Office of Internal Oversight Services

INTERNAL AUDIT DIVISION

REPORT 2021/075

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

UNHCR COVID-19 response arrangements for staff health and wellbeing ensured UNHCR personnel stayed and delivered services to persons of concern during the COVID-19 pandemic. Continued management attention is needed to improve certain governance and result areas to enhance UNHCR pandemic response effectiveness

23 December 2021
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Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

EXECUTIVE SUMMARY

The Office of Internal Oversight Services (OIOS) conducted an audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees (UNHCR). The objective of the audit was to assess the adequacy and effectiveness of measures implemented to mitigate the impact of COVID-19 on the health and wellbeing of its personnel. The audit covered the period from 1 March 2020 to 30 June 2021 and included a review of: (a) governance mechanisms; (b) response and prevention measures; (c) first line of defence and medical evacuation (MEDEVAC); (d) COVID-19 vaccination; (e) inter-agency arrangements; (f) psychosocial support; and (g) gender considerations.

As a front-line humanitarian agency and a workforce of about 17,900, UNHCR stayed and delivered services to its persons of concern across the globe during COVID-19 pandemic including in high-risk areas. UNHCR put in place relevant outbreak response and prevention measures in dealing with COVID-19 to balance between the imperatives of mandate delivery and ensuring the health and wellbeing of its personnel. However, improvements were needed to further enhance future COVID-19 response and prevention arrangements.

OIOS made seven recommendations. To address issues identified in the audit, UNHCR needed to:

- Promulgate its policy on the Organizational Resilience Management System and update its Crisis Management standard operating procedures and playbook;

- Systematically identify and record lessons learned, as well as maintain a central repository of documentation on the COVID-19 response;

- Increase compliance with guidance related to back to office and travel; clarify COVID-19 case management guidance; encourage Representations to campaign for seasonal influenza vaccination; and ensure availability of proof of health insurance for the affiliate workforce;

- Review duty stations with poor healthcare facilities; address gaps in staffing and improve MEDEVAC arrangements;

- Take action to improve COVID-19 vaccination rates among its personnel;

- Improve its senior managers' participation at United Nations Country Team meetings and elevate unresolved matters such as cost-sharing formula for resolution; and

- Develop an organization-wide psychosocial support plan based on needs assessments; use the occupational safety and health framework to strengthen the psychosocial preparedness, response and recovery; and assess the sufficiency and role of peer advisors.

UNHCR accepted the recommendations and initiated action to implement them. Actions needed to close the recommendations are included in Annex 1.

CONTENTS

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

I. BACKGROUND

1. The Office of Internal Oversight Services (OIOS) conducted an audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees (UNHCR).

2. The World Health Organization (WHO) declared coronavirus disease (COVID-19) a public health emergency of international concern on 30 January 2020 and as a pandemic on 11 March 2020. WHO is leading the response to the pandemic with Member States expected to design and implement measures in line with the former's strategic preparedness and response plan. The United Nations Secretariat also issued COVID-19 pandemic guidelines to ensure a timely, consistent and coordinated public health response. These guidelines serve as the framework for implementing response and prevention arrangements for the health and wellbeing of personnel and are adapted to local contexts. For instance, decisions on teleworking, travel restrictions, vaccinations, quarantine and contact tracing are not taken by the United Nations in isolation but often as a direct consequence of host country regulations.

3. UNHCR has a legal and moral obligation of 'duty of care' toward its personnel and must ensure that adequate and effective health and psychosocial measures are in place for continued delivery of its mandate in the safest and most responsible manner.

4. The Division of Human Resources (DHR) is responsible for monitoring the implementation of policies through aggregation and analysis of data, reporting of results, and recommending corrections to ensure global consistency and coherence. DHR's Staff Health and Welfare Service (SHWS) is responsible for ensuring a proactive occupational health approach to address work hazards. As of June 2021, UNHCR reported that it had 1,886 (11 per cent) of its 17,848 personnel infected with COVID-19 and 11 fatalities. As of 23 August 2021, UNHCR also reported 2,764 staff members were fully vaccinated and 1,564 had received the first dose of the vaccine.

II. AUDIT OBJECTIVE, SCOPE AND METHODOLOGY

5. The objective of the audit was to assess whether UNHCR's COVID-19 response and prevention arrangements were adequate and effective in protecting the health and wellbeing of personnel in line with the 'duty of care' principle.

6. This audit was included in the 2021 risk-based work plan of OIOS due to the criticality of ensuring the health and wellbeing of personnel during the pandemic.

7. OIOS conducted this audit from May to July 2021. The audit covered the period from 1 March 2020 to 30 June 2021. Based on an activity-level risk assessment, the audit covered higher risk areas pertaining to: (a) governance mechanisms; (b) outbreak response and prevention; (c) first line of defence (FLOD) and medical evacuation (MEDEVAC); (d) COVID-19 vaccination; (e) inter-agency arrangements; (f) psychosocial support; and (g) gender considerations. The audit included in its scope a review of COVID-19 response and prevention arrangements in the: (a) 12 Representations in Afghanistan, Bangladesh, Brazil, Central African Republic (CAR), Democratic Republic of the Congo (DRC), Ecuador, Jordan, Nigeria, Republic of the Congo (Congo), Rwanda, Ukraine and Yemen; (b) Regional Bureaux for Americas, Asia

and the Pacific, East and Horn of Africa and the Great Lakes, Europe, Middle East and North Africa and West and Central Africa and (c) two headquarters locations in Geneva and Budapest. By reviewing the 12 Representations, Regional Bureaux and 2 headquarters locations, the audit covered offices that constituted 27 per cent of UNHCR personnel.

