent review.

39. Though Staff Rule 106.2 stipulates that the Organization may consult its own medical doctor and take that doctor's report into account before approving continuing sick leave, it is not possible for the medical clinic to perform such secondary reviews because of the inherent conflict of interest whereby most of the sick absence certificates are provided by the ICAO's medical doctor(s) themselves.

40. In the absence of mandatory secondary reviews duly supported by documented rules, the risk of misuse of sick leave entitlements is increased.

Rule on combining certified leave on half pay with annual leave

41. Though not provided under the Staff Rules or any of the Personnel Instructions, HR allows staff members to combine days of certified sick leave on half pay with a half day of annual leave. In the period 2017-2020, 1359 days of certified sick leave on half pay[11] were allowed to be combined with half a day of annual leave. Combining certified sick days on half pay with a half day of annual leave results in a staff member continuing to receive full pay. This practice is also prevalent in most other UN organizations.

Recommendation 5	**Procedural Guidance**
Priority	**High**

ADB should update

a. the rules for independent secondary reviews of prolonged and recurrent sickness. The instructions should specify the mandatory requirement for a secondary review and the obligation of staff members to submit medical reports to the clinic when sick leave exceeds a prescribed limit.

b. the Personnel Instructions to include the eligibility of combining annual leave with certified sick leave on half pay in line with the UN good practice.

Closing criteria:

Revised instructions containing detailed provisions on secondary reviews of prolonged and recurrent sickness cases, and the review of the practice of combining annual leave with certified sick leave on half pay.

Financial and human resources

42. The medical clinic has no specific budgetary allotment. The financial resources are provided from the Staff Employment and Administration Section (SEA) budget and staff welfare budget on a needs basis.

43. There is one fixed term position of a nurse in the ICAO medical clinic. The positions of receptionist and medical doctors are filled through consultancy contracts on a part time basis.

[11] Staff members are entitled to take certified sick leave on half pay after exhausting the entitled certified sick leave days on full pay

44. In the period 2018-2020, a total of 4778[12] medical appointments were made with the medical doctors of ICAO. This represents 12.2[13] medical appointments on average per half-day considering that the medical clinic is operational on three half days a week. The annual immunization programs were conducted for staff members and travel clearances were provided to staff members who approached the clinic. Other activities such as cases of pre employment medical clearance[14], and disability cases were also carried out.

45. The pressure on human resources up to now was more because clinical and first referral services were being provided by the doctors, which left much less time for doing other activities like occupational safety and health awareness, preventative health care, travel clearances, immunization, sickness reviews, etc.

46. In view of the occupational safety needs of 540 staff members and 140 consultants at ICAO Headquarters, about 150 members of delegations, as well as staff from other international organizations located in Montreal, the current staff resources in the medical clinic may be insufficient and an assessment of the staff requirements is required. The current staffing levels include two medical doctors[15] who work on a part time basis and attend the clinic on three half-days a week. The ICAO medical doctor(s) should be available on all working days instead of three half days in a week.

47. Recognizing the current reality that about 400 staff members are not registered with a RAMQ doctor outside of ICAO, any measures to increase resources need to consider the necessity of continuing to provide clinical and referral services on a transitional basis for some time until a final and viable solution is found for all ICAO staff and delegations. In the meantime, medical staffing and financial resources need to be enhanced to allow the medical clinic to provide services of high quality to all service beneficiaries in an effective and efficient manner.

48. ICAO should also assess the need for engagement of outside medical service provider(s) to facilitate medical appointments to ICAO staff members on a priority basis. In such a case, staff members could directly pay the consultation fee to the medical service providers and settle the expenses with CIGNA thereafter.

Recommendation 6	**Assessment of staff resources**
Priority	**High**

ADB should

a. assess the staffing and resource requirements of the ICAO medical clinic to enable it to provide the necessary occupational safety and health services.

b. explore the possibility of engaging third party private medical service providers on framework agreements to improve the access and quality of healthcare services provided to ICAO staff and other beneficiaries.

Closing criteria:

a. Assessment of the need for additional human resources in the ICAO medical clinic.

b. Completion of a feasibility and cost benefit analysis for engaging third party medical service providers on a framework agreement.

[12] 1535 in the year 2018 , 1851 in the year 2019, 1392 in the year 2020

[13] =4778/(130*3)

[14] 226 cases in the period 2017-2020

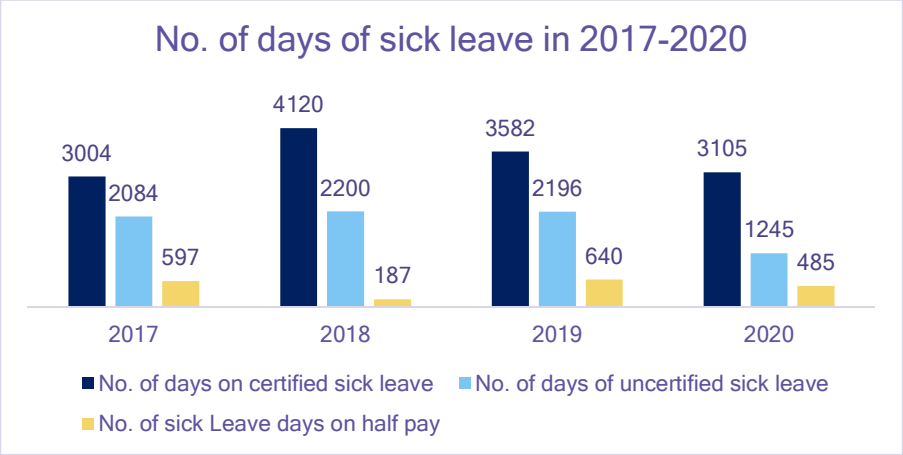
[15] There was only one part-time doctor between November 2020 and August 2021. A second part-time doctor was hired on a short-term consultancy contract in August 2021.

