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OCHA Evaluation of Duty of Care

Final Report

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Photo credited to Yasmina Guerda
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1. Executive Summary

1.1. Introduction

1. OCHA is currently in the implementation phase of a change process, with several important components, which were initially outlined in the 2016 OCHA Functional Review. In January 2018, OCHA launched a People Strategy, which encompasses a mandate related to, but much broader than, duty of care. The People Strategy is intended to foster an improved work culture and, in line with the Secretary-General's vision, to create "a working environment that embraces equality, eradicates bias and is inclusive of all staff."
2. Within this milieu, OCHA commissioned an evaluation to clarify and strengthen the provision of duty of care towards its personnel and their eligible family members, particularly those in high-risk environments. Recommendations from the evaluation are intended to support the recommendations emerging from the High-Level Committee on Management (HLCM) Duty of Care Task Force, as well as the operationalization of the OCHA People Strategy.

1.2. Methodology

3. The evaluation focused on three dimensions within duty of care: security risk management in high-risk environments, staff welfare (health, benefits and entitlements), and an empowering and respectful working environment, free from harassment.
4. The evaluation drew on both qualitative and quantitative measures. The quantitative measures were obtained from a wide range of pre-existing internal and external sources complemented by an online survey to all OCHA personnel to assess current perceptions related to duty of care themes prioritized in the inception report. Qualitative data was collected through virtual interviews with selected OCHA personnel based around the world and in-person interviews during six site visits – one to each headquarter location (New York and Geneva); three country offices (Somalia, Iraq and Mali) and one regional office (The Regional Office for Southern and Eastern Africa in Nairobi). In total, 318 persons (41 per cent female) were interviewed and 510 OCHA personnel responded to the online survey (25 per cent response rate).

1.3. Summary of the Findings

1.3.1. Cross-cutting themes

5. **There is currently no UN system-wide duty of care definition or legal framework.** This is in the process of being developed as a consequence of the High-Level Committee of Management (HLCM) Duty of Care Task Force but is not yet operationalized. This has three important implications for OCHA. First, the policy and process environment for delivering duty of care is widely dispersed across separate entities, organizations, departments and functions. Second, duty of care as a concept is subject to multiple interpretations by stakeholders. Third, this has led to a lack of a systematic articulation of senior-level OCHA manager responsibilities for the delivery of duty of care in their posts.
6. **Multiple assessments or reforms with implications for duty of care have been developed or are being developed.** Since 2014, this includes the current OCHA duty of care evaluation exercise, the OCHA Functional Review of 2016, the OCHA People Strategy of 2018, the HLCM Duty of Care Working Group of 2014, the HLCM Duty of Care Task Force of 2016, as well as proposed Secretary-General reforms.
7. **OCHA has grown rapidly as an organization and has evolved with more similarities – in size and function – to agencies yet the duty of care systems supporting OCHA have not evolved commensurately.**
8. **OCHA's position within the Secretariat affects its capacity for duty of care considerations.** OCHA's reliance on procurement and Human Resources (HR) processes via the Secretariat impacts its provision of duty of care. There are alternative mechanisms available including the special

measures exemption. OCHA also has the ability to utilise other service providers (especially UN sister agencies) to support duty of care and these service providers may be better equipped to deliver on duty of care.

9. **OCHA's role in humanitarian coordination may limit its willingness to access the resources or structures of UN peacekeeping missions related to duty of care.** The principle of neutrality in humanitarian coordination is important in OCHA's coordination role, but also creates a reluctance to make use of generic management, counselling resources, and mission legal support for managing contracts and leases.
10. **OCHA guidance, systems and standards of accountability are minimal for allowing managers to deliver duty of care.** The lack of a guidance, system, standards, and described roles and responsibilities subsequently limits the capacity of the support systems (HR, procurement and finance) to provide the targeted support to field managers for implementing duty of care leading to a field culture which under-delivers on duty of care to its personnel. This is exacerbated by a lack of staff awareness of policy frameworks that do exist.

1.3.2. Security

11. **A security policy framework outlines minimum standards.** In comparison to the other dimensions, a security risk management policy document exists and is more centralized for coherent access. Minimum standards are defined for security.
12. **The perceptions regarding the quality of security risk management is highly variable among countries.** Personnel based in non-family duty stations and personnel on surge deployment were less satisfied with the degree of security support.
13. **The most significant security gaps cited in interviews related to the practices applied to high-risk environments on three elements:**
 - a. **Risks to national staff:** National staff often experience greater security risks while having fewer opportunities and resources for mitigation.
 - b. **Gender considerations:** Gender-specific considerations related to security for women in high-risk environments are perceived as insufficient with respect to accountability measures to mitigate personal security risks.
 - c. **UNDSS capabilities for support:** Security advisors in OCHA at HQ level can play a helpful role, but this is not adequate given the scale of complex contexts that OCHA is operating in. Further, UN Department of Safety and Security (UNDSS) resources are often perceived as not sufficient to meet OCHA's security needs leading to multiple requests for dedicated security officers in certain contexts.
14. **Procurement issues for security were frequently cited in interviews.** Primary concerns cited included the observation of the reliance on Secretariat procurement structures that were not seen as fit for purpose for OCHA needs, lack of sufficient management orientation to procurement processes, different standards for security equipment between the United Nations Office at Geneva/ Department of Field Support procurement processes and those used by agencies, and delays in procurement processes.

1.3.3. Staff Health and Welfare

Benefits, Entitlements, Medical, Psychosocial

15. **There is a widespread perception that a significant percentage of OCHA staff, especially in high-risk environments, may resort to unhealthy stress coping mechanisms, including postponing leaves, or losing leave days, in response to increased workload stress.**
16. **Benefits and entitlements are perceived to be the most problematic duty of care elements for quality of support and inequitable treatment.** The greatest concerns related to processes of administration – particularly the administration of leaves and entitlements - and the need for a more proactive approach to case management in HR issues.

17. **The centralization of HR processes in the UN Office in Geneva (UNOG) – and automated processes without identified focal points – is perceived by field staff as leading to more difficulties in proactive case management and the tracking of claims and questions.**
18. **Some OCHA staff rotate among high-risk duty stations, which may result in potential burnout or high stress.** Staff taking multiple sequential tours in high-risk duty stations is a point of concern for all agencies because of the increased risk of burnout and self-harm. **The creation of a mechanism within OCHA for proactively tracking rotations, identifying possible burnout and ensuring access to sufficient support would help address the risk of burnout among staff.**
19. **Administration, finance, and HR procedures treat critical duty of care issues as any other regular administration request.** This was reported mostly in the context of high-risk environments, for example, in relation to procuring armoured vehicles or accessing insurance, which led to long delays in the procedures and a perception of unresponsiveness and lack of care, causing frustration among staff.
20. **OCHA personnel (national and international staff) reported receiving minimal induction into HR processes, as well as receiving insufficient HR support related to health and welfare issues, causing frustrations.** Among the most commonly mentioned in interviews were incomplete systems for tracking insurance status and individual claims, and perceived differential treatment between national and international staff regarding quality of available care.
21. **National staff were seen to face many of the same difficulties related to health and welfare support that international staff face, but do not enjoy the same welfare provisions** (e.g. leave provisions, R&R, and mental health support).
22. **National staff are particularly challenged by medical access in high-risk environments.** High-risk environments often lack healthcare providers including hospitals, clinics, doctors and pharmacies with an agreement with Cigna, the insurance company. This severely limits national staff members' access to healthcare, especially considering that they often do not get their travel reimbursed when going to a location with better healthcare facilities.
23. **Psychosocial support is a frequently expressed concern among staff.** Although there are 236 psychosocial counsellors currently within the UN system, the staff overwhelmingly reported mentioning just the one psychosocial counsellor based in OCHA-Geneva. Staff mentioned accessing the counsellor after a critical incident and Geneva based staff noted seeking out the counsellor when returning from deployments. However, field staff in other countries did not report using this counsellor except in the circumstances of critical incidents. Only 34 per cent of staff in the online survey reported satisfaction with the degree of psychosocial support available to them and only 18 per cent of staff involved in critical incidents rated the quality of support as satisfactory or very satisfactory.
24. **Psychosocial support receives few resources and it is therefore difficult to address needs in a proactive, strategic or appropriate manner.** This has led to the evolution of a system of psychosocial support that is less proactive in mitigation measures and limited to reactive responses to critical incidents and with little access to outsourced resources which limits the appropriateness of the services for staff and increases confidentiality concerns.
25. **Accommodation (office and personal) is an element of concern for OCHA personnel in high-risk environments.** Those interviewed in countries with peacekeeping or political missions believe that OCHA's needs are not prioritized by the designated official/senior management team leading to sub-optimal conditions and that many deep-field locations do not meet minimum standards and pose long-term health and burnout risks.
26. **The use of Temporary Job Openings (TJO) can lower morale and increase the perception of inequitable treatment.** TJOs have been used as a flexible means to fill vacancies that require an immediate response, resulting in a disproportionate use of these types of contracts in the field placements – especially in the most difficult duty stations. A Secretariat-wide mobility policy widely considered ineffective contributed to the over-reliance on TJOs. This mobility policy has now been

paused, providing an opportunity to correct this disproportionate representation of TJOs in the field, and as part of OCHA's change process, many TJOs are being converted into fixed-term contracts.

Post Incident-Crisis Support

27. **Procedures around critical incidents exist, but staff satisfaction with the quality of support received following a critical incident is very low.** Staff reported getting good support from peers (and to a lesser extent their direct supervisor) following a critical incident, but all other support functions were rated very poorly, with HR support and psychosocial support receiving the lowest ratings.
28. **The resources available for support are widely dispersed across support systems resulting in erratic communication, delays and insufficient responses.** Those affected by critical incidents often require holistic support from incident to resolution. However, the amount of resources available to support personnel and the sometimes isolated communication between medical, HR, psychosocial and administration services at field and HQ offices frequently result in slow and inadequate responses.
29. **There is a lack of a proactive system for ongoing tracking of resolution of critical incidents.** A critical incident committee is convened to review security-related incidents, however, it does not review other forms of critical incidents nor does it continue to track over time to ensure post-trauma support is ongoing and sufficient.

1.3.4. Working Environment

30. **Qualitative interviews reveal a concern related to the working environment.** The online survey did show 66 per cent of respondents rating their work environment as respectful. However, 45 per cent noted that they are under high stress and 35 per cent – across all country offices and levels – reported having witnessed or experienced harassment.
31. **The quality of the working environment was seen as disproportionately shaped by the particular characteristics of managers.** Although creating a harmonious and respectful working environment is the responsibility of all staff, managers have heightened responsibilities in this arena. Even so, managers were not assessed on their skills for delivering duty of care, nor given a systematic induction or training to duty of care management, and accountability mechanisms were lacking.
32. **Grievance mechanisms are not trusted.** Although a large majority of the respondents in the online survey reported knowing the mechanisms for reporting harassment, only a quarter of the respondents believed that they would be protected from retaliation if they did report a grievance. These patterns were reflected in the qualitative interviews as well.
33. **Field and headquarters interviews with OCHA staff highlighted a concern over insufficient guidance** on sexual harassment prevention, management of incidents and protections of the victims or those filing grievances. There are ongoing initiatives in the UN system, including upgrading mechanisms and providing a helpline. Many respondents expressed a concern over the management of these incidents and, as with general grievances, concerns over the protections of the victims or those filing a complaint.
34. **The current OCHA duty of care practices are not appropriately gender-sensitive. Nor do they take into account the specific concerns of women working in deeply conservative cultures, high-risk environments or emergency contexts.** Living within a peacekeeping mission culture in high-risk environments creates a heightened state of anxiety and puts OCHA personnel – especially women – at increased risk.