8. The audit methodology included: (a) interviews with key personnel from headquarters, Regional Bureaux and Representations; (b) review of UNHCR and United Nations COVID-19 related documents, reports and dashboards, (c) review of data from Managing for Systems, Resources and People, the UNHCR enterprise resource planning system, and (d) sample testing of controls. OIOS conducted 84 online meetings with selected personnel from headquarters, Regional Bureaux and Representations, eight face-to-face meetings and one field mission to Ukraine.

9. The audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.

III. AUDIT RESULTS

A. Governance mechanisms

There was a need to promulgate the policy on the Organizational Resilience Management System and update Crisis Management standard operating procedures and playbook

10. The United Nations Policy on the Organizational Resilience Management System (ORMS) requires strong governance structures with efforts coordinated and led from the highest management levels. A well-functioning ORMS provides a robust institutional and operational framework enabling critical decisions and actions to be taken quickly in response to crisis situations. This includes protecting the health and wellbeing of personnel in an integrated and coordinated manner during pandemics and incorporating the key components of enhanced risk management, consultative decision-making, business continuity management, and communications.

11. An essential requirement for the effective application of ORMS is the development of a United Nations System organization-specific guidance that is aligned with the related policy. The OIOS advisory engagement on the status of implementation of ORMS in UNHCR covering the period October 2019 to January 2020 noted that UNHCR had not promulgated an ORMS policy. At the time of this audit, the policy was still outstanding although the crisis management document (playbook) and standard operating procedures (SOPs) for crisis management had been drafted. UNHCR in its Strategic Risk Register committed to implementing a holistic ORMS policy in the Organization by June 2022.

12. In early 2020, the Director of the Division of Emergency, Security and Supply headed a multi-functional task force that was established to oversee the COVID-19 response. However, due to the rapid evolution of the pandemic, this taskforce was unable to provide the required leadership. Therefore, in February 2020, a Crisis Management Team (CMT) was formed to replace the task force which was headed by the High Commissioner and comprised senior UNHCR leadership in Geneva and heads of the SHWS and the Copenhagen and Budapest Global Service Centers. The CMT was effective in providing the required coordination and oversight for crisis management. This included amongst other things, (a) making the decision to 'stay and deliver'; (b) updating of business continuity plans (BCPs); (c) development of preparedness and response plans; (d) periodic review of COVID-19 statistics; (e) procurement and distribution of Personal Protective Equipment (PPE); (f) status monitoring of COVID-19 vaccination for personnel; (g) identification of related risks for mitigation; and (h) communications to personnel. These discussions and the related action points were monitored in subsequent meetings.

13. In March 2020, UNHCR developed a COVID-19 risk register to capture risk scenarios and the related mitigating measures. The audit nonetheless noted gaps in the COVID-19 preparedness checklist, maintenance of risk registers and BCPs in the locations reviewed. For example, only (a) 3 of the 12 Representations had completed the COVID-19 preparedness checklist; (b) 5 of the 12 Representations identified and prioritized specific COVID-19 risk ratings and 3 of these had actions to mitigate risks; and (c) 3 had BCPs for the COVID-19 response and prevention arrangements but none of the others comprehensively dealt with the subject.

14. Therefore, to be better prepared to respond in crises situations, UNHCR needs to develop and finalize its policy on ORMS, including ensuring that field operations have current BCPs, as well as risk registers and relevant treatment plans.

(1) UNHCR should promulgate its policy on the Organizational Resilience Management System and adopt an updated version of its Crisis Management standard operating procedures and the crisis management playbook in line with the relevant United Nations Policy.

UNHCR accepted recommendation 1 and would work to promulgate a policy on ORMS and adopt an updated version of the ORMS SOP and playbook.

There was a need to identify, assess and apply lessons learned

15. ORMS requires that lessons are learned, assessed, recorded and applied to the continuous improvement of policies and procedures. UNHCR identified lessons learned in relation to the back to office guidelines and the strengthening of FLOD. Five of the 12 Representations provided evidence of lessons learned but they were not available for the others, as well as for the headquarters office in Budapest. This may have been due to poor records management.

16. Additionally, due to lack of time, resources and guidance, UNHCR had no dedicated repositories for COVID-19 related documentation at headquarters and in 10 of the Representations reviewed. A central repository could optimize institutional learning and ensure continuity of operations.

(2) The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) put in place mechanisms to systematically identify and record lessons learned to improve COVID-19 prevention and response measures and planning for future pandemics; and (b) maintain a central repository of documentation on the COVID-19 response to facilitate informed decision-making.

UNHCR accepted recommendation 2 and stated that DHR would maximize its efforts in organizational learning, to put in place mechanisms to improve preventive measures and maintain a central repository of documentation on the COVID-19 response.

B. Outbreak response and prevention

There was a need to enhance some components of the outbreak response and prevention arrangements

17. UNHCR instituted preventive measures including cleaning of offices, physical distancing and promoting personal hygiene. SHWS supported personnel by responding to hotline calls, providing guidance, maintaining contact with persons infected by COVID-19 and their dependents, and conducting online 'brown bag' discussions. Flexible/alternative working arrangements were put in place based on the

country context and this enabled physical distancing and reduced exposure. UNHCR provided PPE and training to the frontline healthcare workers in the 12 countries reviewed. However, field staff informed OIOS that to ensure effective case management, more clarity was needed in the definition of the terms used such as primary contact, secondary contact, isolation, quarantine and contact tracing.