Sick Leave Analysis

49. Staff Regulation 6.3 provides that a staff member who holds a fixed-term appointment and who has completed less than three years of continuous service shall be granted sick leave of up to three months on full salary and three months on half salary in any period of 12 consecutive months; and a staff member who holds a continuing appointment, or who holds a fixed-term appointment for three years or who has completed three years or more of continuous service shall be granted sick leave of up to nine months on full salary and nine months on half salary in any period of four consecutive years.

50. In addition to certified sick leave, a staff member may take uncertified sick leave not exceeding three consecutive working days at a time, for up to seven working days within a calendar year. Uncertified sick leave can be used in the case of illness or injury which would prevent a staff member from performing his duties. Family-related emergencies qualify as well, in which case the limitation of three consecutive days does not apply.

51. 23447[16] sick days[17] were taken by staff members during 2017-2020. The details are as follows:



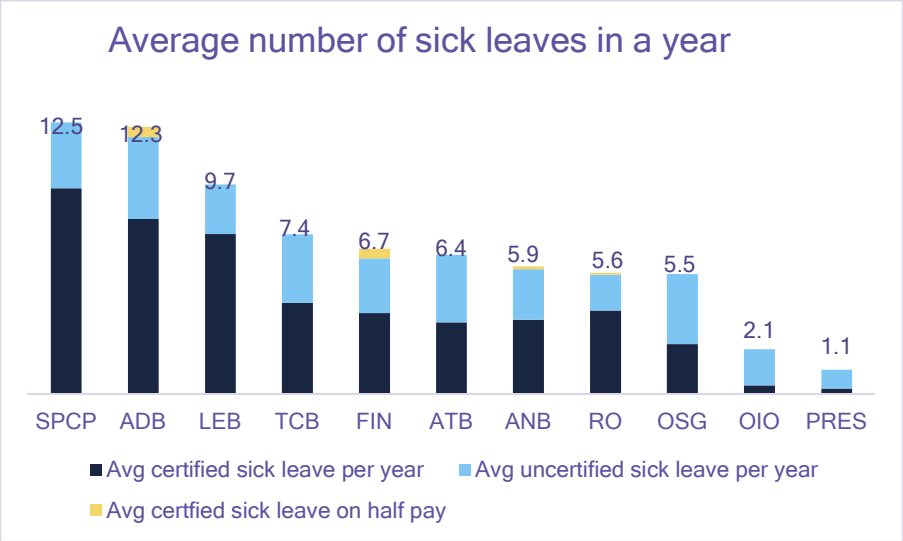
Data Source: HR leave statistics as maintained in Unit4 ERP

Chart 1: Number of sick leave days in the period 2017-2020

52. The average number of sick days reported by staff members in a year was calculated on the basis of data of four years (2017-2020). While the organizational average is 8.4 sick days per staff member in a year, the average number of sick days reported were not consistent across Bureaus with high averages in SPCP, ADB and LEB.

[16] 2017:5685, 2018:6508, 2019:6419, 2020:4835

[17] Includes certified sick leave, uncertified sick leave, and sick leave at half pay

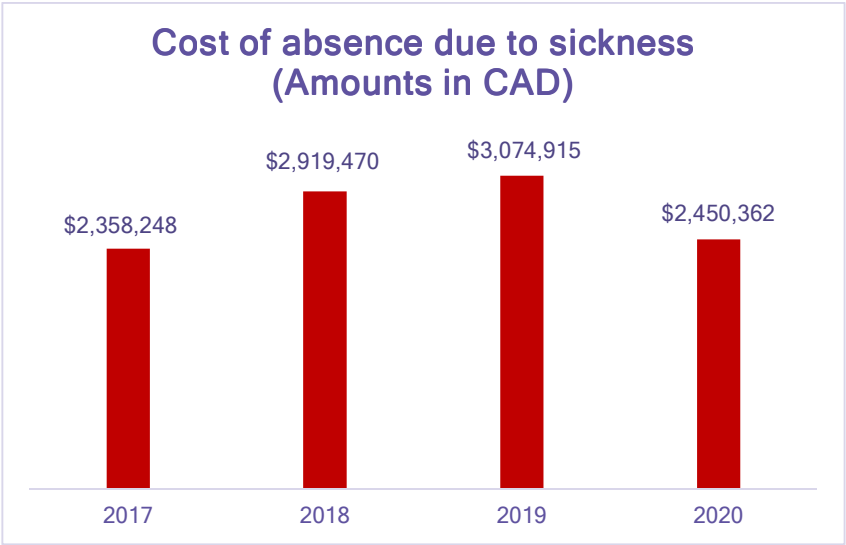


Data Source: HR leave statistics as maintained in Unit4 ERP

Chart 2: Average number of sick leave days in a year by Bureau / Office

Costs of absence

53. The total cost[18] borne by the Organization on account of missing work-days due to sickness during 2017-2020 was close to CAD 11 million. There was a rising trend in the first three years and a decrease of about 20% in 2020 when remote working arrangements were in place[19].



Data Source: SEA

Chart 2: Financial Implication to the Organization on account of sick leave burden

Causes of staff absenteeism

54. An internationally-accepted definition of absenteeism is 'the manifestation of a decision by an employee not to present themselves at their place of work at a time when it is planned by management that they should be in attendance'. The high levels of absence due to sick leave and associated costs to the Organization warrant further analysis in terms of its root causes and

[18] Calculations based on estimated average pay and emoluments at each grade.

[19] Decrease was noted despite COVID-19 pandemic situation in 2020.

potential solutions to the problem. The current situation maybe indicative of unresolved conflicts among staff and/or management and it therefore has an adverse impact on the staff morale.

55. While the majority of absences are for limited durations, a significant proportion is due to long-term sick leave. The analysis indicated that 73 out of 692 staff members (10.5%) took 60 days or more certified sick leave on full pay during 2017-2020. A thorough review of long term sickness cases would shed light on the reasons of long term staff absenteeism which in turn would help find realistic solutions for a harmonious workplace and enhanced staff morale. Going forward, more efforts are needed for improving organizational occupational health and safety of staff.

56. The average number of sick days per staff member per year is more than 12 in some bureaus/offices such as SPCP and ADB, which is higher than the organizational average of 8.4 days.