1.4. Recommendations

35. The People Strategy and the Change Implementation processes are already implementing a wide range of actions intended to promote an enhanced duty of care environment even as this evaluation exercise was being conducted. The following recommendations are intended to affirm existing processes and to complement or strengthen ongoing duty of care activities. In terms of priorities, 'Critical' would imply addressing these issues within the next six months. 'Important' would imply addressing over the course of 12 months. 'Opportunity for Improvement' would imply within the next 18 months.

Section 1: Overall Approach to Duty of Care

Rationale: There is a need to establish in OCHA a systematic approach to duty of care that is comprehensive and integrated. This approach would include the definition of *standards*, clarification of *roles and responsibilities* and the establishment of *accountability mechanisms*.

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
1	<p>Drawing on the existing Secretariat policies and the work of HLCM Task Force, and linked to the People Strategy, OCHA should develop a duty of care framework. The framework plan should:</p> <ul style="list-style-type: none"> Operationalize a definition of duty of care that enables OCHA to interpret the existing HLCM definition Include a statement on how the organization will manage and minimize the risks to the physical and psychological health, safety and security of its personnel Outline the minimum standards in the different areas of duty of care such as security management, staff welfare and entitlements, health support, wellbeing and a working environment free from harassment (or refer to existing UN or Secretariat standards) Establish responsibilities for duty of care, including for ensuring a respectful work environment, as part of the job descriptions of senior management for the USG/ERC, ASG/DERC, specified directors, branch chiefs, and all Heads of Offices and their deputies. Duty of care responsibilities will need to be incorporated into the performance management system. <ul style="list-style-type: none"> - USG/ERC: Responsibility for representing duty of care issues for the humanitarian community at the highest levels of the UN and addressing key issues of principle at the higher levels of the Secretariat. - ASG/DERC: Responsibility for overall duty of care management within OCHA. - HCs: Should be considered as a resource to Heads of Offices in assessing the OCHA duty of care delivery and to ensure overall duty of care in the humanitarian community. - Managers: Those responsible for personnel in high-risk environments which may include: OAD, Director of the Coordination Division (for surge), the Executive Office, specified HQ staff and HOOs and Deputies. 	Critical	USG/ASG with EMC, OAD and SPEGS	<p>Overview par. 85-87, Security par. 95, Staff Health and Welfare par. 111, Working Environment par. 149</p> <p>Security par. 101-102, Staff Health and Welfare par. 110-111, 124. Working Environment par. 149-153, 155, 157-163</p>

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
1a	As part of the duty of care framework, and under the auspices of the OCHA People Strategy and Management Committee, OCHA should integrate into the organizational workplan elements pertaining to duty of care . Specifically, field offices in High Risk Environments (HREs) should have in their annual work plans a section related to duty of care which identifies measures to meet basic standards of security, accommodation (office and living), medical provision, and administration processes including leave management. Progress in the implementation of the annual work plans' components related to duty of care should be reported twice a year to the People Strategy and Management Committee.	Critical	ASG with Change Implementation Team and SPEGS	Current duty of care context par. 59-63, 65. Security par. 95-97, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-136, 139,144, Working Environment par. 149, 155-157, 158, 162-163
1b	OCHA should also collect concerns on duty of care when conducting regular staff engagement surveys and follow up with a report on actions taken in response to the survey. This should be integrated into the annual reporting on duty of care.	Opportunity for Improvement	ASG with EO or SPEGS	
2	Personnel at all levels need to be more involved in the provision of duty of care. At HQ level, the People Strategy and Management (PS&M) Committee should either establish a sub-group to review and develop the annual duty of care workplan, or hold twice-annual meetings dedicated to duty of care. At field level, country and regional offices should either establish a working group that meets regularly to review and contribute to the duty of care workplan or existing groups should hold twice-annual meetings dedicated to duty of care.	Important	ASG with PS&M Committee, OAD and HOOs	Current duty of care context par. 59-62, 65. Security par. 95-97, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-137, 139,144, Working Environment par. 149, 155-157, 158, 162-163

Recommendations and Sub-Recommendations		Priority	Responsible	Links to Report
3	OCHA should draw on the best practices of duty of care systems from other organizations to improve guidance, training and awareness raising on duty of care considerations, especially for managers, including a respectful work environment free from harassment.	Important	ASG with PS&M Committee, OAD and HOOs	Current duty of care context par. 59-62, 65. Security par. 95-98, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-136, 139,144, Working Environment par. 149, 155-157, 158, 162-163
3a	Create internal policy documents such as SOPs and guidance , and accompanying training materials for guidance, including on duty of care responsibilities of managers. All duty of care-related SOPs, guidance and other information should be available in one place, e.g., a page on OCHA's intranet. The OAD Security Advisors could be important resources for the development of the necessary guidance, training and awareness raising.	Important	USG/ASG with EO and SPEGS	Current duty of care context par. 59-62, 66. Staff Health and Welfare par. 116, 123-124, 132, 134, 141, 144. Working Environment par. 152-154, 162-165. Annex 7, Annex 8
3b	Staff induction should integrate duty of care modules with descriptions of rights and responsibilities. Specific induction modules on duty of care should also be provided to managers to discharge their responsibilities. The OAD Security Advisors could be important resources for the development of the necessary guidance, training and awareness raising.	Important	EO	
3c	Consideration should be given to incorporating duty of care discussions and briefings into the annual Heads of Offices meeting and Global Management Retreat and provide staff involved with the duty of care appropriate policy guidelines and documents.	Important	OAD	

Section 2: Security

Rationale: : OCHA's role and work requires that it works predominantly in high-risk environments and is extensively involved in deep field operations. This creates a different set of security requirements beyond the current capacity and resources of the Secretariat systems in UNDSS to support. Adjustments to protocols should be made to ensure better attention to high-risk environments and national staff.

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
4	In specific high-risk environments with a large OCHA presence, OCHA should ensure the provision of a <i>dedicated international security officer, supported by a local security assistant.</i>	Critical	OAD	Security par. 97-99
5	OCHA should undertake a corporate review with relevant stakeholders (UNDP, DM) to determine what <i>additional measures can be put in place for national staff</i> to enhance their security support, to address their increased risks resulting from inadequate accommodation, to travel to and from work, to travel in deep-field operations, to assess their work and leave arrangements, and to support their health and well-being needs. Heads of Offices will need to consider appropriate working modalities that help to mitigate these security risks.	Important	EO, OAD and HOO	Security par. 95-97
6	6a OCHA should carry out a <i>review of procurement-related processes</i> which apply to accommodation, security and communications equipment to make them more efficient, faster and more attuned to field needs. This should include the issuance of guidance and checklists and securing permission and/or delegating authority for the use of the most effective options for service provision, given contexts, so that relevant staff, including Heads of Offices, are better informed about and engaged in options, required processes, focal points and obligations.	Important	EO	Security par. 106-109
	6b OCHA should review sister agency processes and suppliers to identify best placed suppliers and standards to be utilities and OCHA should <i>ensure that it has consistent, easy and quick access to UN system contracts</i> to procure security equipment, in particular armoured vehicles, of the required quality.	Important	EO and OAD	

Section 3: Staff Health and Welfare

Rationale: The recommendations cover the five major themes raised in the findings related to staff welfare: a) an impersonal approach to the administration; b) the overuse of temporary job opportunities (TJOs); c) living and working conditions of accommodation; d) medical support; and e) lack of effective case management for critical incidents and other HR considerations. The recommendations target on establishing a case management process and a more proactive oversight for access to quality medical and psychosocial provision.

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
7	<p>Linked to the People Strategy, and as part of the OCHA Duty of Care framework, OCHA should develop a policy on a case management process for staff. This should include:</p> <ul style="list-style-type: none"> - a systematic case management system with a broader mandate to include not only those affected by critical incidents, but also those affected by burnout, prolonged periods in extreme hardship postings and those suffering from a debilitating sickness - a standard definition for what constitutes a critical case and a typology of incidents that require this type of case management support - the appointment of a staff member with sufficient authority to manage critical case processes, including any fast-track procedures that may be required - quarterly dedicated discussions in People Strategy and Management Committee meetings to review critical cases and to ensure that appropriate actions have been taken both in OCHA and by external parties. 	Critical	OAD (Security Advisors), PS&M Committee and EO	Staff Health and Welfare par. 133-134, 136, 139-144
8	<p>Building on the existing tracking efforts among OAD section chiefs, OCHA should institute a more systematic and transparent process for tracking and reviewing the periods of duty undertaken by both national staff and international staff in hardship and in particular deep-field hardship locations (while maintaining staff confidentiality) and periodically report to senior management. Taking into account budget implications or contextual sensitivities, Heads of Offices and their deputies should be encouraged to be proactive in considering rotation of staff, especially national staff, amongst sub-offices and main offices that are more or less severe when feasible.</p>	Critical	EO	Staff Health and Welfare par. 135-139

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
9	OCHA should develop processes for the regular assessment of work and leave arrangements of staff in high-risk environments to accommodate their security challenges and to support their health and well-being.	Important	HOO	Security par. 96 Staff Health and Welfare par. 131-132, 147
10	OCHA should appoint a dedicated officer to provide oversight of OCHA's property portfolios – particularly office space, but also housing when staff live in guesthouses or compounds. The property officer would proactively promote a common premises approach for both accommodation and office space in high-risk environments and develop a work plan with objectives to increase the numbers of staff living in accommodation that reach minimum standards. Particular attention should be paid to additional issues of harassment that affect women and the gender aspects of duty of care.	Critical	OAD (Security Advisors), EO	Security para. 102 Staff Health and Welfare para. 138-140
11	As an issue of priority, OCHA should discuss the management of the Cigna contract with UN Medical Services to improve the claims processes including online tracking of claims, and in high-risk environments, to ensure that Cigna services are accessible and that more recognized medical providers are available especially for the needs of national staff.	Critical	EO with DM	Staff Health and Welfare para. 133-135, 144, 147 Annex 6
11a	OCHA should adapt the recommendations from the HLCM Task Force to incorporate national staff's access to health, medical referral and medevac services in capital cities or neighbouring countries for the treatment of chronic illnesses and regular medical checks. This may require altering contract agreement phrasing with medical services or UNDP contracts used by OCHA.	Critical	EO with DM	
11b	OCHA should develop mandatory SOPs on medical and insurance issues that ensure the appropriate HR administration of medical insurance (to reduce gaps) and outline the reporting requirements, enabling staff to submit and track their claims and ensuring swift responses to longstanding medical conditions such as PTSD.	Important	EO and DM	

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
12	OCHA should establish a proactive and strategic approach to the development of a psychosocial support system , particularly in high-risk environments and for staff recognized as working in a highly stressful environment, e.g. in surge capacity. As part of this strategic approach, OCHA should review its own practices and approaches (including procedures for appropriate leaves to enable access) to align with the UN Mental Health Strategy currently being finalized. The approach should prioritize offices where support is most needed and provide input to the People Strategy on the issues where psychosocial support is required.	Critical	EO	Staff Health and Welfare par. 145-148
12a	The OCHA psychosocial staff should ensure that all country offices have guidance on outsourced mental health and psychosocial support services that can be accessed locally, and medical insurance to facilitate this.	Critical	EO	
13	For security and critical incident cases, security-related procurement and other duty of care-related administrative requests, a special fast-track should be created in OCHA – with agreements from DM including OHRM – to ensure priority is given to addressing this issue. For HR issues, this special track should include a case-designated HR focal point assigned to each critical incident case as stated in the People Strategy. A single HR case manager at a senior and authority level should support the case from initiation to completion with the authority and capacity to take the necessary actions. This would include (but not be limited to) administration of insurance, medical, pay and entitlements, claims and compensation support, liaison with medical providers, accommodation, medical and psychosocial support, leave and travel arrangements, and role transition.	Critical	EO	Staff Health and Welfare par. 139-148

Section 4: Working Environment

Rationale: OCHA works within a background culture that is male-dominated and militarized with poor cultural sensitivity, and where there is a risk and acceptance of a more abusive culture. In combination with high-stress environments, this can create a pathology of abuse or harassment in the workplace. Currently, there are inadequate processes to deal with the issues arising from this internal and external culture. Recommendations relate to establishing or strengthening mechanisms for addressing and mitigating abuse.