18. In July 2020, Headquarters moved to a back to office flexible phase (40-50 per cent occupancy) to balance the imperatives of service delivery and duty of care with strict measures to ensure physical distancing. UNHCR piloted this in Geneva with an expectation that these arrangements would be adapted globally. However, personnel interviewed in two Representations stated that in their view the back to office modality was not well thought through, as some field offices did not have proper ventilation. Feedback was also received that some field managers were insensitive to staff that had medical concerns and were pressing them to return to office even if they were delivering while teleworking.

19. WHO introduced risk mitigation measures aimed at reducing travel-associated transmission of COVID-19. In UNHCR, travel by the Senior Executive Team decreased by 75 per cent (64 to 16) from April to December 2020 as compared from the same period in 2019. Also, the travel of Directors decreased by 79 per cent (1,802 to 371) compared to the same period in 2019. However, this precaution was not consistently applied across the organization. For instance, three Representations continued with 44 in-country travels from March 2020 to March 2021 for meetings and training/capacity building workshops which could not be categorized as essential for emergency purposes. The Representations were of the view that these meetings would be more effective if done face-to-face.

20. In October 2020, the United Nations Medical Directors (UNMD) strongly recommended that personnel be vaccinated with seasonal influenza vaccination to reduce respiratory illnesses and a burden on healthcare systems. Based on this advice, four Representations and the two headquarter offices arranged for their personnel to get the flu vaccine, with between 30 to 50 per cent of staff in these locations taking the vaccine. No information was available for the remaining 10 offices and in case of Budapest, the flu vaccination arranged by the office did not materialize due to government restrictions.

21. At the outset of the pandemic, DHR sent reminders to field operations that Affiliate Workforce (AWF) personnel provide proof of health insurance to UNHCR to ensure that they are up to date. However, from a sample review of 57 of the UNHCR's 4,299 AWF personnel, the audit found that Representations were not systematically ensuring that they had adequate proof of health insurance, with only 6 of the 12 Representations reviewed having such proof. The other six Representations did not know the insurance status of AWFs because they believed that this was taken care of by their respective entities, in accordance with the relevant contractual arrangements. This raised the risk that AWF would be unable to access medical care and MEDEVAC during an emergency.

22. While positive efforts had been made by UNHCR in line with directives from WHO and UNMD, a stronger monitoring mechanism to ensure their implementation could have improved the effectiveness of the response measures.

(3) The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) ensure that guidance related to back to office and travel is complied with; (b) clarify COVID-19 case management guidance including the definition of primary and secondary contact, isolation, quarantine and contact tracing; (c) encourage Representations to campaign for seasonal influenza vaccination; and (d) ensure availability of proof of health insurance for the affiliate workforce.

UNHCR accepted recommendation 3 and stated that in coordination with the Regional Bureaux, DHR would continue to ensure relevant guidance related to back to office, travels and COVID-19 case

management is established and clarity on definitions. UNHCR would also encourage seasonal influenza vaccination campaigns in Representations and ensure proof of health insurance is available for affiliate workforce.

C. First line of defence and medical evacuation

There was a need to review duty stations with inadequate national healthcare facilities and address staffing and medical evacuation issues

23. The United Nations COVID-19 Pandemic Guidelines require that United Nations personnel obtain medical care and advice through the standard national medical infrastructure. FLOD aims at ensuring that at the country level, adequate COVID-19 healthcare and clinical testing capacity exists for United Nations personnel. In assessing healthcare capacity, the FLOD Working Group used six key performance indicators (KPIs) related to: (a) risk mitigation; (b) supplies for risk mitigation; (c) access to testing; (d) isolation capacity; (e) access to hospital beds; and (f) MEDEVAC.

24. The United Nations established a system-wide MEDEVAC mechanism to protect and ensure emergency treatment of patients with severe COVID-19 symptoms in countries with inadequate healthcare facilities. There was also an inter-agency initiative to reduce reliance on MEDEVAC and increase in-country healthcare. UNHCR actively participated in the FLOD working group and MEDEVAC task force, with its medical officers playing a significant role in the United Nations-wide assessment of national healthcare facility capacity in 146 countries. Also, in partnership with other United Nations agencies, UNHCR established healthcare facilities in Afghanistan and Bangladesh to provide medical and mental support to United Nations personnel. Regarding MEDEVAC activities, SHWS: (a) maintained constant communication with Regional Medical Officers (RMOs) and country COVID-19 focal points; and (b) actively participated in the MEDEVAC response led by WHO.

25. The FLOD dashboard monitored six KPIs on whether United Nations Country Teams (UNCT) were meeting the UNMD COVID-19 model of care. This measurement helped determine where funding was most needed to improve FLOD facilities. The dashboard showed that three KPIs were not being achieved. This included: inadequate access to hospital beds (47 countries); insufficient testing (26 countries); and lack of isolation capacity (23 countries). UNHCR had 42 per cent of its personnel based in countries with medium to high risk FLOD status, mostly in the Bureaux of East and Horn of Africa and the Great Lakes, Middle East and North Africa and West and Central Africa. FLOD status in the 12 countries reviewed by OIOS as of November 2020 was mostly satisfactory except for Afghanistan, Congo, DRC and Jordan that fell short in one or more KPIs.

26. There were challenges in the reliability of the dashboard and some reporting elements needed recalibration. For instance: (a) the FLOD rating could be misleading as it was not up to date to reflect current status of the capacity of national healthcare facilities particularly when COVID-19 surged in the country. It also provided information on the whole country and not specific locations and therefore did not disclose disparities[1] across different healthcare facilities; and (b) with the Delta variant, the UNMD model of care was unable to predict the significant increase in demand for intensive care unit beds and shortage of oxygen in countries like Bolivia, India, Indonesia, Peru and Uganda. Moreover, the poor status of national healthcare facilities was already known to UNHCR, hence, the benefits of the dashboard data for crisis management were limited.