57. HR and relevant bureaus/offices should jointly look into this matter to identify and address the root causes of such high staff absenteeism without further delay. Prevention and early intervention is a cost effective way of reducing long-term absence. Internal communication is also an important factor in the successful management of long-term sickness absence.

58. The possibility of misuse of the entitlement of sick leave cannot be ruled out in a few cases because of the following reasons/indicators:

    a) There are no formal instructions to submit medical reports to the medical clinic in cases where the cumulative sick leave exceeds 10 days in a calendar year as is the practice in other UN organizations.

    b) A number of medical certificates were issued in the past by doctors while acting as family physicians. Some of the certificates were of a long duration including cases where it stretched to nine months. Since the certificates were issued by the doctors themselves, there was no opportunity of a second review by the Organization. This led to a situation of conflict of interest and raised the risk of non-compliance and misuse of the Organization's resources. Also, there is no institutional mechanism to carry out an independent secondary review of sick absence cases by an external medical practitioner.

    c) When authorizing sick leave, the medical clinic does not always consider the past historical records of sick leave.

Recommendation 7	**Root cause analysis of long term sickness absenteeism**
Priority	**High**
ADB should conduct a root cause analysis of staff absenteeism due to long term sickness and identify areas for improving overall monitoring, internal communication between line managers and staff members, reporting on sick leave and taking appropriate HR measures to improve the work environment and staff morale and hence performance.	
Closing criteria:	
Conduct a root cause analysis on staff absenteeism and develop a clear action plan to resolve the identified issues.	

59. Analysis of sick leave also showed that two staff members who have taken sick leave on a recurrent basis in the past, were granted an excessive number of days of **special leave with full pay** in 2020. These cases of long duration of special leave were inappropriately approved and not in line with the ICAO rules and procedures and the provisions of Staff Rule 105.8 on special leave, which states

that *"special leave of absence with or without pay or partial pay may be granted by the Secretary General for extended illness of a staff member after all entitlements to sick leave has been exhausted."* In these two cases, special leave with full pay was not approved at the level of the Secretary General.

Recommendation 8	Review of cases of special leave with full pay
Priority	**High**

ADB, in close cooperation with relevant offices, should review all cases where special leave with full pay has been granted for long periods and propose appropriate action and in case of non compliance, fully document the circumstances and send it to the competent authority for appropriate action.

Closing criteria:

Review of all cases of staff members who were granted special leave with full pay for prolonged periods and submission of all non-compliant cases to the competent authority.

Maintenance of medical records

60. Medical records are permanent confidential records which need to be maintained for all staff as well as retirees (UNJSPF requires this in respect of retirees). The proper maintenance of these medical records was not a priority for the medical clinic and no attention was paid to this important aspect.

61. ICAO took steps to have all medical records digitized by MEDFAR in 2019 but this has not yet been completed. Medical files were not kept in an organised manner e.g. lab reports were found in one file and other medical records in other binders. Consequently, there are delays in the digitization of medical records because the documents are not properly arranged. Non-availability and/or inaccessibility of medical records can lead to insufficient information on patients leading to errors and gaps resulting in poor medical care.

Recommendation 9	Digitization of medical records
Priority	**High**

ADB should review the status of the digitization of medical records of staff members and establish a timetable for completion of this work.

Closing criteria:

Completion of the digitization of the entire medical records maintained by the medical clinic.

Cost Sharing Arrangements

62. ICAO is a designated medical facility for all UN staff members in Canada. However there is a need to review the terms of reference setting out what services should be provided by ICAO.

63. There are no cost sharing arrangements with other UN agencies in Canada unlike in other duty stations where medical services are provided by a single UN agency to others on a cost sharing basis. If ICAO is providing services to staff members of other organizations at the duty station, there should be cost sharing arrangements on a pro-rata basis in line with UN practice at other UN duty stations.

Recommendation 10	Cost sharing agreements with other organizations
Priority	Medium

ADB should finalize cost sharing arrangements with UN agencies located in Montreal if their staff members use the occupational safety and health services provided by the ICAO medical clinic.

Closing criteria:

Finalization of cost sharing agreement(s) with those Montreal based UN agencies whose staff use the medical services provided by the ICAO medical clinic.

Benchmarking with other Organizations

64. OIO conducted a survey of United Nations and other international organizations regarding their medical services. A total of 19 organizations participated in this survey. Four organizations reported that they do not have a designated medical clinic. The results of the survey are presented in Annex 2.

65. The salient points from the survey can be summarized as follows:

    a. 10 out of 15 Organizations (66%) who have medical services units do not provide family physician and first referral services. The other 5 organizations (34%) provide family physician or first referral services only in respect of difficult geographical locations where access to medical services is not available.

    b. 80% of UN Common System Organizations responded that they do not provide family physician medical services for members of delegations.

    c. 14 out of 15 respondent organizations (93%) issue sick absence certificates only up to three/five days duration as opposed to the ICAO medical clinic, which has been issuing medical certificates to staff members for prolonged periods of sickness.

    d. Unlike ICAO, nine out of 15 respondent organizations (60%) stated that there is no requirement for the medical doctor hired by the organization to be registered in the local health system. Of the remaining six that have a requirement for the medical doctor to be registered with the local health system, only two provide family physician services to their staff members.

    e. In all 19 organizations that responded to the OIO benchmarking survey, secondary independent reviews of prolonged sickness cases are carried out by their respective medical services unit.

    f. Like ICAO, 14 out of 15 respondent organizations (93%) maintain statistics on sick leave.

    g. 6 out of 15 (40%) respondent organizations have adopted an occupational and health policy as mandated by the UN System Chief Executives Board for Coordination (CEB). ICAO has yet to adopt a policy in this regard.

    h. 12 out of 15 (80%) respondent organizations maintain medical records using electronic means. ICAO has introduced a system for electronic capture of staff members' medical records but there are delays in data entry of historic data in this system.

Results of the survey of staff and delegations

66. OIO conducted an anonymous survey to obtain direct feedback from staff members on the quality of medical services. 264 staff members out of 538 at the Headquarters duty station (49%) responded to the OIO survey. The responses to the various questions are presented in Annex 3.