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
14	OCHA should actively promote a culture of respectful communication that builds on the online courses and trainings provided by the Secretariat.	Critical	PS&M Committee	Working Environment par. 153-158, 162
14a	This should include a strong training component , constituting of the following: <ul style="list-style-type: none"> - Integrate a respectful communication module into staff induction and ensure the completion of mandatory online trainings on this issue - Develop additional staff training opportunities on topics such as stress management, resilience and self-awareness, equality and diversity 	Important	EO	
14b	In annual retreats – country, regional and global – include a refresher topic on harassment and workplace communication.	Opportunity for Improvement	HOO and USG/ASG	
14c	In management training for Heads of Offices, strengthen the module on respectful communication.	Critical	EO	
15	OCHA should develop a detailed internal guidance note to managers and staff describing the process to handle cases in response to allegations of sexual misconduct and abuse. This process should prioritize the need for timely response and the importance of ensuring protection from retaliation, establish a mechanism for sanctions, outline support available for victims, and mechanisms to support those who are the subject of allegations – particularly in instances where allegations are proved to be false.	Critical	EO	Working Environment par. 149-152, 156-161

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
16	In high-risk environments, there are additional issues concerning <i>harassment that affect women</i> and OCHA should operationalize the gender aspects of duty of care in these contexts by providing appropriate accommodation standards, special trainings, contextualized policies, and special procedures for women's personal safety and security while operating in high-risk environments.	Critical	EO and OAD	Security par. 89-90 Working Environment par. 136, 138, 145

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2. Introduction

2.1 Background

36. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) is an entity in the United Nations Secretariat whose five core functions are coordination, humanitarian financing, policy, advocacy and information management. The organization maintains a staff of more than 2,000 people based in 63 countries, plus surge deployments from standby partners, consultants, contractors and interns. Headquarters are shared between New York and Geneva. Over the last 15 years, OCHA's size has significantly expanded. In 2003, the organization had 398 international and 421 national staff (819 total). By 2018, according to OCHA data as of 5 February 2018, this number had grown to 2,038 personnel (38 per cent women) with 60 per cent comprised of national staff and 40 per cent international contracts.¹ The increase in personnel requires more formal, better defined systems to address organizational duty of care.
37. OCHA is undergoing a change process, which has involved significant restructuring and the launch of a People Strategy² intended to improve the management of human resources in the Organization – in line with the Secretary-General's vision to create a working environment that embraces equality, eradicates bias and is inclusive of all staff. Part of the impetus for the strategy was the 2016 Functional Review,³ which found that OCHA personnel were over-extended and suffered from inconsistent organizational application of duty of care.⁴
38. Within this milieu, OCHA commissioned an evaluation of its duty of care, to clarify and strengthen OCHA's provision of duty of care towards personnel and their eligible family members, particularly those in high-risk environments, covering the period from 2015 to 2017.

2.2 Current Duty of Care Context

39. In addition to OCHA's change process, the work of the UN-wide High-Level Committee on Management (HLCM) Duty of Care Task Force is most relevant to this evaluation.⁵ The HLCM had established a working group in 2014 to reconcile duty of care for United Nations personnel with the "Stay and Deliver" concept in high-risk environments. Fifty-four common issues were identified. The main areas of concern revolved around medical, safety and security, psychosocial support, administration and human resources (HR) issues. The HLCM Duty of Care Task Force was formed in 2016 and a final report is expected to be published in mid-2018.
40. One important constraint identified by the working group was the lack of a common definition for duty of care in the United Nations system. The group developed 11 possible definitions and eventually opted for a working definition of duty of care as "a non-waivable duty on the part of the organization to mitigate or otherwise address foreseeable risks that may harm or injure its personnel and their eligible family members."⁶ This working definition has not been operationalized across the system and has not yet been integrated into a legal framework for the UN system. To some extent, duty of care is derived from the UN Staff Regulations and Rules, which state that "*the Secretary-General shall seek to ensure... that all necessary safety and security arrangements are made for staff*".⁷ However, this legal definition only describes safety and security and does not specifically articulate elements such as health. The CEB decision on occupational safety and health (OSH) does include them as one issue.⁸ However, it has been noted that OCHA and the Secretariat have not met the commitments in the OSH CEB decisions.

[1] Paragraph 121 provides further gender disaggregation by duty stations

[2] People Strategy, OCHA. January 2018.

[3] OCHA Functional Review: Final Report. July 2016.

[4] OCHA Functional Review: Final Report. July 2016.

[5] The HLCM is part of the United Nations System Chief Executives Board for Coordination (CEB).

[6] UN Final Report: High-level Working Group on Reconciling Duty of Care for UN personnel while operating in high risk environments. March 2016.

[7] United Nations Secretariat. (30 December 2016). Secretary-General's bulletin: Staff Regulations and Rules. ST/SGB/2017/1, Regulation 1.2(c).

[8] CEB/2015/HLCM/7/Rev.2 31 March 2015

41. The final report and recommendations of the HLCCM Duty of Care Task Force were not available at the writing of this report, but themes relevant to this evaluation, listed in the draft report and described in interviews with Task Force members, include the following elements:
 - a. Medical and psychosocial services across the system need to be strengthened and risks need to be managed and communicated to ensure that personnel make informed choices regarding medical and psychosocial wellbeing.
 - b. There is a need for an improved communication system and first response to critical incidents in high-risk environments.
 - c. Resources are often in place, but personnel are often not sufficiently trained or informed to make use of available resources.
 - d. Differences in entitlements, benefits and allowances between national staff and international staff were seen as a negative influence on morale and overall performance.
 - e. To ensure a holistic approach with coordination and engagement from all networks, the Task Force recommends the establishment of a UN Duty of Care Coordination Committee to act as an oversight body and ensure that recommendations are implemented.
42. The Task Force's recommendations and final report are intended to provide a base point – a set of duty of care minimum standards to which all UN entities and organizations should subscribe. However, the report will also emphasize that organizations integrate additional measures that address the duty of care particularities pertinent to each of them. The task force recommendations are to be viewed as the “floor” rather than the “ceiling” for organizations.
43. Other relevant UN initiatives with duty of care implications include the Secretary-General's reform efforts, in particular the management reform, the Secretariat's Gender Parity Strategy and the Secretary-General's efforts to strengthen mechanisms against harassment,⁹ an upcoming OIOS audit of medical insurance issues, and a UN Mental Health Strategy that is being finalized with the creation of a senior position for implementation.
44. Within OCHA, previous evaluations, audits and reviews over the last five years have generated more than 100 duty of care relevant recommendations for OCHA.¹⁰ These recommendations mostly targeted the areas of administration, finance, training and learning, and emphasized increased training of personnel in systems and processes, increased security measures, and improved administration, communications and induction processes.
45. Finally, a subsection of OCHA's new People Strategy – launched in 2018 – outlines a series of objectives and articulates proposed actions for addressing duty of care. The strategy seeks to address a broad range of elements that all influence duty of care, including better managing critical incidents, encouraging a harmonious and cohesive work environment, maintaining work-life balance and building a culture of trust. Also, as part of OCHA's change process, a Change Implementation Team is working on several areas, such as making administrative processes more efficient and effective, which would have an impact on duty of care issues.

[9] In the form of sexual harassment, discrimination and an environment free from harassment. The Secretary-General's 2008 bulletin on the prohibition of discrimination, harassment, including sexual harassment, and abuse of authority (ST/SGB/2008/5) defines harassment as follows: “Harassment is any improper and unwelcome conduct that might reasonably be expected or be perceived to cause offence or humiliation to another person. Harassment may take the form of words, gestures or actions which tend to annoy, alarm, abuse, demean, intimidate, belittle, humiliate or embarrass another or which create an intimidating, hostile or offensive work environment. Harassment normally implies a series of incidents. Disagreement on work performance or on other work-related issues is normally not considered harassment and is not dealt with under the provisions of this policy but in the context of performance management.”

[10] As recorded in OCHA's Recommendations Tracking System.

3. Evaluation Features

3.1 Evaluation Scope

Evaluation Scope and Key Questions

46. The purpose of the evaluation is to clarify and strengthen OCHA's provision of duty of care towards its personnel and their eligible family members. It is a summative evaluation for the period 2015-2017 that identifies gaps, lessons learned and best practices in OCHA and other UN entities on ways in which coordination, collaboration and cooperation with relevant UN departments and agencies on duty of care should be strengthened. Recommendations from the evaluation are intended to support the recommendations emerging from the HLCM Duty of Care Task Force and the operationalization of the OCHA People Strategy.
47. Because of the short timeframe of the evaluation, not all aspects of duty of care could be included in the analysis. According to the terms of reference (TOR, see Annex 1), the evaluation's scope should include all OCHA personnel, including international and national, in general service, professional and management positions at the headquarters and in field locations, on permanent, continuing, fixed-term, temporary and other contracts, plus their eligible family members, as well as non-staff personnel such as consultants, contractors, UN volunteers, interns, etc.,¹¹ with a particular emphasis on personnel serving in high-risk environments (HRE) including surge deployments. The evaluation should not cover: trainings related to professional development (but should review trainings for duty of care obligations), career development, recruitment, or OCHA's duty of care to implementing partners.¹²
48. The TOR and a scoping document outlined **five evaluation criteria** to be integrated into the evaluation design: relevance, efficiency, effectiveness, connectedness, impact, and internal and external factors contributing to the results. Each criterion included a set of sub-questions profiled in Annex 5.