[1] The local healthcare facilities in Cox's Bazar can be different from the overall healthcare situation in Bangladesh.

27. There were 42 United Nations clinics in 648 duty stations located across the 146 countries where UNHCR was working as of June 2021. SHWS reported that many high-risk duty stations did not have adequate in-country healthcare facilities pre-COVID-19, and this inadequacy was magnified by the pandemic. It was reported in the WHO publication: "Health emergency preparedness after COVID-19: Building for the future" that where FLOD was inadequate or non-existent and United Nations clinics are insufficient, investments need to be planned and made to avoid future costly interventions, since the costs of effective preparedness are overshadowed by those related to a failure to prepare.

28. At the beginning of the pandemic, 2 of the 7 Regional Bureaux (Middle East and North Africa and Americas) did not have RMOs. UNHCR subsequently provided SHWS with additional personnel during the pandemic, e.g., four RMOs and five Regional Staff Counsellors (RSC). However, the office in Budapest did not have a dedicated medical officer even though the office has over 500 personnel.

29. Additionally, UNHCR MEDEVAC case data was only available up to November 2020 as after that the system did not segregate the information by organization due to the sensitivity of information. Available data showed that there were 13 UNHCR cases, the status of 8 of which was 'completed' and 5 'cancelled' either because the patients died or recovered before their evacuation. However, SHWS mentioned that the effectiveness of MEDEVAC arrangements was impacted by: (a) inadequate in-country coordination among United Nations agencies; (b) late notification by the United Nations physicians of MEDEVAC requests related to UNHCR; and (c) inadequate action from and expertise of COVID-19 coordinators. There were also delays in partner staff accessing MEDEVAC due to lack of clarity regarding their eligibility for services and lengthy approval procedures. This regretfully contributed to the death of a partner's staff member in the West and Central Africa region. In two cases, the cultural context and reluctance to be evacuated for family and personal reasons also delayed the process.

30. The shortcomings in FLOD occurred due to delays in addressing long-standing and well-known healthcare capacity gaps and MEDEVAC issues were caused by in-country inter-agency challenges and delays in notification. These issues impacted the health and wellbeing of personnel.

(4) The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) review duty stations with poor healthcare facilities and assess if UNHCR can make direct investments or partner with other United Nations agencies under inter-agency arrangements; (b) address gaps in staffing; and (c) resolve, internally or through inter-agency arrangements, the medical evacuation issues including inadequate in-country coordination, lack of clarity on partner staff eligibility for services and lengthy evacuation process.

UNHCR accepted recommendation 4 and stated that in coordination with the Regional Bureaux, DHR would continue to formally review duty stations with poor local healthcare system, looking into staffing and resolving issues internally or through inter-agency arrangements.

D. COVID-19 vaccination

There was a need to implement an action plan to improve COVID-19 vaccination rates

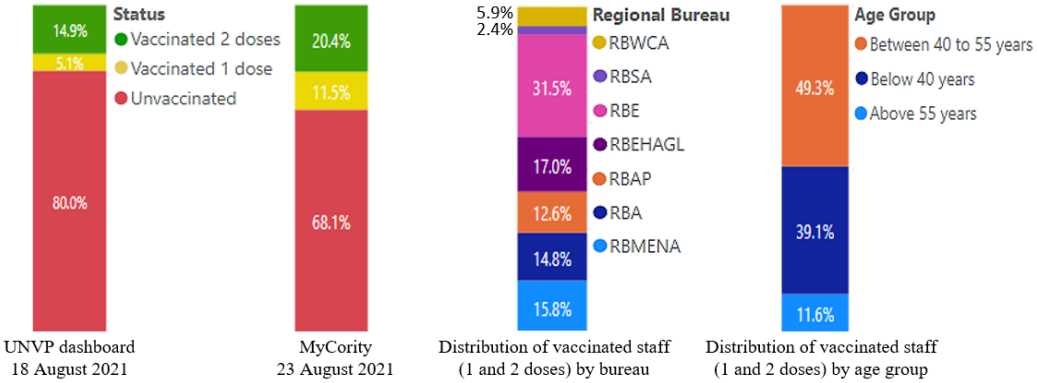
31. Member States are responsible for ensuring that United Nations personnel and their dependents were included in national vaccination programmes (NVPs) in the country where they serve. In the absence and/or inadequacy of NVPs, UNHCR personnel can get vaccinated through the United Nations System-wide COVID-19 vaccination programme (UNVP).

32. Accurate data is a critical aspect of a public health response, and while personnel under UNVP received the necessary certificates evidencing their vaccinations, this was not always the case when United Nations personnel received vaccines from national authorities.

33. The UNVP used the United Nations vaccination digital platform, Everbridge, for registration, appointment and knowledge management. UNHCR used its own platform MyCority to monitor the COVID-19 vaccination status of staff members. The data in MyCority portal was updated through the Everbridge portal (UNVP dashboard[2]) for staff members vaccinated under UNVP; and by self-reporting for those vaccinated under NVP. As of 23 August 2021, the MyCority dashboard recorded that 2,764 UNHCR staff members were fully vaccinated (20 per cent of 13,563 staff members)[3] and 1,564 had received the first dose. This global data, however, did not include AWF and staff dependents.

34. For UNHCR personnel, both the UNVP and MyCority dashboards showed gaps in vaccination rates. The COVID-19 vaccination statistics are depicted in Figure 1, with the Bureau for Southern Africa having the lowest number of vaccinated staff (first/second dose).