67. A significant proportion of staff members expressed concerns on the following:

    a. 111 out of 264 (42%) of the respondents stated that do not have a regular family physician.

    b. While 51% of the respondents gave positive feedback, 19% gave a negative response on the quality of service provided by the medical clinic.

    c. 68 out of 264 respondents (26%) responded that medical appointments are not available promptly. This is a high proportion which may require careful assessment of the workload and resource availability in the medical clinic. This was possibly the result of previous practice when the medical doctors provided first referral / family physician services to staff members as well as their dependents, which was a deviation from its mandate.

    d. 73 out of 264 respondents (28%) stated that access to the ICAO medical clinic deteriorated after the start of the COVID-19 pandemic.

68. A similar survey was also addressed to members of delegations however only 16 replies were received. The responses to the various questions in this survey are presented in Annex 4.

69. The results of both internal and external surveys support the conclusions of this audit and recommendations have been made accordingly. Adoption of good practices implemented by the UN system and other international organizations should be given due consideration in initiatives for future improvements to ICAO's medical services.

ANNEX 1: DEFINITION OF AUDIT TERMS

Audit Ratings

In providing an overall assessment of the results of the audit, OIO uses the following standardized audit rating definitions:

Audit Assessment	Definition
Effective	Controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Some Improvement Needed	A few specific control weaknesses or areas for improvement were noted; generally however, controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Major Improvement Needed	Several key control weaknesses were noted and/or several areas of strategic/high importance were identified where significant improvements can be made to increase efficiency and effectiveness.
Unsatisfactory	Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met.

Internal control is defined as a process effected by senior management and staff, designed to provide reasonable assurance regarding the achievement of objectives relating to operations, reporting and compliance objectives. Whilst internal control provides reasonable (but not absolute) assurance of achieving organizational objectives, limitations may result from:

- suitability of objectives established as a precondition to internal control;
- reality that human judgment in decision making can be faulty and subject to bias;
- breakdowns can occur because of human failures such as simple errors;
- ability of management to override internal control;
- ability of management, other staff, and/or third parties to circumvent controls through collusion;
- external events beyond the organization's control.

Priority of Audit Recommendations

The audit recommendations in this report are categorized according to priority as a guide to management in addressing the issues raised. The following categories are used:

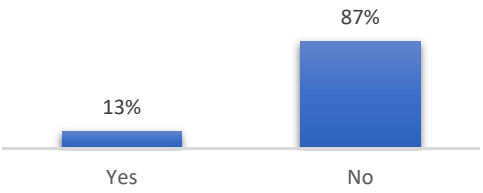
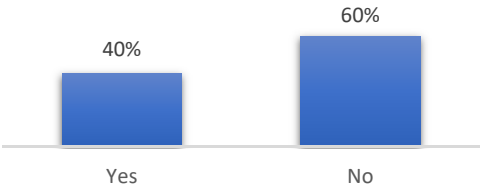
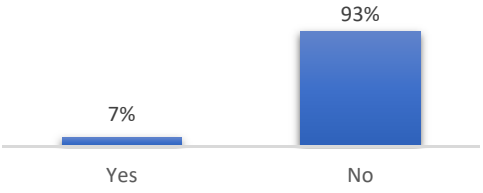
High: recommendations, which address significant and/or pervasive deficiencies or control weaknesses, or areas where significant improvements can be made.

Medium: recommendations, which address important deficiencies or control weaknesses, or areas where some improvements can be made.

Low: suggestions, which represent best practice, or general opportunities for improvement.

ANNEX 2: RESULTS OF BENCHMARKING SURVEY

A total of 19 UN common system organizations and other international organizations replied to the benchmarking survey. Four out of 19 do not provide medical services. The responses of the 15 organizations who provide medical services is presented below:

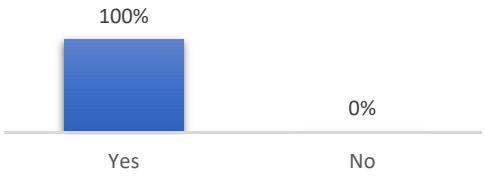
Are the medical doctors of the Organization providing family physician (general practitioner) services to staff members?
Most organizations do not provide family physician services. A small number of organizations are providing family physician (general practitioner) services but such arrangements are made only in respect of difficult geographical locations where access to medical services is not available. 
Are members of delegations (representatives of Member States) eligible to use the medical services provided by the medical center?
80% of the UN Common System Organizations and International Organizations do not provide medical services to members of delegations. In ICAO, members of delegations were registered with ICAO medical clinic for clinical services including family physician services. 
Does the Organization allow and pay health care contributions to host country healthcare system?
The dual arrangement of medical insurance is not there in almost all International organizations. ICAO is paying 4.26% of the staff remuneration to the local health system to enable staff members to avail the services of local health system. This is in addition to the ICAO arrangements for staff medical insurance with CIGNA. 
Are medical doctors hired by the Organization need to be registered with the local health system?
Such a requirement is not there in respect of majority of international organizations. In ICAO, the common interpretation is that any medical consultant doctor who is hired by the organization should be registered in the local health system. 
Does the medical center/unit issue prolonged sickness certificates to staff members?
In UN organizations where sickness certificates of only up to three days duration can be issued by the organizational medical center. The ICAO medical clinic had been issuing medical certificates to staff members. In practice, there were no restrictions on the number of days that ICAO medical clinic issued sickness certificates to particular staff members. The medical clinic could also not 

carry out independent secondary reviews of cases of prolonged sickness as the certificates were issued by the medical clinic itself.

Is there an independent second review of all cases of prolonged sickness cases?

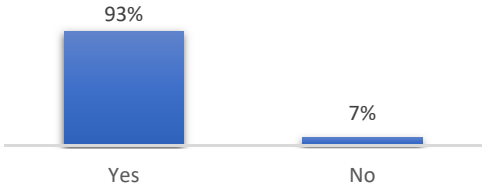
In all organizations, which responded to the OIO benchmarking survey, secondary reviews of prolonged sickness cases are carried out.