3.1.1 Duty of Care Conceptual Framework

49. The working definition of duty of care has only recently been proposed by the HLCM and has not been fully operationalized. For the purposes of this evaluation, a more detailed conceptual framework for duty of care needed to be elaborated to refine the evaluation objectives (Annex 4). This framework included definitions of the various sub-dimensions described in the TOR such as security, safety, health and wellbeing, and has been reconstructed from several key documents within OCHA and beyond, which implicitly or explicitly provide insights into how OCHA and other organizations may conceptualize duty of care:
 - a. OCHA People Strategy¹³
 - b. OCHA Duty of Care Evaluation – Scope
 - c. Duty of Care: An Analytical Approach¹⁴
 - d. 10 Tips on Duty of Care, April 2016¹⁵
 - e. Duty of Care and Security Management¹⁶
 - f. Duty of Care – Informed Consent¹⁷
 - g. The Management of Employee Risk in the Humanitarian Aid and Security Sectors¹⁸

[11] Except those who are both locally-recruited and paid on the basis of hourly rates

[12] Humanitarian organizations implementing projects with money from the OCHA-managed pooled funds

[13] OCHA People Strategy 2018-2021

[14] Witting, Christian. 2005. *Journal of Legal Studies*

[15] Williamson, Christine. *Duty of Care International*. 2016

[16] *Ibid*

[17] *Ibid*

[18] Darby R, & C. Williamson. *International Journal of Human Resources Development*. 2012

3.1.2 Additional Considerations

50. Based on the document review and inception interviews, there are several factors that defined the parameters of the evaluation:
- Duty of care is a multi-faceted**, multi-dimensional concept that is understood differently by different stakeholders.
 - The depth of interest** in the topic and the wide variety of elements cited in inception interviews suggests that duty of care is a high priority and a wide range of issues need to be addressed.
 - The **timeframe** of the evaluation was extremely limited.
 - OCHA occupies a **hybrid place** within the UN architecture as part of the Secretariat but heavily involved in field operations. The continued use of Secretariat processes provides less autonomy than many of the other field-oriented entities and agencies.
 - Many of the tension points and critical issues cited are the products of an array of **inter-connected policies, procedures and processes**.
 - The evaluation prioritized the duty of care experiences of personnel in **high-risk environments** even though many issues are relevant for all postings and sectors.¹⁹
 - The evaluation explored duty of care dynamics for both **international staff** (managed by the UN Secretariat) and **national staff** (managed by UNDP) to understand commonalities and distinctive differences.
 - Recommendations focus on **actionable elements** that can be managed by OCHA even if the evaluation notes elements beyond OCHA's control as driving forces for the duty of care configurations observed.

3.1.3 Evaluation Themes

51. Based on this working model for duty of care, the evaluation focused on three dimensions: security risk management in high-risk environments, staff welfare (health, benefits and entitlements²⁰), and an empowering and respectful working environment free from harassment.²¹ The evaluation explored **six sub-dimensions** under the three dimensions and focused on one to five themes per sub-dimension (Table 1).
52. For each of the described themes, five categories of analysis are indicated: a) **policies, standards and practices**, which will influence how individuals experience duty of care within an organization; b) **roles, responsibilities and competencies**, which need to be clearly defined and understood; and c) **monitoring and feedback systems**, and how these take into account duty of care to monitor for efficiency and effectiveness and to identify gaps; d) **gender** considerations; and, e) perceptions of **fairness and equitable treatment**.
53. International and national, fixed and temporary contracts are to receive the most consideration – especially with respect to equal treatment. Duty of care obligations for other workers including consultants, contractors, and implementing partners are important and necessary for any review of a duty of care system. Although some UN Volunteers and standby partners were interviewed in the evaluation field missions and remote interviews, given the scope and limited time available, the perspectives of international and national staff on fixed and temporary appointments were prioritized and the bulk of the interviews were with these groups.

[19] Given the timeframe available, the evaluation had to focus on prioritizing international and national staff in HRE. However, where surge personnel from OCHA and standby partners are also present, consideration of their specific situations were integrated into the interview analysis.

[20] Including access to relevant and confidential psychosocial support.

[21] Harassment, especially sexual abuse elements, is a sensitive issue that affected persons would have been reticent to share with the ET. For this reason, the ET did not explore SEA issues or personal cases, but whether the duty of care in OCHA – in terms of systems, policies, response and support – would be considered appropriate.

Table 1: Organizational Matrix of Assessment Landscape

Dimension	Sub-Dimension	Themes to explore
Security Risk Management	Security decision-making and support	<ol style="list-style-type: none"> 1. Security risk management: Programme criticality frameworks and business continuity plans 2. Security advice and support to personnel
	Orientation and preparation for new staff on security	<ol style="list-style-type: none"> 3. Context analysis and personal risk mitigation measures 4. Security and safety training 5. Informed consent – role and context briefing, risk acceptance
	Access to security equipment	<ol style="list-style-type: none"> 6. Armoured vehicles and PPE
Staff Welfare: Health, Entitlements and Benefits	Entitlements & benefits	<ol style="list-style-type: none"> 1. Pay administration 2. Accommodation standards for compounds (and sub-offices) – office and living quarters 3. Medical provisions and allowances for routine and incident support (medevacs) 4. Mobility and rotation practices (linked to burnout) 5. Security risk management support, allowances/criteria for danger pay, vehicle assignments
	Psychosocial support	<ol style="list-style-type: none"> 6. Occupational health and wellbeing (staying healthy, mental health) support 7. Incidents, trauma (PTSD, vicarious) support 8. Stress management & burnout support (linked to mobility and rotation)
Respectful and Harmonious Working Environment	Free from harassment	<ol style="list-style-type: none"> 1. Behaviours and style of communication (values) 2. Incident reporting systems 3. Manager training on duty of care issues 4. Staff training on duty of care issues

3.2 Evaluation Methodology

3.2.1 Evaluation Approach

54. The evaluation matrix in Annex 5 describes in detail the categories, key questions, judgement criteria, data collection and analysis methods. The evaluation matrix serves as the foundation of the evaluation process and dictates the structure of this report. Cumulatively, the evidence available for each question and performance indicator should enable a response to the relevant evaluation question.
55. The evaluation drew on both qualitative and quantitative information. Quantitative measures were obtained from pre-existing sources including OCHA's 2014-2017 Strategic Results, Management and Country/Regional Offices Results Frameworks. Additional databases from the Executive Office also included information on diversity, gender balance and HR-related issues. Several recent surveys, within and beyond OCHA, and previous studies, including the Functional Review, provided additional information relevant to OCHA's provision of duty of care. A systematic review was conducted of policies, standards and practices of each dimension profiled in the evaluation (Annex 7). The evaluation distributed an online survey to all OCHA personnel to assess current perceptions related to duty of care themes prioritized in the inception report.
56. Qualitative data was collected during the inception and data collection phases through remote and face-to-face interviews. Interviews were carried out individually or in guided group discussions. The evaluation team visited both headquarter locations in New York and Geneva, three country offices in Somalia, Iraq, and Mali, and the Regional Office for Southern and Eastern Africa in Nairobi. The countries were selected based on feedback received during the inception phase and in consultation with the Operations and Advocacy Division (OAD). The evaluation mission schedule is in Annex 10.
57. The interviews were held with multiple stakeholders both inside and outside of OCHA who had interests in the provision of duty of care. The list in Annex 3 describes the stakeholders and their roles. Given the nature of the evaluation mandate, most of the interviewees were drawn from OCHA personnel. However, stakeholders outside of OCHA with an interest in the evaluation including relevant parts of the UN Secretariat (UNDSS, UNDP, DM, DFS, DPKO) who have indirect involvement in and influence on OCHA's duty of care were also interviewed. In addition, other humanitarian UN agencies provided examples of best practices.
58. Interview notes were compiled from all interviews using a standard matrix which was structured to respond to the evaluation matrix categories and questions. The evaluation team reviewed the responses from stakeholders and employed a standard qualitative approach of an iterative analysis of emergent themes.²² Key thought units were identified in interviews, which were then clustered into categories. Emergent themes from each category were identified for further analysis and re-categorization to identify key patterns.
59. Evidence for conclusions was built via iterative triangulation. Themes or patterns were examined to determine if they were coming from multiple stakeholder levels and categories. Observations or comments that were only coming from a single source or category of stakeholder were given less conceptual weight during the building of the analysis. The report highlighted the findings from multiple actors and across multiple levels with different types of stakeholders. 318 persons (41 per cent female) were interviewed either individually or in groups during the inception and data collection stages and 510 OCHA personnel responded to the online survey. Annex 3 lists all persons interviewed in the process except for personnel who requested confidentiality. Annex 5 contains a table summarizing the links between findings, conclusions and recommendations.
60. The four main sources for data collection were: a) qualitative stakeholder interviews (and field visits); b) the policy document review; c) the online survey; and d) additional key performance indicators relevant to duty of care abstracted from Country/Regional Offices Results Frameworks (Annex 9). A more extensive description and analysis of the online survey and its results is in Annex

[22] Patton, Michael Quinn. 2010. *Qualitative Research and Evaluation*. Sage Publication. San Francisco, California.

8. The response rate for the online survey of 25 per cent is in line with previous surveys administered by OCHA, but due to potential self-selection bias, the low response rate can limit generalizability. Caution was taken not to build conclusions based solely on the online survey data since it is possible that the responses from those who voluntarily participated would not be representative of the entire population. Patterns from the survey were triangulated with other data sources for confirmation.

3.2.2 Evaluation Limitations

61. The evaluation team interviewed a broad range of stakeholders from all levels and many different countries. Overall the field mission went smoothly and faced few significant challenges. Five limiting factors need to be considered in the analysis.
 - a. The timeframe for the evaluation exercise was limited while the scope was ambitious. The evaluation has identified specific elements to focus on, but this limits the ability of the exercise to provide generalized assessments of relevance, efficiency, effectiveness, connectedness and impact on OCHA's duty of care.
 - b. Many of the factors that affect OCHA's duty of care lie outside the direct control of OCHA. This limits the ability of the evaluation to provide feasible recommendations for some of the identified weaknesses.
 - c. OCHA operates in a wide variety of contexts and across many levels, each of which has unique duty of care aspects. Combined with the limited timeframe, this limits the ability of the evaluation exercise to provide recommendations relevant to the entire system.
 - d. Based on the results of extensive internal conversations among OCHA departments (OAD, SPEGS, OASG, etc), the final selection of country visits ended up being to integrated missions with peacekeeping missions. This is not necessarily representative of all OCHA deployments. This imbalance is partially mitigated through intensive remote interviews with personnel not based in integrated missions, as well as a broadly distributed online survey.
 - e. OCHA national staff may operate in multiple languages, but the evaluation was weighted towards English – both because of the operational environments of the two headquarter locations and the language distribution among the evaluation team. Three processes helped counteract the language weighting: The online survey was available in English and French, one of the selected country visits was to a Francophone country (Mali), and one remote group discussion in French was offered. Nevertheless, these adjustments only partially ameliorate the language weighting.