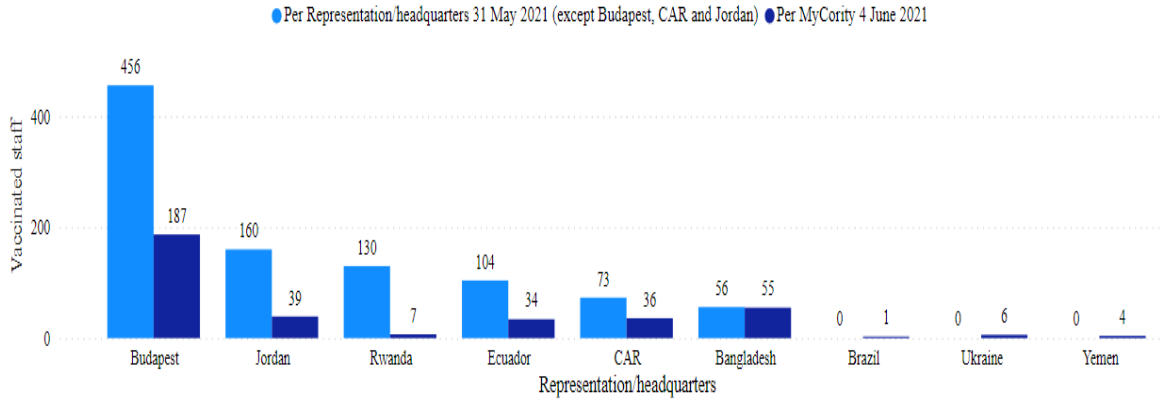
Figure 1: **Number of vaccinated UNHCR personnel/staff members**



35. As of 23 August 2021, MyCority showed that for the 12 Representations and two headquarters locations reviewed, 1,412 staff members were either partially or fully vaccinated. Although only 9 of the 14 entities reviewed provided vaccination data, these showed that of the 2,533 personnel, 32 per cent were fully vaccinated and 28 per cent had received the first dose. In addition, of the 2,610 dependents, only 1.4 per cent were fully vaccinated and 4 per cent had received the first dose. This data differed from what had been provided for the same entities by SHWS as shown in Figure 2, with differences attributed to delays in self-reporting and synchronization issues between Everbridge and MyCority. Incomplete and inaccurate vaccination data increased the risk that decisions made relating to return to work, travel etc., may not have been adequately informed.

[2] The two datasets are not comparable. MyCority contains vaccination data only for staff members from both NVP and UNVP. UNVP dashboard contains vaccination data for personnel (staff members and affiliate workforce) and dependents vaccinated only under UNVP.
[3] MyCority portal only covered staff members and excluded affiliate workforce thus the difference in numbers from staff totals of 17,848. It also did not cover dependents.

Figure 2: **Number of vaccinated UNHCR staff members**



36. The UNMD country prioritization model produced a standardized and risk-based list of countries to be included under UNVP on a priority basis, which considered factors such as: FLOD rating, security level determined by the United Nations Department of Safety and Security, MEDEVAC rates/cases, mobility and hardship category, United Nations COVID-19 case rates, and Human Development Index.

37. From the sample of 12 Representations and 2 headquarters offices, personnel assigned in: (a) eight countries had an option to receive COVID-19 vaccination either from UNVP or NVP; (b) four countries only had the option to be vaccinated under NVP; and (c) 2 only had the option of being vaccinated under UNVP. There were some gaps in the prioritization model, as Yemen did not have an NVP and was initially not included in UNVP, and due to the slow roll-out of the NVP in Bangladesh and Brazil, they were belatedly included in UNVP. Jordan on the other hand, had a robust NVP and yet was also selected for UNVP.

38. The low vaccination rates were due to: (a) global shortage of COVID-19 vaccines; (b) vaccine inequity in distribution especially for low/medium income countries, e.g., the COVID-19 Vaccines Global Access (COVAX) faced vaccine shortages, which greatly impacted NVPs supported by this facility; and (c) vaccine hesitancy due to misinformation and/or cultural attitudes and personal decision which could potentially be addressed through awareness and outreach.

(5) The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should take action to improve COVID-19 vaccination rates by: (a) maintaining complete and accurate vaccination data; (b) combating misinformation and vaccine hesitancy through awareness and outreach campaigns; (c) reviewing synchronization issues between the MyCority and Everbridge systems; and (d) reviewing and coordinating the timely issuance of vaccination certificates.

UNHCR accepted recommendation 5 and stated that DHR would in coordination with the Regional Bureaux take action to improve COVID-19 vaccination rates as soon as possible, combatting vaccine hesitancy while maintaining complete and accurate vaccination data. DHR would also review synchronization issues between systems and coordinate timely issuance of vaccination certificates.

E. Inter-agency arrangements

There was a need to improve UNHCR's participation in inter-agency arrangements

39. UNHCR leveraged on inter-agency arrangements and coordinated with host countries on COVID-19 response arrangements. This included harmonized communications to staff, joint MEDEVAC, COVID-19 vaccinations, teleworking arrangements, and medical and psychosocial support to personnel. At the global level, senior management participated in the Task Forces (FLOD/MEDEVAC/COVID-19 Vaccination) and attended meetings of the Assistant Secretary-General Medical Support Services Task Force in 2020 and meetings of the MEDEVAC Task Force. The Head of SHWS also attended the FLOD Working Group meetings in 2020-2021 and the meetings of the COVID-19 vaccination Working Group in 2021. At the country level, Representatives attended UNCT meetings and its sub-groups (e.g., Task Force, Task Team) to coordinate COVID-19 response measures.