This practice needs to be strictly followed in ICAO.



Does the Organization maintain statistics on staff absences due to sick leave?

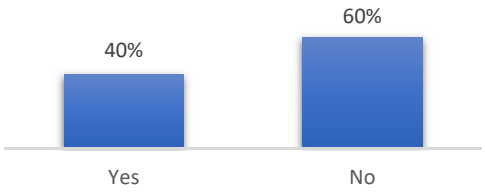
Sickness statistics are maintained in 93% all UN organizations and International Organizations who responded to the benchmarking survey.



Is there a formal Occupational Safety and Health policy?

6 out of 15 (40%) respondent organizations adopted occupational and health policy as mandated by CEB.

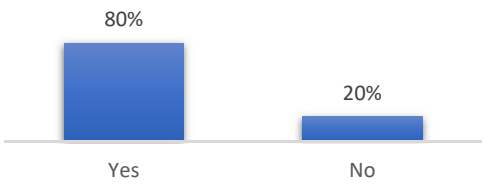
ICAO has yet to adopt a policy in this regard.



Are there systems enabling the electronic capture/archiving of staff members' medical records?

80% of the Organizations have implemented systems for electronic capture of medical records.

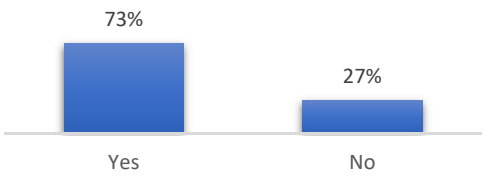
ICAO introduced the system for electronic capture of staff members medical records but there are delays in data entry of historic data in this system.



Are there documented procedures and guidelines for maintaining confidentiality of medical records?

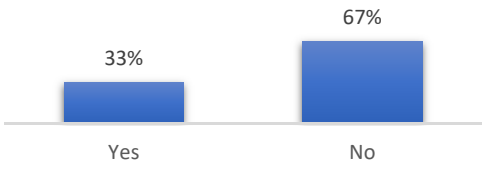
Majority (73% of organizations) have procedures for maintaining confidentiality of medical records.

ICAO also developed such procedures.

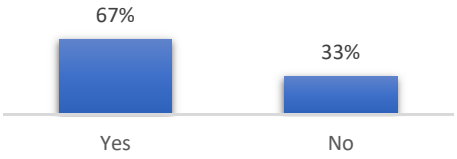
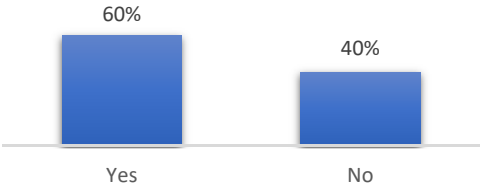


Are there any key performance indicators on occupational health and medical services?

It is a good practice to develop and measure KPIs for the medical clinic. Few organizations in the UN common system have implemented KPIs for their medical units.



Are surveys regularly conducted to get feedback on quality of medical services?

67% of the organizations regularly carry out a survey on this aspect. In ICAO, a survey on medical services was last conducted in 2012.	
Are there cost sharing agreements with other organizations for providing medical services?	
ICAO has cost sharing arrangements with United Nations for providing medical services to the staff of regional offices at Nairobi. Accordingly, we partly reimburse the expenditure incurred by UN medical services. However, ICAO does not have such cost sharing agreements with organizations whose staff is provided medical services by ICAO at Montreal.	

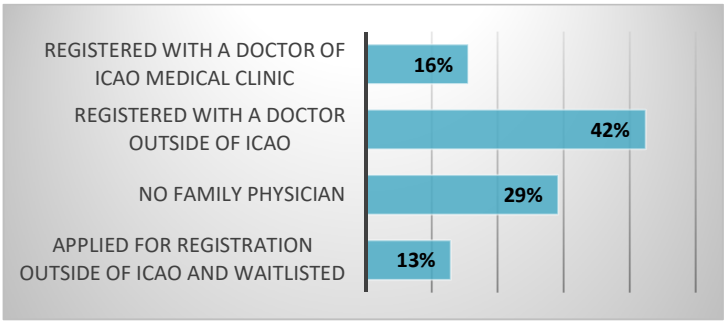
ANNEX 3: RESULTS OF STAFF SURVEY

The staff survey was conducted in April-May 2021. The questionnaire was issued to 538 staff members at ICAO Headquarters. 264 staff members replied to the questionnaire. A summary of the results is presented below:

What is the status of registration with a general practitioner (family physician)?

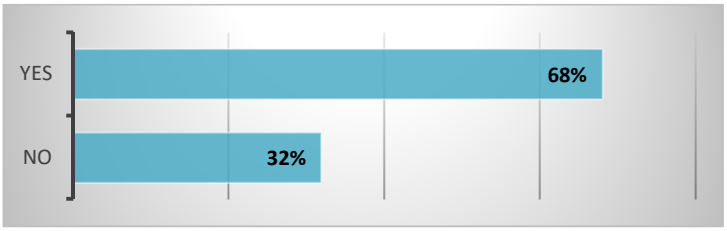
112 out of 264 respondents (42%) stated that they were registered with a doctor outside of ICAO and 41 (16%) stated that they continue to be registered with the ICAO medical clinic.

111 out of 264 (42%) of the respondents replied that do not have a regular family physician.



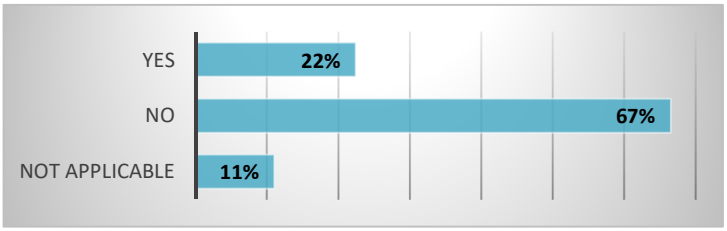
Do you use the services of ICAO medical clinic for prescriptions and first referrals?