4 Evaluation Findings

4.1 Overview

62. The Findings narrative is organized according to the three dimensions explored in the evaluation: security, staff welfare and working environment. The evaluation criteria of relevance, efficiency, effectiveness, connectedness and impact are integrated into each of the narratives. Annex 5 contains responses organized by the evaluation matrix themes.
63. There are five general observations that warrant consideration because of their influence on the responses across all targeted duty of care dimensions and on the responses to the indicators in the evaluation matrix.
64. **No UN system-wide Duty of Care Definition or Legal Framework.** The first important dynamic, as noted in Section 2.2, is that there is no broad legal definition – or legal obligation – regarding duty of care for the UN system. The Staff Regulations and Rules provide a narrow (implied) definition of duty of care concerning safety and security but not including health and other aspects. This has several important ramifications: the policies and processes for delivering duty of care are widely dispersed across separate entities, organizations, departments and functions. More than 14 different policies, manuals, bulletins or guidance documents were identified as providing relevant inputs into the three dimensions under review. The dates of their development ranged from 2001 to recently enacted documents, as well as draft documents that had not been published at the time of the evaluation, such as the UN Mental Health Strategy. This dispersed treatment of duty of care is likely one reason why many OCHA staff interviewees did not feel that the organization had a duty of care culture.
65. Another important ramification of the absence of a duty of care framework is that duty of care as a concept can be interpreted differently by different stakeholders, with no common framework for addressing inconsistencies. This dynamic influenced the findings in all three dimensions, sub-dimensions and themes.
66. **High Interest in Duty of Care.** Although no system-wide formal duty of care definition, system or legal framework exists, there is high interest across multiple levels and stakeholders to address duty of care. This is evidenced by the number of current initiatives with duty of care implications. In addition, in the process of organizing the interviews for this evaluation, many stakeholders proactively requested to be interviewed and several OCHA personnel provided unsolicited written inputs by email. Proactive volunteering is sufficiently unusual in evaluations to merit mention.
67. **OCHA Growth, Location and Comparators.** OCHA is located within the UN Secretariat. General Assembly resolution 46/182 of 1991 created OCHA under the premise that the support services required – including those with duty of care implications – are handled by Secretariat entities (or other agencies through MoUs). The spirit of the special measures appears to be intended to ensure that the UN Secretariat – and OCHA – was able to operate rapidly and effectively in emergency situations; however, the rapid growth of the organization, and the particularities of its mandate and its large field presence in high-risk environments have caused the organization to evolve with more similarities – in size and function – to agencies rather than most Secretariat entities but with less autonomy for duty of care considerations.
68. Thus, OCHA staff tend to use agencies as points of comparison, with a subsequent shift in expectations regarding duty of care standards. For example, during interviews and field visits, a considerable percentage of OCHA personnel would refer to OCHA as an agency or used terms such as “like the other agencies” when talking about duty of care, while they were of course aware of OCHA’s location in the Secretariat. Using agencies – in particular UNHCR, UNICEF and WFP, which are larger and have more resources – as a point of comparison subtly influences the expectations regarding duty of care standards, as well as the degree to which Secretariat processes are considered for resolving duty of care issues.

69. **OCHA's Position in the UN System.** OCHA's position within the Secretariat and its reliance on Secretariat systems and policies has additional implications for the provision of duty of care to its personnel. OCHA has been unevenly represented on higher-level groups and committees, which hinders its capacity to advocate for its duty of care needs. For example, although the HLCM Duty of Care Working Group was formed in 2014 and the HLCM Duty of Care Task Force in 2016, OCHA representation on the Task Force only began in late 2017. These two factors combined to leave OCHA's needs vis-à-vis duty of care relatively unaddressed within the broader UN policy environment.
70. Many interviewees believed that OCHA's position within the Secretariat to be limiting its ability to provide duty of care comparable to other Secretariat entities, peacekeeping operations and political missions or agencies. The conditions of duty of care in OCHA, according to interviews, are perceived to be worse than in other Secretariat entities, and also worse than in agencies operating in the same environments.
71. Some HQ interviewees pointed out that OCHA can exercise special measures that permit deviations from Secretariat procedures. As noted above, this special measures clause is integrated into its founding General Assembly (GA) resolution²³ and could – in theory – allow for special procedures and policies to improve duty of care to OCHA personnel if Secretariat functions and resources are deemed insufficient. In the Secretariat, special measures are typically used on an exceptional basis for the start-up phases of peace operations, or crisis and emergency situations, granted by the Secretary-General for a renewable period of six months. They involve greater delegations of authority to manage budgets and finances, procurement, property and human resources.²⁴ But at OCHA, special measures have not been used, including for the provision of improved duty of care to personnel, even though OIOS has recommended that OCHA consider a more systematic use of the special measures provision.²⁵ In addition, OCHA does have the ability to utilise other service providers (especially UN sister agencies) to enable OCHA to deliver on its duty of care. These service providers may be better equipped to support duty of care for OCHA personnel.
72. **The Humanitarian Mandate and OCHA Affiliation.** As certain duty of care issues emerged, interviewees in the field recounted a reluctance to consider peacekeeping mission resources as the first option of response. In mission contexts, there is a tension in OCHA's role between mission integration and the coordination role with all actors. One interpretation provided for this pattern is that OCHA's humanitarian coordination mandate requires neutrality, which extends to the use of physical assets that could confuse or compromise OCHA's humanitarian status and would compromise OCHA's neutrality and their ability to conduct humanitarian coordination. This is important in OCHA's coordination role, but can have duty of care implications by limiting the degree to which OCHA proactively avails itself of the common resources related to duty of care or defining the first point of response for determining how to address duty of care issues. The peacekeeping or political mission may have a dedicated counsellor or may provide management trainings and orientations on Secretariat processes. Mission legal support can also provide assistance for the management of contracts and leases. These common assets could be drawn upon to enhance duty of care without prejudicing OCHA's humanitarian standing. However, when discussing shortfalls in duty of care resources in field interviews, the first options proposed from respondents involved seeking more support from agencies and only subsequently would mission resources be contemplated for use – if at all.

[23] Paragraph 29 of GA Resolution 46/182 (<http://www.un.org/documents/ga/res/46/a46r182.htm>)

[24] United Nations (not dated). Information for SMART programme – Information on Standing Administrative Measures: Terms of reference for review of key processes. Retrieved from <http://dag.un.org/bitstream/handle/11176/387433/HIPPO%20implementation%20May%202016.docx?sequence=4&isAllowed=y> (accessed 6 April 2018)

[25] OIOS (31 October 2016). Audit of management of human resources in the Office for the Coordination of Humanitarian Affairs. Report 2016/127. Retrieved from <https://oios.un.org/page?slug=report> (accessed 10 May 2018)

4.2 Dimension 1: Security Risk Management

73. **Overview.** This dimension was disaggregated into three sections in the interviews : security decision making and support, orientation and preparation for new staff, and access to security equipment. The four most pressing concerns were: a) insufficient resources are allocated to duty of care, both at the HQ level and in the country offices; b) duty of care standards are not consistently applied in field situations and more often depend on the discretion of the manager in question than a specific framework; c) administrative policies developed for Secretariat entities are seen as not fit for purpose for the needs of OCHA personnel – especially those in high-risk environments and deep-field duty stations; and d) OCHA personnel and needs are being less prioritized compared to entities within a peacekeeping mission.
74. In terms of **security risk management**, the policy documentation review (Annex 7) identified that policies do exist for each of these security elements. While duty of care policies for OCHA are usually highly decentralized – distributed across multiple units and procedures – the policies related to security are more centralized, and consolidated in the UNSMS Security Policy Manual.
75. **National staff in high-risk environments** can end up in higher-risk security situations, such as being deployed on low-profile missions, deep-field placements and living outside a security compound. When national staff have to travel to stations outside of their home community, they operate with the risks of being outsiders and associated with the United Nations, but do not receive special considerations. In some of the high-risk field sites visited, women were particularly at risk if identified as working for the United Nations and would often take measures to ensure they could not be identified when entering or exiting UN compounds. These factors are compounded when coupled with highly sensitive political environments. National staff may be required to be in contact with different parties – putting them at risk within their communities. Should these parties be considered illegal non-state armed groups, they may be vulnerable to legal reprisals. In other situations, national staff members may be required to work in contexts that may be difficult or hostile due to their ethnic or religious affiliation.
76. Although these conditions heightened national staff members' security risks, no basic policy standards exist to address extra security needs or meet minimum security requirements.²⁶ Heads of Offices often took the initiative to develop flexible working modalities which allowed staff to work from home or to come to the office at irregular hours to avoid being targeted as UN personnel or being exposed to risks in movement. Others provided internet access to allow working from home. However, these approaches were at the discretion of the manager and not standardized. There has been an ongoing two year study through the Inter-Agency Security Management Network (IASMN) on this issue of national staff needs particularly with reference to security outside of working hours. A policy and guidelines on the specific support to national staff will be submitted to the IASMN in June 2018. This may result in more standardized management responses to these issues.
77. At the country level, OCHA coordinates with the relevant security actors, such as UNDSS, UNDP and DPKO. Documentation in the form of policies or procedures articulate the expected responsibilities among the entities with respect to the coordination of security management. However, interviewed stakeholders in the countries visited did not perceive there to be sufficient security-related duty of care support from these entities for OCHA personnel. Even UNDSS stakeholders agreed that resources are insufficient to meet OCHA's security needs. OCHA personnel often shared the perception that the organization received low priority for access to Secretariat resources – such as access to UNDSS security officers for field missions or to office and personal accommodation from a peacekeeping mission. At the same time, OCHA did not have the same level of resources and autonomy to apply the duty of care considerations that the agencies exercised. A few respondents in interviews referred to official or unofficial agreements with UNDP or other agencies to provide security coverage for OCHA personnel, although these appeared to be actions taken at the discretion of the Heads of Offices in

[26] UNDSS Training Section and Critical Incident Stress Management Unit (CISMU) are developing procedures for enhancing staff welfare through deep-field counselling and outreach interventions with counsellors and peer volunteers. This resource would be available from UNDSS for OCHA personnel.

each country rather than an established practice or policy.