40. By their participation in inter-agency meetings, UNHCR ensured synergy and enabled efficiencies, e.g., UNCT's coordination with host government on teleworking, travel, vaccination, quarantine and contact tracing which benefited UNHCR. However, from the information gathered, Representations were not always effectively participating in country inter-agency meetings: only 8 of the 12 Representations reviewed provided minutes of their attendance at meetings. Three of them could not provide evidence of their active participation in UNCT meetings and sub-groups. For instance, UNHCR Nigeria was not included as a member of the United Nations COVID-19 Task Team and in Afghanistan and Ecuador, UNHCR was not always represented by senior managers in meetings. Non-attendance could impact on ensuring harmonization in decision-making.

41. Lessons learned from inter-agency arrangements were documented in 2 of the 12 Representations and 2 headquarters locations but none were available for the others. Documenting lessons learned is a good practice and ensure that important issues are identified for corrective action to be taken. For example, lessons learned included the need to: (a) improve coordination on decisions taken by the Humanitarian Coordinator and the UNHCR Representative on teleworking; and (b) accelerate the pace of procurement, as well as ensuring good quality PPE is procured under UNCT arrangements.

42. At 2 of the 12 Representations, UNCT, in sharing costs, used a cost-sharing formula based on the number of personnel in each duty station within the country. For the remaining 10 Representations, the cost-sharing was based on a total personnel count, assuming they were all located at the capital office. This was disadvantageous to UNHCR, since many of its staff were in field offices, where costs were lower than in the capital city.

43. Although good practices emerged in inter-agency arrangements, improved coordination by UNHCR and documenting lessons learned would better harmonize procedures going forward and may result in further efficiencies.

(6) UNHCR should: (a) actively participate in meetings of the United Nations Country Team (UNCT); (b) advocate at UNCT to improve documentation of lessons learned; and (c) elevate unresolved matters such as cost-sharing formula to the Inter-Agency Standing Committee for resolution.

UNHCR accepted recommendation 6 and stated that Regional Bureaux Directors would continue to ensure country operations adhere to available guidance related to engagement with the UNCT. Regional Bureaux would implement this recommendation with support of relevant Divisions as needed.

F. Psychosocial support

There was a need to improve psychosocial interventions for the wellbeing of personnel

44. Mental health and psychosocial support to personnel was coordinated and delivered by the Psychosocial Wellbeing Section (PWS), Office of the Ombudsman and Ethics Office, and provided by 18 Staff Counsellors. Assistance was also provided from the Peer Advisors Network (PAN), which comprised UNHCR personnel trained in providing psychosocial first aid, resolving conflicts and being ethical influencers.

45. From March 2020 to March 2021, PWS provided support to 4,185 individuals involving 10,799 interventions. There were also 918 group events attended by 22,000 participants. During the pandemic, PWS held: regular meetings with senior management, group and 'brown bag' sessions, and webinars on coping with COVID-19. It also launched a psychosocial wellbeing hotline and platforms on the intranet and individual and group sessions led by the peer advisors.

46. The UNHCR-wide ratio of staff counsellors to staff members was 1:991. There were also disparities in counsellors to staff ratio in headquarters and across Bureaux. The Bureau for Southern Africa had 1:395 while the Bureau for Americas and Headquarters (Geneva, Budapest and Copenhagen) had 1:1,241, and 1:1,661 respectively. One Bureau RSC mentioned that he had to cover 20 Representations which was difficult. Four of the 12 Representations mentioned that there was inadequate: (a) support from RSCs including assistance needed by personnel infected with COVID-19; (b) coordination with staff counsellors from United Nations Department of Safety and Security, and (c) capacity and professionalism among peer advisors. There was also feedback that the volume of psychosocial information from headquarters overwhelmed field personnel and that the information could not be used effectively.

47. PAN is a global network of 448 UNHCR personnel volunteering to support field colleagues and were trained on how to provide low-intensity psychosocial support. PAN became a key component of the support network for personnel during COVID-19. In the 12 Representations, the average number of peer advisors per 100 UNHCR personnel was 3.8, with the lowest ratio as 1.9 and the highest as 7.4. There was no established indicator, based on country specific context, to ensure adequacy of peer advisors per Representation.

48. The interventions and support provided was well appreciated by UNHCR personnel. However, it was difficult to assess if the range of services provided fully addressed all the social, relational, psychological and personal issues of all personnel wellbeing. Therefore, going forward, and to improve future interventions, a more formal UNHCR-wide psychosocial support plan could be developed based on needs assessments against which the interventions could be benchmarked, with indicators established for monitoring changes in psychosocial health. PWS informed that psychosocial needs were assessed continuously as part of regular meetings with management, Representatives, RSCs, RMOs and PAN had in place strategies to guide their implementation of interventions.

(7) The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) develop a UNHCR-wide psychosocial support plan based on needs assessments against which the interventions could be benchmarked, with indicators established for monitoring changes in psychosocial health; (b) use the occupational safety and health framework to strengthen the psychosocial preparedness, response and recovery; and (c) reassess the sufficiency and role of peer advisors in a public health emergency.

UNHCR accepted recommendation 7 and stated that DHR would monitor occupational psychosocial hazards and mental health of personnel through comparable indicators and instruments to adjust the organizational response strategy, including the psychosocial response strategy. This would be implemented in line with the changes in operational/organizational context and within the framework of the United Nations mental health strategy.

G. Gender considerations

49. Gender issues were adequately addressed in the COVID-19 response and prevention arrangements in the review of the 12 Representations and headquarters in Geneva and Budapest. This included: (i) addition of pregnant women in the vulnerable groups to be protected; (ii) documented risk of increased domestic violence, impacting both men and women, when teleworking from home; and (iii) issuance of psychosocial wellbeing guidance.