68% of respondents (179 out of 264) use the ICAO medical clinic for basic health services. This practice is not aligned with the mandate of medical services in the UN common system organizations.



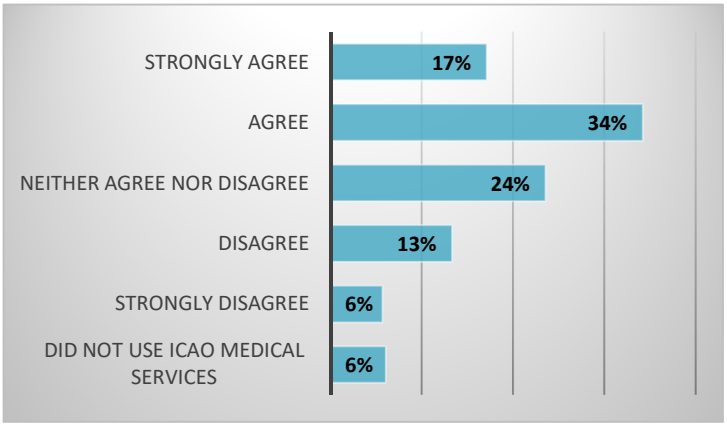
Is/Are your dependent family member(s) registered with ICAO medical doctor for family physician services?

59 out of 264 (22%) respondents stated that their dependent family members are registered with the ICAO medical doctor for family physician services. This is not aligned with the mandate of the ICAO medical clinic and should not have been allowed by ICAO.



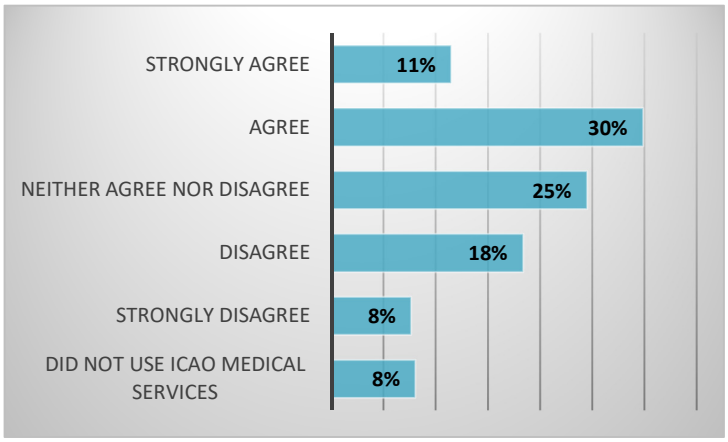
Are you satisfied with the quality of services provided by the medical unit?

While 51% of the respondents gave positive feedback, 19% gave a negative response on this aspect.



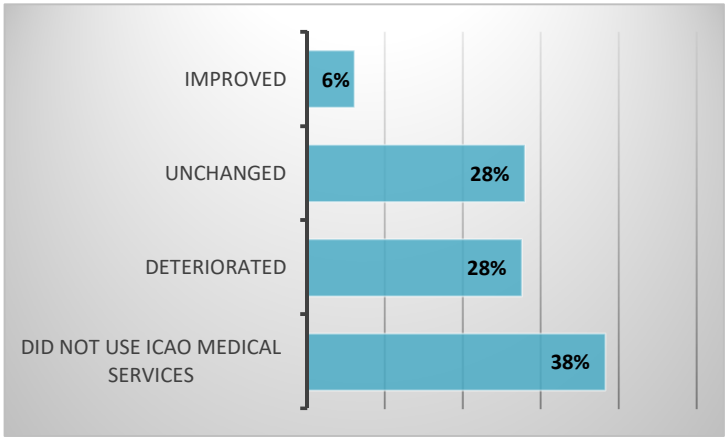
Do you get the medical appointments in a prompt manner?

68 out of 264 respondents (26%) responded negatively to this question. This is a high proportion which may require careful assessment of the work-load and resource availability in the medical clinic. This was possibly the case because first referral / family physician services were provided by medical doctors to not just staff members but also their dependents which are a deviation from its mandate.



How is the access to services of ICAO medical clinic since the pandemic started in March 2020?

73 out of 264 respondents (28%) responded negatively and stated that access to the ICAO medical clinic deteriorated after the start of the COVID pandemic.

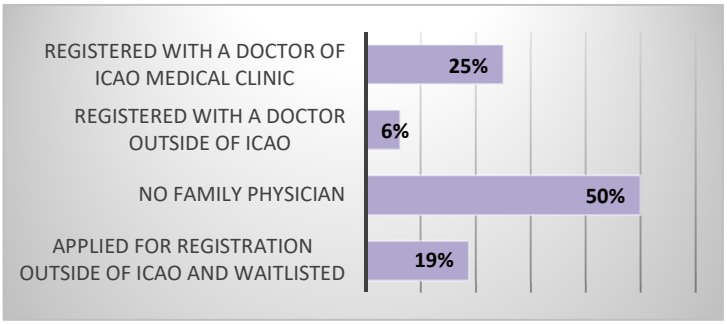


ANNEX 4: RESULTS OF SURVEY - MEMBERS OF DELEGATIONS

The survey of all delegations was conducted in April-May 2021. 16 members of delegations replied No definite conclusion can be drawn from this survey as the response rate was poor. However, a summary of the results is presented below:

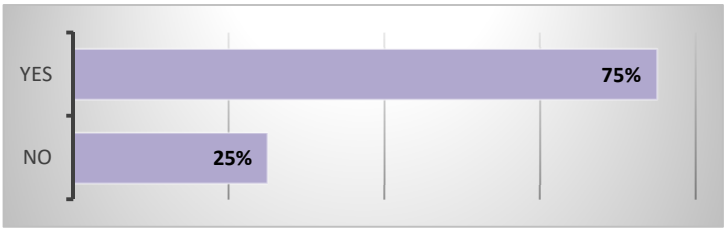
What is the status of registration with a general practitioner (family physician)?

Four out of 16 respondents (25%) stated that they are registered with a doctor of ICAO medical clinic for family physician services.