78. In the survey, 65 per cent of respondents rated the security support they received from OCHA as either satisfactory or very satisfactory. Personnel in family duty stations rated security support lower compared to personnel in non-family duty stations, and this difference was statistically significant.²⁷ Surge deployment respondents tended to be less satisfied with the security support they received,²⁸ with about 5 per cent fewer respondents rating the quality of in-country security support as satisfactory or very satisfactory. However, they tended to rate the quality of orientation and induction before deployment as good. Almost all respondents (97 per cent) reported taking the online security trainings prior to deployment and about half reported taking the SSAFE training, which is only required in the highest-risk environments. However, when controlling for just those based in E duty stations (the highest risk), still only about 65 per cent of the survey respondents in E duty stations reported having gone through SSAFE training prior to assuming their post.
79. In the interviews, the perceived quality of security coverage provided by UNDSS varied from country to country. In some countries the relationship was considered to function well while in others the quality of coverage was considerably criticised. However, there was a common pattern from respondents that UNDSS coverage was not sufficient for the needs of OCHA staff. In all three field visits, respondents perceived that UNDSS gave priority to the peacekeeping or political mission's need for resources rather than to humanitarian coordination or response. This response was reiterated in the remote interviews with peace operations. Respondents based in country offices without peacekeeping or political missions did not tend to have the same perceptions. Some respondents in high-risk environments additionally asserted that UNDSS did not understand the humanitarian mission needs and tended to pursue "protection" or risk avoidance rather than risk mitigation strategies. In other instances, respondents gave low marks to the quality of services, such as inadequate security briefings or a lack of awareness by UNDSS regarding their responsibilities to OCHA as part of the Secretariat.
80. According to interviews, staff felt that they received insufficient security briefings and were not kept informed about changes in risks or ways to reduce their vulnerabilities. Some interviewees often found out about changes in the security context from colleagues in agencies who had received updated briefings. This contradicts somewhat the relatively high percentage of survey respondents stating that they had received adequate security support – but even in the survey, only two-thirds of the respondents going to the highest-risk duty stations had taken the SSAFE training prior to assuming their posts. The consistency of the pattern in the field mission and remote interviews responses and the relatively low percentages of respondents reporting taking the mandatory SSAFE training prior to assignment does at least suggest that increasing security support in specific high-risk environments may be an important priority.
81. One gap identified in the interviews related to the description of **accountability**. Any organization has an obligation to provide support to its personnel including ensuring the security of its personnel, their health and welfare, and providing an appropriate workplace atmosphere. Accountability mechanisms are those mechanisms in place to allow an organization to confirm that it is providing adequate duty of care to its personnel. The field visits and remote interviews highlighted that there were few accountability mechanisms in place to monitor actual provision of duty of care obligations – even in the case where these were being provided. This was a greater concern for the dimensions of staff health and welfare and workplace environment. In the security dimension, this was seen as a less pressing issue because most of the security policies described roles and responsibilities and there were more accountability mechanisms in place regarding critical security incidents. However, interviewed stakeholders were not aware of accountability mechanisms to monitor security considerations prior to the emergence of a critical security incident.

[27] Care should be taken regarding over-interpreting results that may have generalizability concerns. However, where patterns are reported as being statistically significant, the P- and r-values will be reported. In this case, P=.000, r=.273

[28] P=.000, r=.325

82. For example, this issue of accountability was referenced mostly regarding **personal security risks and measures**. In addition to concerns about security briefings, as noted above, there were also references to security assessments of accommodation potentially not being carried out according to standards or the perceived extensive use of waivers for security certificates, briefings or accommodation leases.
83. In addition to concerns about the quality of security briefings and assessments, two other factors could contribute to staff awareness about the security risks they may face in their work. First, awareness among personnel of Programme Criticality Framework (PCF) and Business Continuity Plans (BCP) was limited, and OCHA, unlike some agencies, does not seem to conduct drills of their BCP. Second, the SSAFE training, in addition to preparing staff, was seen as an opportunity for them to become aware of security risks, their personal response to these risks, and ‘whether this kind of work is for them’.
84. The personal acceptance of risk is an important component of the informed consent process. The informed consent process prior to deployment or contracting is intended to be a mechanism whereby individuals are informed of the level of risk they face and their acceptance of the level of risk. Interviews during the field visits and virtual phases suggested that the informed consent process is not systematically applied to all staff at the beginning or during a mission or contract. There also appears to be a lack of a fully monitored HR mechanism in place for staff to raise risk concerns and receive a response – especially if there has been a change in the security situation. Without this mechanism documented, it is not possible to ascertain whether the staff have been oriented to, and accepted, the risks inherent in their role and environment.²⁹
85. **Gender considerations** are given a chapter in the UNSMS Security Policy Manual. UN security guidelines for women were approved by the HLCM in 2006, but no update could be found and there is no specific operationalization of gender and security yet. The Security Gender Policy and guidance on reporting currently exist. The manual on operational gender implementation in Security Risk Management (SRM) is due to be submitted to the IASMN in June 2018. In the absence of operational standards, there appears to be considerable variation in how gender and security issues are addressed among country offices.
86. During interviews, several staff noted that in many high-risk environments – especially those with peacekeeping missions with a very high gender imbalance – coupled with conservative cultural contexts exposed women to more risks, which were not always seen as being adequately addressed. Examples included women being deployed to duty stations with no extra provisions put in place. As a comparator, in one of the countries visited, UNICEF, as part of the induction process, provides a video for its female staff on special safety and security considerations for women. Although SRM includes security trainings and cultural awareness briefings, a high number of women interviewed during the field missions reported not receiving these measures.
87. **Armoured vehicles (AV)** and the use of **Personal Protection Equipment (PPE)** was a sufficiently contentious issue to merit its own set of questions in the evaluation TOR. In the field interviews, most AV-related concerns pertained to having adequate access to armoured vehicles to carry out operations. In high-risk environments, the lack of armoured vehicles usually caused postponement and cancellation of a mission. However, some interviewees reported that if AVs were not available, staff would travel in regular vehicles to carry out their missions – which put them at higher risk. In the online survey, two-thirds of respondents who had been based in or travelled to a non-family duty station over the last three years said they had received the necessary security equipment, while one-quarter said they had not received adequate security equipment. Over a dozen respondents stated in the comments section that they had not received helmets, bulletproof vests, satellite phones or other security equipment.

[29] The HLCM Duty of Care Task Force notes that “While the concept of ‘informed consent’ in the strict sense of requiring the agreement of personnel prior to any deployment/assignment does not apply in the UN system due to the Secretary-General’s authority to assign staff to any activity or office of the UN under UN Staff Regulation 1.2(c), the spirit of the principle and basic premise that individuals should be informed and agree to undertake an assignment may be met in the UN context through the responsibility to inform UN personnel of any risks.”

88. Nearly 25 per cent of OCHA staff reported being exposed to higher risk because they do not have minimum security equipment. This would be considered a gap in SRM and duty of care. However, it cannot be confirmed from the available online survey data if the respondents are reporting a real lack of equipment or are reporting perceptions related to a lack of equipment quality. During the country field visits, only one person interviewed reported not being given PPE for their work,³⁰ however, numerous interviewed persons in one field visit observed that OCHA's armoured vehicles and PPE were inferior to those used by the agencies. The agencies' PPE was considered to be lighter, allowing for greater mobility and usage, and their armoured vehicles were seen as more resistant to IEDs and other threats.³¹ According to UNDSS interviews, the PPE and armoured vehicles provided to OCHA in the country visits met specifications of the DFS systems contract.³² However, both the internal DFS procurement in the country as well as the UNOG procurement representative in Geneva noted that OCHA has different standards in DFS procurement from the standards used by the agencies.³³
89. Interviews with UNOG representatives tended to ascribe this discrepancy to OCHA administrators not being aware of their options and a lack of initiative from managers to make their requirements known. They observed that UNHCR, UNICEF and WFP impose stringent quality stipulations on AV suppliers that must have a history of meeting these standards. However, the DFS systems contract is with other suppliers and the stipulations for quality described by DFS in this contract are lower.³⁴ The UNOG respondents contended that OCHA had the option to requisition different standards in their purchase orders, but it was perceived that the Heads of Offices – or the administration staff tasked with procurement – were often not aware of: a) what the DFS standards were when orders were submitted; and b) OCHA's options for requisitioning different standards within the system. OCHA stakeholders in turn contended that if they do want to procure higher quality AVs, they face additional administrative procedures leading to longer delays. Although there was disagreement across the different stakeholders about the cause of the quality issue, there was an admission from a range of stakeholders that the differential standards from agencies affected morale – and possibly also performance – for OCHA staff operating in some high-risk environments. The lack of delegation of authority that OCHA has for procurement processes likely contributes to these frustrations. Whether procurement issues were real or perceived, interviews from both the online survey and the virtual interviews plus the field visit interviews consistently reported a perception from staff that: a) the equipment they receive is inferior to other entities; b) they do not receive the necessary equipment upon arrival; and c) that these dynamics have led to a perception that the organization did not value its staff as much as other entities in the UN system.
90. Perceptions of inequity regarding the quality of security equipment may also be surfacing inequality concerns between international and national staff. Among some national staff in high-risk environments, who are often able to travel in unmarked – and therefore non-armoured – vehicles without being associated with the UN, the perception existed – whether true or not – that international staff received more security duty of care consideration than national staff.

[30] 24 per cent of the respondents on the survey reported not receiving adequate security equipment, but this also included whether they received radios or cellphones, not only PPE. Thirteen people in the open comments section of the survey (2.5%) commented that they had not received PPE at some point.

[31] It was reported to the evaluation team that in all other country operations, OCHA reportedly uses the same PPE as used by other humanitarian agencies. However, this could not be confirmed.

[32] DFS is currently developing a new systems contract for the provision of armoured vehicles, providing an opportunity for OCHA to advocate for more appropriate specifications. See United Nations Procurement Division (27 February 2018) Request for Proposal 3100002818: Armoured Vehicles including Spare Parts and Ancillary Services for the UN and the UN Entities.

[33] In 2017, UNDSS/PSU developed and circulated a bulletin on armoured vehicles which stipulates standards and requirements. Agencies may choose to procure armoured vehicles at a higher classification.

[34] Subsequent information suggests that there is a standing agreement to utilize WFP procurement processes, but this was not mentioned in the field interviews – which could suggest that managers were not aware of this option.

4.3 Dimension 2: Staff Health and Welfare

91. This dimension explores a range of sub-themes, including benefits and entitlements, access to medical provisions and access to psychosocial support. Special attention was given to the management of critical incidents and post-incident support. The policy review shows that, as with the security dimension, policies exist, but are highly decentralized (Annex 7). Minimum standards are defined for benefits and entitlements but are lacking for psychosocial support and critical incident support. Respondents in field interviews indicated that the policies are not applied consistently.
92. From a duty of care perspective, this dimension was the most problematic in terms of perceived inequitable treatment among different categories of staff (the other dimensions were more equitable, even if the standards were lower than desired). International staff perceived differential – and inequitable – treatment related to entitlements and benefits between those on fixed-term, continuous or permanent contracts,³⁵ and those on temporary contracts. While only about 10 per cent of all OCHA personnel are on temporary appointments, these are mainly used for international staff in the field. Only 3 per cent of national staff are on temporary contracts, compared to 20 per cent of international staff. Among international staff, the share of temporary appointments is almost three times as high in the field (27 per cent) as at headquarters (10 per cent), and particularly high in the most difficult duty stations (category D: 42 per cent, category E: 34 per cent).³⁶ Benefits for staff on temporary contracts are more limited than for those on fixed-term contracts: fewer leave days (18 vs 30 days per year), lower insurance plans, constrained availability of compensatory days and more restricted family allowances. These limited benefits create perceived inequitable treatment, affecting morale.
93. Staff also perceived inequity between national staff and international staff. Disparities between national staff and international staff on duty of care issues were highlighted particularly in situations when national staff are located in duty stations far from their homes and thus face similar conditions as an expatriate worker but without the same support, or when their families could not reside with them, usually for security reasons. In addition, national staff face what they perceive to be unnecessary obstacles when applying for international posts: OCHA national staff are technically considered as external candidates and cannot keep a lien against their national posts – meaning they often must decide between a fixed-term national contract and a temporary international contract. These situations create additional perceptions of inequitable treatment among personnel who are all operating within the same environment.
94. The staff welfare dimension also raised the greatest concerns with the administrative processes of the system. In the survey, respondents were asked to rate the quality of support they received along six dimensions: security, medical, psychosocial, accommodation, working space, and HR benefits and entitlements. A higher percentage of respondents were satisfied or very satisfied with security in terms of quality of support and the lowest level of satisfaction was related to HR support on benefits and entitlements. The percentage of respondents who rated the quality of support as satisfactory or very satisfactory were:
- a. Security: 65 per cent
 - b. Medical: 57 per cent
 - c. Working Space: 55 per cent
 - d. Accommodation: 46 per cent
 - e. HR Support: 32 per cent
 - f. Psychosocial Support: 34 per cent

[35] In the following, “fixed-term contracts” should be read to include continuous and permanent contracts, unless otherwise noted. Fixed-term contracts are the most common of these three types.