IV. ACKNOWLEDGEMENT

50. OIOS wishes to express its appreciation to the management and staff of UNHCR for the assistance and cooperation extended to the auditors during this assignment.

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ANNEX I

STATUS OF AUDIT RECOMMENDATIONS

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

Rec. no.	Recommendation	Critical[4]/ Important[5]	C/ O[6]	Actions needed to close recommendation	Implementation date[7]
1	UNHCR should promulgate its policy on the Organizational Resilience Management System and adopt an updated version of its Crisis Management standard operating procedures and the crisis management playbook in line with the relevant United Nations Policy.	Important	O	Receipt of evidence of the issuance of the ORMS policy and an updated version of the Crisis Management SOPs and playbook.	30 June 2022
2	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) put in place mechanisms to systematically identify and record lessons learned to improve COVID-19 prevention and response measures and planning for future pandemics; and (b) maintain a central repository of documentation on the COVID-19 response to facilitate informed decision-making.	Important	O	Receipt of evidence of lessons learned and examples of records maintained in the central repository.	31 March 2022
3	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) ensure that guidance related to back to office and travel is complied with; (b) clarify COVID-19 case management guidance including the definition of primary and secondary contact, isolation, quarantine and contact tracing; (c) encourage Representations to campaign for seasonal influenza vaccination; and (d) ensure availability of proof of health insurance for the affiliate workforce.	Important	O	Receipt of evidence that: (i) monitoring of compliance with back to office and travel guidance was in place; (ii) COVID-19 case management guidance is clarified; (iii) Representations are encouraged to continuously campaign for seasonal influenza vaccination; and (iv) proof of health insurance for AWF is available at the Representations.	30 April 2022

[4] Critical recommendations address those risk issues that require immediate management attention. Failure to take action could have a critical or significant adverse impact on the Organization.
[5] Important recommendations address those risk issues that require timely management attention. Failure to take action could have a high or moderate adverse impact on the Organization.
[6] Please note the value C denotes closed recommendations whereas O refers to open recommendations.
[7] Date provided by UNHCR in response to recommendations.

ANNEX I

STATUS OF AUDIT RECOMMENDATIONS

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

Rec. no.	Recommendation	Critical[4]/ Important[5]	C/ O[6]	Actions needed to close recommendation	Implementation date[7]
4	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) review duty stations with poor healthcare facilities and assess if UNHCR can make direct investments or partner with other United Nations agencies under inter-agency arrangements; (b) address gaps in staffing; and (c) resolve, internally or through inter-agency arrangements, the medical evacuation issues including inadequate in-country coordination, lack of clarity on partner staff eligibility for services and lengthy evacuation process.	Important	O	Receipt of evidence that: (i) UNHCR duty stations with poor local healthcare facilities had been reviewed; (ii) gaps in staffing were addressed; and (iii) MEDEVAC issues including inadequate in-country coordination, lack of clarity on partner staff eligibility for the services and lengthy evacuation process, were resolved either internally or through the inter-agency arrangements	30 June 2022
5	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should take action to improve COVID-19 vaccination rates by: (a) maintaining complete and accurate vaccination data; (b) combating misinformation and vaccine hesitancy through awareness and outreach campaigns; (c) reviewing synchronization issues between the MyCority and Everbridge systems; and (d) reviewing and coordinating the timely issuance of vaccination certificates.	Important	O	Receipt of evidence of action taken for improving COVID-19 vaccination rates including maintenance of accurate vaccination data; combatting misinformation and vaccine hesitancy; resolution of synchronization issues between MyCority and Everbridge; and review and coordination with host governments for the timely issuance of vaccination certificates.	31 March 2022
6	UNHCR should: (a) actively participate in meetings of the United Nations Country Team (UNCT); (b) advocate at UNCT to improve documentation of lessons learned; and (c) elevate unresolved matters such as cost-sharing formula to the Inter-Agency Standing Committee for resolution.	Important	O	Receipt of evidence of: (i) improved monitoring by the Regional Bureaux to ensure that senior managers at Representations actively participate in UNCT meetings; (ii) documentation of lessons learned; and (iii) elevation of unresolved issues such as cost-sharing for resolution.	30 June 2022
7	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) develop a UNHCR-wide psychosocial support plan based on needs assessments against which the interventions could be benchmarked, with indicators	Important	O	Receipt of evidence of the: (i) UNHCR-wide psychosocial support plan based on needs assessment, with indicators established for monitoring changes in psychosocial health; (ii) use of occupational safety and health framework;	30 June 2022

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STATUS OF AUDIT RECOMMENDATIONS

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

Rec. no.	Recommendation	Critical[4]/ Important[5]	C/ O[6]	Actions needed to close recommendation	Implementation date[7]
	established for monitoring changes in psychosocial health; (b) use the occupational safety and health framework to strengthen the psychosocial preparedness, response and recovery; and (c) reassess the sufficiency and role of peer advisors in a public health emergency.			and (iii) reassessment of the sufficiency and role of peer advisors.	