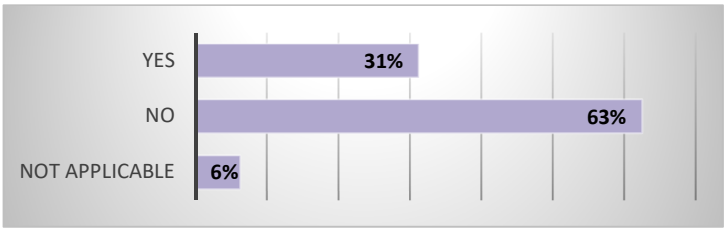
Do you use the services of ICAO medical clinic for prescriptions and first referrals?

A high proportion of 75% respondents (12 out of 16) use the ICAO medical clinic for basic health services. This practice is not aligned with the mandate of medical services in the UN common system organizations.



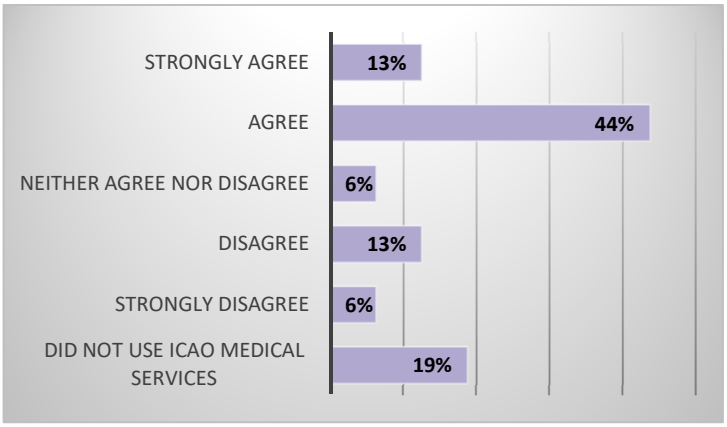
Is/Are your dependent family member(s) registered with ICAO medical doctor for family physician services?

5 out of 16 (31%) respondents stated that their dependent family members are registered with the ICAO medical doctor for family physician services.



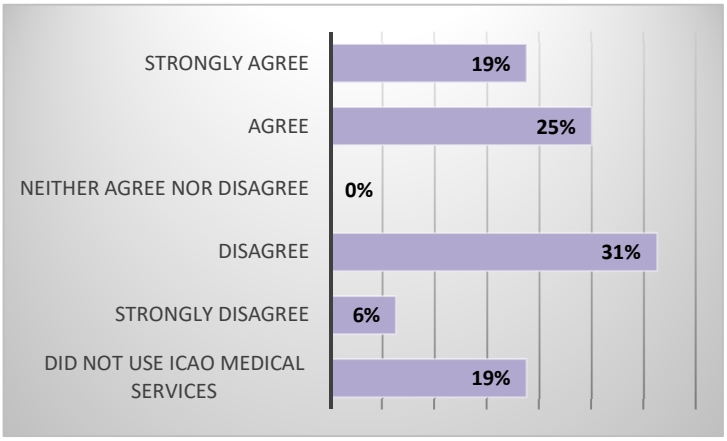
Are you satisfied with the quality of services provided by the medical unit?

While 57% of the respondents gave positive feedback, 19% gave a negative response on this aspect.



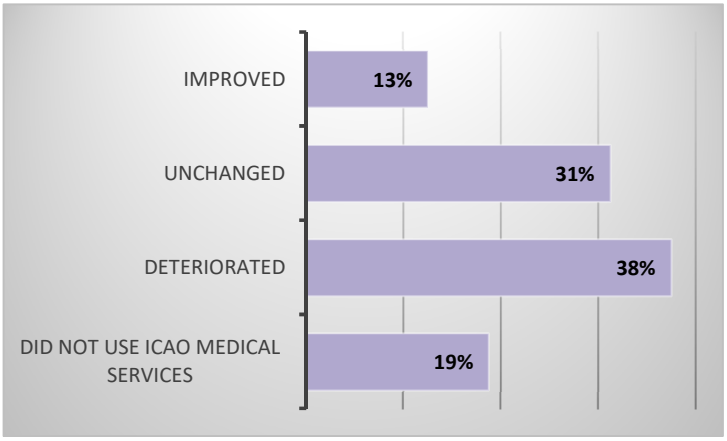
Do you get the medical appointments in a prompt manner?

Six out of 16 respondents (37%) responded negatively to this question.



How is the access to services of ICAO medical clinic since the pandemic started in March 2020?

Six out of 16 respondents (38%) responded negatively and stated that access to the ICAO medical clinic deteriorated after the start of the COVID pandemic.



ANNEX 5: MANAGEMENT ACTION PLAN

Ref	Recommendation	Priority Rating	Accepted (Y/N)	Management Comments	Agreed Actions	Office/ Section Responsible	Target Date
1.	ADB should develop Administrative Instructions on occupational safety and health for the Organization which, inter alia should identify the primary objectives, roles and responsibilities, and activities of the medical clinic covering all aspects of occupational safety and health in line with the practice adopted by UN common system organizations.	High	Y	The United Nations common system is currently working towards an OHS framework for common system organizations, which includes streamlining of OHS across the UN system, as a fundamental component of how Organizations meeting their obligations of duty of care.	Development of a Administrative Instructions and guidelines on Occupational Health and Safety (OHS)	SEA, POD & SAC	3rd Quarter of 2022
2.	ADB, under the direction of the Council and in coordination with relevant ICAO units, should draw up a plan to transform the ICAO medical clinic into a medical service provider focusing on Occupational Safety and Health (OSH) services of high quality in line with UN good practice. Since the discontinuation of the current practice of providing family physician services to staff members, Council delegations and their dependents may lead to difficulties because of long waiting times in registering with an outside family physician, transitional measures should be adopted to facilitate for a smooth transition.	High	Y	Transitional measures have already commenced since 23 November 2011, when the Organization advised staff and Delegations of the list of medical facilities they could approach for family physician and that as an interim measure the Clinic would continue to issue renew prescriptions and issue any referrals that might be necessary.	To explore the possibility of establishing a relationship with Clinics to accommodate staff and Delegations; while reforming the operations of the Clinic so that it focuses on Occupations Health and Safety, as other UN Medical Clinics	SEA/Medical Clinic	4th Quarter of 2022