[36] According to OCHA data as of 5 February 2018. Only temporary appointments are considered, not temporary assignments for staff that keep a lien against a fixed-term, continuous or permanent contract.

95. There was a statistically significant difference in ratings between those in family compared to non-family duty stations. People in non-family duty stations tended to rate medical, security, and psychosocial support lower.³⁷ Women rated the quality of psychosocial support, working office, entitlements and benefits, accommodation and HR support more negatively than men, at a statistically significant level.³⁸
96. In the qualitative interviews, five factors were frequently mentioned that reduced effective duty of care for all elements:
97. Combined HR, Finance, Administrative Roles. Within OCHA field offices, the administration, HR, finance and procurement duties are often combined into a single unit (or person). The personnel in this unit – while often seen by the respondents as willing and trying to help – tended to lack sufficient expertise across all four systems to provide timely or accurate support. This was particularly noted in office start-up contexts or when there was a significant increase in personnel joining the country office.
98. Split Contract Management. International contracts are managed by OCHA and the UN Secretariat Office of Human Resources Management (OHRM) while national contracts are managed by UNDP. This led to confusion regarding roles and responsibilities for induction of new staff or for addressing case management issues. National staff perceived themselves to be in an ambiguous position. UNDP interviewees reported that they administered national staff contracts on behalf of OCHA, and OCHA national staff are not considered part of UNDP. However, in Umoja³⁹ – which is required for many management activities – national staff have to enter themselves as “non-OCHA”. This did not have operational implications but furthered national staff’s impression that the organization did not view national staff as full-fledged members.
99. While the evaluation team heard some comments critical of the quality of UNDP administrative support for national staff contracts, overall, interviewees primarily appreciated how effectively and efficiently UNDP administered their contracts. The issues raised focused on the separate platforms rather than the efficiency of administration.
100. HR Focal Points and Case Management. HR management under OHRM and, to some extent, within OCHA has come to resemble third-party management. OCHA staff interviewed in the field missions reported that when they have case management issues, they are no longer able to contact a specific focal point nor were they able to track where their case management issue was being addressed. This had three consequences: First, it led to a perception of an aloof, impersonal and non-caring HR function. Second, long delays in resolving HR issues were reported. Third, staff received little information about HR processes and their entitlements.
101. Health and Welfare Induction. A consistent theme that emerged in the interviews was that OCHA staff reported receiving minimal induction into the processes, procedures and standards related to health and welfare. This sometimes led to uncertainty regarding whom to communicate with on important issues and to delays in insurance claims and repayments, as processes were not clearly understood.
102. Induction processes and preparation for roles were widely noted across the range of stakeholders. There was a consistent message of a lack of information in induction and the necessity of learning from colleagues upon arrival rather than being supported by the organization. Seconded personnel such as standby partners, as well as UN Volunteers, noted this issue even more forcefully with frequent mention of feeling mistreated, poor accommodation standards, poor predeployment briefings, the late arrival of contracts, and lack of consistent entitlements.
103. Management Induction and Orientation to Duty of Care. Interviewed stakeholders, including managers, frequently mentioned the lack of preparation for duty of care induction and orientation for managers. The policy documentation may outline roles and responsibilities for delivering duty

[37] $P < .05$, r between .20 and .35 for cited dimensions

[38] $P < .05$ for all, r between .10 and .25 for cited dimensions

[39] The primary HR management system of the Secretariat used for all procurement issues as well

of care, yet stakeholders perceived there to be minimal standards for holding managers accountable to deliver duty of care. Managers generally reported receiving no induction or orientation on their responsibilities for duty of care, no duty of care obligations in their job descriptions, nor specified indicators for related performance.⁴⁰ Yet, they were expected to provide duty of care, including in critical situations such as medical evacuations. This contrasts with the Security Policy Manual and the OCHA Security Policy, both of which clearly assign responsibilities.

104. **Entitlements and Benefits.** This section covers a range of themes including pay administration, accommodation standards, medical provisions, mobility and rotation practices, and security risk management allowances and criteria. Among the targeted themes, respondents tended to emphasize accommodation, access to medical services, mobility and rotation, leave days and R&R. Security risk management allowances for improving personal accommodation to meet security standards and general security support for movement were primarily mentioned by national staff in high-risk environments.
105. **Pay administration** was not frequently cited as a concern in the interviews. During the inception phase, this was an important duty of care issue with multiple reports of staff not receiving their salary on time. However, this issue rarely emerged during the field missions. The HR database shows that the number of salary advances during a six-month period in 2017 varied from 5 to 20 cases per month (0.2 per cent to 0.9 per cent of all employees). It seemed that the number of delays in payments had decreased from a peak in 2015 when OCHA started using Umoja, the UN's enterprise resource planning tool. During interviews only one person noted a current pay administration issue and this was related to abrupt communication regarding withholding payment rather than pay not being received. However, many persons did recount having experienced pay issues in the past – especially with respect to accommodation expenses – and these experiences were still affecting their perceptions of the organization's function with respect to duty of care. Given the degree of potential seriousness, further investigations to assess the extent of pay withholding and accommodation expenses may be warranted to confirm that it is indeed not widespread as reported to the evaluation because it is possible it was not reported to the evaluation because it would be a withholding rather than a “delay” per se.
106. **Accommodation** issues were more frequently cited in the field mission interviews. Although there are general UN guidelines on accommodation standards, no specific or minimum standards exist for accommodation quality except for security standards through the current Residential Security Measures (RSM) and the now-discontinued Minimum Residential Security Standards (MORSS).⁴¹ Interviews in the field missions noted a large percentage of respondents who viewed accommodation arrangements as sub-standard and OCHA staff in mission countries perceived that OCHA housing and office space were usually allocated after the interests of other entities in the mission or agencies.
107. Due to resource constraints, OCHA does not typically set up guest houses, unlike many agencies and missions. This makes it harder for staff to receive adequate accommodation and to organize adequate and regular provision of basic sustenance with the support of the office – which may be required in deep-field locations. In addition, the lack of a capital fund in OCHA for accommodation was seen as a barrier to meeting accommodation standards due to the limitations that this created for spacing arrangements. In some instances, agreements were managed with agencies to link OCHA accommodation to co-sharing facilities. This functioned well in some circumstances although the exact nature and quality of the relationship was dependent on the discretion of the managers in question.
108. Of more concern from a security perspective were reports of personnel signing waivers to live in non-RSM compliant accommodation or of Heads of Offices using annual waivers on RSM compliance

[40] As part of the HLCM Duty of Care Task Force, DFS is partnering with UNDP/OHRM in the development of two new induction packages – one for standard predeployment for all staff and a second for managers in high-risk environments. These will eventually be important resources for OCHA personnel as well.

[41] Respondents often still referred to MORSS even though this policy is no longer extant.

standards for their offices. The latest data from the 2014 country results framework notes that 76 per cent of OCHA field offices exceeded 90 per cent MORSS Compliance. However, data for more recent years with RSM was not available.

109. Many respondents noted concerns over the lack of flexibility with regards to **leave arrangements**. One dynamic was that due to workload demands and priorities, staff commonly postponed their R&R cycles or planned annual leave, or did not use their allotted leave in a year. Leave would accrue to the point that it exceeded rollover limits and staff often reported losing these leave days. In a similar fashion, R&R cycles were often postponed, leading to increasing stress and ill effects. The difficulties faced by national staff working outside their home environment were also noted. They had few opportunities to visit their families, especially if travel costs were not covered and compensatory days were not available during intense work periods.
110. In many interviews, staff reported that their managers encouraged informal arrangements for leave, R&R or compensatory days. But in the absence of a flexible policy, these informal arrangements were at the discretion of the manager rather than resulting from a minimum standard in policy.⁴²
111. **Medical provision** – especially access to insurance – was often reported as a concern among both international and national staff. National staff were particularly concerned about their family members for whom access to medical care was seen as more difficult for several reasons: some UN clinics would not treat them and it was difficult to travel to places with better healthcare, both domestically for security reasons and internationally for visa and financial reasons. Policies exist regarding rights to access UN medical services for staff in the field, but the field interviews showed that personnel were not always clear about the rules to access UN clinics.
112. The arrangements with the insurance provider were also frequently mentioned. Some issues related to the lack of sufficient orientation or induction into the medical provision processes and how to manage claims in a timely manner. There were reports of some family members not receiving medical coverage because of failure to register the family member within a given period. Others reported not having insurance coverage despite insurance premiums being deducted from the salary. In high-risk environments, there were often issues with local hospitals, clinics, doctors or pharmacies not having agreements with the insurance provider which resulted in out-of-pocket-payment and slow reimbursements. According to Cigna, this is mainly due to the 80/20 co-pay arrangement where staff contribute 20 per cent of the cost and get reimbursed for 80 per cent. This arrangement makes it more complicated to enter into agreements with healthcare providers. Staff – especially national staff – often commented that they were not aware of how to track their claims once submitted into the system and were unclear who their point of contact was for medical coverage. There was also a perceived difference between national and international staff regarding opportunities to travel for medical treatment, especially in more serious cases. Some managers create special exemptions for national staff in a country, but these were reported as ad hoc measures taken at the discretion of the manager in question rather than a systematic policy for supporting national staff.⁴³
113. **Staff burnout and extended high-risk environment placements**. One issue that emerged repeatedly across interviews with staff in high-risk environments was a perception that a significant number of staff were rotating among high-risk duty stations for extended periods and were at high risk of burnout and other psychosocial trauma. Staff serving multiple sequential tours in high-risk duty stations is a point of concern for all agencies because of the increased risk of burnout and self-harm. Some UN agencies and entities have policies in place to identify and address sequential tours in high-risk contexts. However, respondents perceived that within OCHA there was a lack of policies, resources, and systems in place to provide the support required for multiple high-risk duty tours. Interviewed respondents felt this also led to unintentionally discriminatory outcomes.