APPENDIX I

Management Response

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Management Response

Audit of the COVID-19 response arrangements for health and wellbeing of personnel at the Office of the United Nations High Commissioner for Refugees

Rec. no.	Recommendation	Critical[8]/ Important[9]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
1	UNHCR should promulgate its policy on the Organizational Resilience Management System and adopt an updated version of its Crisis Management standard operating procedures and the crisis management playbook in line with the relevant United Nations Policy.	Important	Yes	Controller and Director of the Division of Financial Management and Administration	30 June 2022	UNHCR accepts this recommendation and will work to promulgate a policy on ORMS and adopt an updated version of the ORMS SOP and playbook.
2	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) put in place mechanisms to systematically identify and record lessons learned to improve COVID-19 prevention and response measures and planning for future pandemics; and (b) maintain a central repository of documentation on the COVID-19 response to facilitate informed decision-making.	Important	Yes	(a) Senior Occupational Safety Officer (b) Senior Technical Coordinator	(a) 31 March 2022 (b) 31 March 2022	DHR accepts this recommendation and will maximize its efforts in organizational learning, to put in place mechanisms to improve preventive measures and maintain central repository of documentation on the COVID-19 response. DHR reviewed its target date and aims to implement this by 31 March 2022.
3	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) ensure that guidance related to back to office and travel is complied with; (b) clarify COVID-19 case management guidance including the definition of primary and secondary contact, isolation, quarantine and contact tracing; (c) encourage Representations to campaign for seasonal influenza	Important	Yes	(a) Senior Occupational Safety Officer (b) Chief, Medical Section (c) Chief, Medical Section (d) Chief of Section, APRS	(a) 31 March 2022 (b) 30 April 2022 (c) 30 April 2022 (d) 31 March 2022	In coordination with the Regional Bureaux, DHR will continue to ensure relevant guidance related to BTO, travels and COVID-19 case management is established, ensuring clarity on definitions, and encouraging seasonal influenza vaccination campaigns in Representations. DHR will also take steps to encourage and ensure proof

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[9] Important recommendations address those risk issues that require timely management attention. Failure to take action could have a high or moderate adverse impact on the Organization.

Rec. no.	Recommendation	Critical[8]/ Important[9]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
	vaccination; and (d) ensure availability of proof of health insurance for the affiliate workforce.					of health insurance is available for affiliate workforce.
4	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) review duty stations with poor local healthcare facilities and assess if UNHCR can make direct investments or partner with other United Nations agencies under inter-agency arrangements; (b) address gaps in staffing; and (c) resolve, internally or through inter-agency arrangements, the medical evacuation issues including inadequate in-country coordination, lack of clarity on partner staff eligibility for services and lengthy evacuation process.	Important	Yes	(a) Senior Technical Coordinator (b) Chief, Medical Section and Chief of Section, Staff Welfare (c) Senior Technical Coordinator	(a) 30 June 2022 (b) 30 April 2022 (c) 30 March 2022	DHR accepts the recommendation and in coordination with Regional Bureaux will continue its work to formally review duty stations with poor local health care, looking into staffing and resolving issues internally or through inter agency arrangements by 30 June 2022.
5	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should take action to improve COVID-19 vaccination rates by: (a) maintaining complete and accurate vaccination data; (b) combating misinformation and vaccine hesitancy through awareness and outreach campaigns; (c) reviewing synchronization issues between the MyCority and Everbridge systems; and (d) reviewing and coordinating the timely issuance of vaccination certificates.	Important	Yes	(a) Chief, Medical Section (b) Head of Service (Staff Health and Wellbeing) (c) Senior Technical Coordinator (d) Head of Service (Staff Health and Wellbeing)	(a) 31 March 2022 (b) 31 January 2022 (c) 31 March 2022 (d) 31 January 2022	DHR accepts the recommendation and will in coordination with the Regional Bureaux take action to improve COVID-19 vaccination rates as soon as possible combatting vaccine hesitancy while maintaining complete and accurate vaccination data. DHR will also review synchronization issues between systems and coordinate timely issuance of vaccination certificates.
6	UNHCR should: (a) actively participate in meetings of the United Nations Country Team (UNCT); (b) advocate at UNCT to improve documentation of lessons learned; and (c) elevate unresolved matters such as cost-sharing formula to the Inter-Agency Standing Committee for resolution.	Important	Yes	Director for the Bureau for the Middle East and North Africa Director for the Bureau for the	30 June 2022	Regional Bureaux Directors will continue to ensure country operations adhere to available guidance related to engagement with the UNCT such as the UNHCR/AI/2019/1 - Planning for 2020-2021, The Quick Guide to UNSDCF (ex-UNDAF) issued in

Rec. no.	Recommendation	Critical[8]/ Important[9]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
				East and Horn of Africa and the Great Lakes Director for the Bureau for Asia and the Pacific Director for the Bureau for the Americas Director for the Bureau for West and Central Africa Director for the Bureau for Europe Director for the Bureau for Southern Africa		July 2019, and the updated UNHCR Programme Manual (Chapter4) launched in February 2020. RBs will implement this recommendation with support of relevant Divisions as needed (e.g., DESS/DER) and the AHC-O who supervises the RBs.
7	The UNHCR Division of Human Resources, in coordination with the Regional Bureaux, should: (a) develop a UNHCR-wide psychosocial support plan based on needs assessments against which the interventions could be benchmarked, with indicators established for monitoring changes in psychosocial health; (b) use the occupational safety and health framework to strengthen the psychosocial preparedness, response and recovery; and (c) reassess the sufficiency and role of peer advisors in a public health emergency.	Important	Yes	Chief of Section, Staff Welfare	(a) 30 June 2022 (b) 30 March 2022 (c) 30 June 2022	DHR accepts this recommendation and will monitor occupational psychosocial hazards and mental health of personnel through comparable indicators and instruments to adjust the organizational response strategy, including the psychosocial response strategy. This will be implemented in line with the changes in operational/organizational context and within the framework of the

Rec. no.	Recommendation	Critical[8]/ Important[9]	Accepted? (Yes/No)	Title of responsible individual	Implementation date	Client comments
						United Nations mental health strategy.