Ref	Recommendation	Priority Rating	Accepted (Y/N)	Management Comments	Agreed Actions	Office/ Section Responsible	Target Date
3.	ADB should review and update Staff Rule 106.2 on sick leave and set a maximum limit on the number of sick leave days which the medical clinic can certify and issue sickness certificates. This should be implemented to ensure alignment with UN practice so that no conflicts of interest arise when the medical clinic performs secondary independent reviews of prolonged and recurrent sickness cases.	High	Y	Staff Rule 106.2 will be reviewed and updated accordingly.	Staff Rule has been updated and awaiting the review by the Staff Advisory Committee, at its next meeting.	SEA & POD	January 2022
4.	ADB in close cooperation with LEB and FIN, (i) Should review ICAO's existing practice of paying for RAMQ subscription as well as CIGNA medical insurance for staff members. The review should *inter alia* include an assessment of existing legal provisions, a cost benefit analysis of the existing practice, and available realistic options for the Organization, (ii) Explore ways of reducing the cost of contributions to RAMQ including renegotiating the terms of the Understanding with the Government of Quebec in this regard with a view to improving access and delivery of high quality healthcare services while reducing the associated costs.	High	Y	This recommendation may not be achievable anytime soon given the long established practice in relation to access to Medicare. Notwithstanding, a comprehensive assessment of RAMQ subscription vis-à-vis the cost efficiency of enhancing Cigna will be undertaken, and the possibility of renegotiating the terms of the Understanding with the Government of Quebec will be explored.	Undertake a comprehensive cost benefit analysis of current arrangement of health care for staff members via Cigna and RAMQ subscription to Quebec health care system. This will inform a decision as to whether to cease further payment towards RAMQ and to enhance Cigna coverage for all staff. In coordination with LEB, ADB will also explore the possibility of renegotiating the terms of the Understanding	SEA, FIN & LEB	4th Quarter of 2022

Ref	Recommendation	Priority Rating	Accepted (Y/N)	Management Comments	Agreed Actions	Office/ Section Responsible	Target Date
					with Quebec, with a view of reducing cost, and having better access and delivery of health care services.		
5.	ADB should update (a) the rules for independent secondary reviews of prolonged and recurrent sickness. The instructions should specify the mandatory requirement for a secondary review and the obligation of staff members to submit medical reports to the clinic when sick leave exceeds a prescribed limit, (b) the Personnel Instructions to include the eligibility of combining annual leave with certified sick leave on half pay in line with the UN good practice.	High	Y	Staff Rule 106.2 will be reviewed and updated to address, inter alia, recommendations (a) and (b)	Staff Rule 106.2 has been updated and awaiting the review by the Staff Advisory Committee, at its next meeting.	SEA & POD	January 2022
6.	ADB should (a) assess the staffing and resource requirements of the ICAO medical clinic to enable it to provide the necessary occupational safety and health services; (b) explore the possibility of engaging third party private medical service providers on framework agreements to improve the access and quality of healthcare services provided to ICAO staff and other beneficiaries.	High	Y	The Medical Clinic will provide occupational health and safety services to the organization and staff and where the medical doctor will serve as the physician of the organization and not the family physician of staff.	Management will explore the availability of funds to create a post for a full time Medical Officer to take the lead in the provision of OHS services to the Organization and staff. Management will also explore the possibility of establishing a	SEA & Medical Clinic (and possibly Procurement)	4th Quarter of 2022

Ref	Recommendation	Priority Rating	Accepted (Y/N)	Management Comments	Agreed Actions	Office/ Section Responsible	Target Date
					relationship with Clinics to accommodate medical appointments for staff and Delegations.		
7.	ADB should conduct a root cause analysis of staff absenteeism due to long term sickness and identify areas for improving overall monitoring, internal communication between line managers and staff members, reporting on sick leave and taking appropriate HR measures to improve the work environment and staff morale and hence performance.	High	Y	All forms of sickness beyond 3 days must be supported by a medical certificate, which must indicate the cause of illness. Sick leave is not supposed to be used to circumvent work conflict.	Medical Clinic will provide annual reports on the causes of long-term sick leave. Management will strengthen informal mechanisms in dealing with work related conflicts and to improve internal communication, so that staff can have trust in using this route than to resort to sick leave.	Medical Clinic, SEA & D/ADB	3rd Quarter of 2022
8.	ADB, in close cooperation with relevant offices, should review all cases where special leave with full pay has been granted for long periods and propose appropriate action and in case of non compliance, fully document the circumstances and send it to the competent authority for appropriate action.	High	Y	Compliance with relevant policies by managers and staff is important. Management will remind managers of the consequences of non-compliance of relevant policies in the granting of special leave with full pay.	D/ADB will remind managers and staff of the consequences of non-compliance of relevant policies in the granting of special leave with full pay. A decision will be taken as to whether cases need to be sent to OIOS if	D/ADB & SEA	1st Quarter of 2022

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					there is a likelihood of misuse of authority by managers and supervisors and/or the exploitation of a benefit by staff members.		
9.	ADB should review the status of the digitization of medical records of staff members and establish a timetable for completion of this work.	High	Y	The digitization of the medical records has been put on hold due to COVID 19	This activity will resume only after the pandemic is over and the company is agreeable to have its staff and equipment on the premises to continue.	Medical Clinic & SEA	4th Quarter of 2022
10.	ADB should finalize cost-sharing arrangements with UN agencies located in Montreal if their staff members use the occupational safety and health services provided by the ICAO medical clinic.	Medium	Y	This will be pursued.	Management will explore cost-sharing arrangements with UN agencies in Montreal subject to the availability of adequate resources for the Medical Clinic, such as a full time medical doctor and a staff compliment for the Clinic	SEA & Medical Clinic	2nd Quarter of 2022