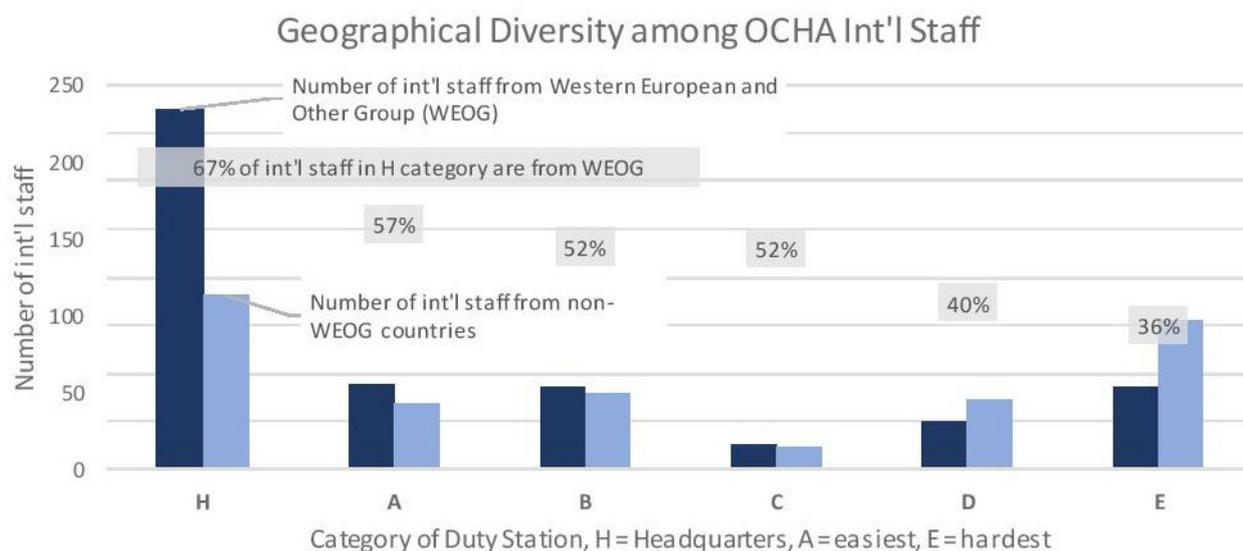
[42] Other UN Secretariat entities reported that they encourage the granting of administrative leave of up to two weeks for all categories of civilian staff affected by critical incidents. However, this is not always systematically granted to or taken by affected OCHA staff according to field interviews.

[43] UNDSS has introduced a concept of Regional Areas of Care (RAC) intended to address the access to adequate medical facilities. This may be worthwhile for consideration for OCHA procedures.

114. One barrier to proactive assessment is that OCHA does not have a monitoring system to keep track of the length of time staff spend in high-risk environments. There is a process led by the efforts of the OAD Section Chiefs to track and monitor rotation, but there appears to be limited connection between the HR administration systems through UNOG and the management of staffing through OAD Sections. Another factor was the high percentage of international field staff on temporary contracts (29 per cent), whom respondents perceived to be less integrated into proactive HR management. As a disproportionate percentage of vacancies will be in emergencies and high-risk environments due to OCHA's mandate, respondents frequently commented that larger agencies such as WFP could rotate staff among hardship and non-hardship duty stations, while OCHA had relatively fewer non-hardship stations in which to rotate personnel. This may not actually be true considering the size of the organization, but it was a widely recounted perception in interviews. It may be worthwhile for OCHA to explore opportunities for an internal OCHA-specific mobility scheme that would allow managers to select staff with appropriate qualifications while also ensuring the need for staff to be mobile.
115. The combination of these factors led to the perception among staff that they were generally left on their own to decide on their move. This lack of proactive management gave rise to two perceptions: First, personnel based in non-hardship stations (such as HQ) tended to stay in their posts, thus blocking others from these opportunities; and second, some staff of specific nationalities tended to spend many years in hardship duty stations – and only rotated between hardship stations. It was noted that some organizations such as WFP or UNHCR have a committee that meets annually to review personnel assignments and needs across the entire workforce. WFP is perceived to actively manage their personnel assignments to reduce burnout and to provide more movement between field and HQ stations. Currently, this type of management would be problematic for OCHA, but it may be worth considering options for a more proactive approach to personnel placement issues.
116. The lack of a more systematic management process combining administration and management can lead to geographic and gender imbalances. Overall, 55 per cent of OCHA's international personnel are from the 29 countries that form the UN's 'Western European and Other Group' (WEOG),⁴⁴ yet staff from WEOG countries are over-represented at headquarters (67 per cent) and in easier duty stations but under-represented in the most difficult duty stations (36 per cent in category E duty stations).⁴⁵ Staff from WEOG countries are also relatively under-represented at the P3 level (44 per cent) and over-represented at most higher levels (71 per cent of P5s, 92 per cent of D1s).

[44] Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, Turkey and the United Kingdom in Europe; Australia, Canada, Israel and New Zealand outside of Europe; and the United States as an observer.

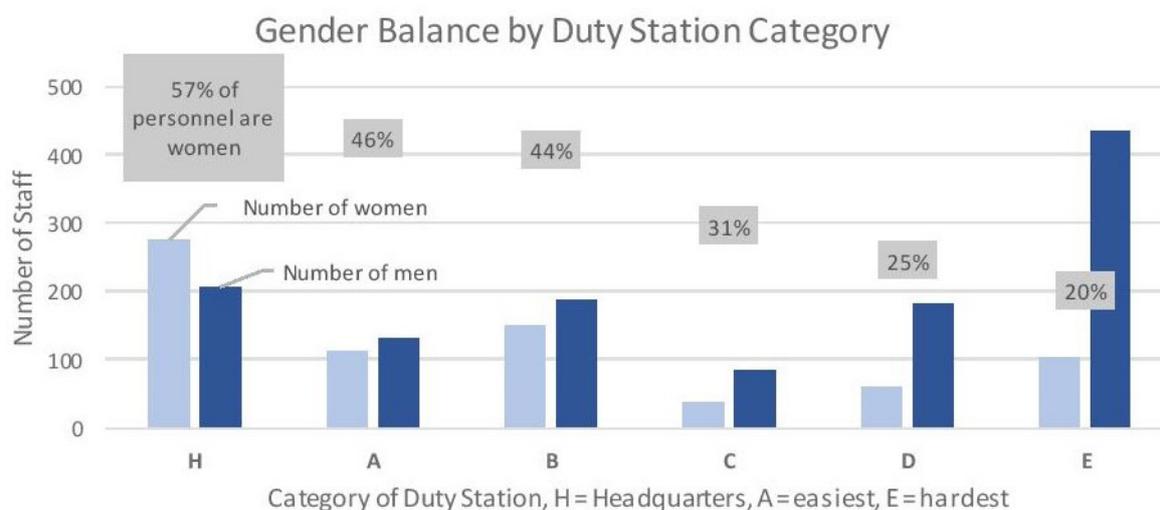
[45] According to OCHA data as of 5 February 2018.

Figure 1: Geographic Diversity among OCHA International Staff

117. Women on the other hand are under-represented in high-risk duty stations. While 38 per cent⁴⁶ of all OCHA personnel (and 43 per cent of international staff) are female and while gender distribution remains relatively consistent across professional grades for international staff (between 41 and 47 per cent⁴⁷), the gender share is higher at headquarters (57 per cent) and significantly lower in the most difficult hardship duty stations (category D: 25 per cent, category E: 20 per cent). Several interviews noted the difficulty of recruiting and retaining staff with families or women who wanted to have families and in the absence of pro-active policies and processes for increasing gender balance in high risk stations, subtle factors such as single sex accommodation in high risk duty stations and more pernicious factors such as women facing greater risks of sexual harassment in high risk duty stations can create ad hoc environments that maintain imbalanced representation. It may be helpful for OCHA to investigate with female staff the perceptions regarding hardship duty stations and conditions required for increasing gender balance at these stations. It may be important to consider integrating additional special needs for female staff into the Residential Security Measures, having a special module in SSAFE training, and carrying out a Women's Security Awareness Training (WSAT) for female staff in high-risk complex security environments as part of this process.

[46] According to OCHA data as of 5 February 2018.

[47] UN Gender data found at: <https://www.un.org/gender/content/un-secretariat-gender-parity-dashboard>

Figure 2: Gender Balance by Duty Station Category

118. Post-Incident/Crisis Support: According to UNDSS data, over the last five years, an average of three incidents per month related to OCHA occurred, with about seven impacts per year rated “critical.”⁴⁸ These security incidents do not include burnout, PTSD diagnoses from workplace stress or harassment cases. Nevertheless, even this limited dataset suggests that critical incidents are sufficiently frequent to merit policy defining roles and responsibilities, and accountability mechanisms.
119. Documentation exists on the processes for post-incident support although, as with the relevance dimension, this documentation is dispersed among several different arenas – security, medical, psychosocial, and HR documents describe different aspects of incident support with no single guidance or manual consolidating all elements.
120. In the survey, 15 per cent (65 out of 510) of respondents reported having directly experienced a critical incident. Overall, 77 per cent of incidents witnessed or experienced were reported. When asked about the quality of support they received on various dimensions related to post-incident response, the following percentage of respondents rated the quality of response as satisfactory or very satisfactory:
- Support from peers: 66 per cent
 - Support from supervisor: 48 per cent
 - Security: 38 per cent
 - Medical: 23 per cent
 - Psychosocial support: 18 per cent
 - HR support: 12 per cent
121. Peer support received the highest-rated satisfaction, followed by support from supervisors. The quality of HR support after a critical incident was rated low with only 12 per cent rating it satisfactory or very satisfactory. Women were not disproportionately affected by critical incidents (32 per cent for women and 34 per cent for men), but, to a statistically significant degree, rated the quality of the psychosocial and HR support they received as less satisfactory than men did.⁴⁹
122. According to the qualitative interviews, OCHA personnel did not perceive the level of support provided to be commensurate to their needs. Although many stakeholders affirmed that they

[48] The data covers the time from 31 January 2013 to 31 December 2017. “Critical impacts” include abductions and hostage-taking (4), death (2), serious injury (4) and arrests and detention (23).

[49] $P < .05$, r between .250 and .350 for both cited dimensions

received considerable informal support from peers and colleagues, they received minimal – and inadequate – organizational support after a critical incident.

123. Common factors described were: a) a lack of awareness among different entities responding to the incident (HR, security and medical) regarding relevant standards; b) insufficient resources allocated to support needs; or c) procedures and processes had not been adequately implemented. For example, to access malicious acts insurance for post-contract continued medical coverage or psychosocial support, the affected person or the Head of Office must register the incident within four months of its occurrence. If the incident is not reported or registered, the staff member is not eligible for post-contract coverage. Some respondents noted that not all incidents were reported, leaving those affected vulnerable to losing coverage post-contract.
124. **Psychosocial Support.** This sub-dimension includes a range of themes, from trauma and PTSD support to occupational health and wellbeing or stress management. Psychosocial support, although considered to be an increasingly important priority within the UN system, is under-documented in policy. Consequently, agencies and organizations such as OCHA have pursued more individualized approaches to psychosocial support – leading to some duplications. The HLCM Duty of Care Task Force noted that 236 psychosocial counsellors currently work within the UN system, with little coordination and the subsequent level of support provided is not seen as commensurate with the needs of OCHA staff. OCHA has one psychosocial counsellor based in Geneva who provides support to the entire organization of more than 2,000 staff (a ratio of 1 counsellor per 1,000 staff was cited as appropriate). The Task Force is seeking to promote more outsourcing of counselling. This would redefine the role of the psychosocial specialist to be more strategically focused on reviewing psychosocial support procedures and resources available across all duty stations rather than providing direct psychosocial counselling. A UN Mental Health Strategy under development aims to promote a collaborative system-wide response to mental health needs of staff and to establish an overarching psychosocial and healthcare policy framework.
125. The most frequently cited concerns pertained to a perceived need for a more proactive psychosocial support system. Examples were cited from other organizations that provide a dedicated psychosocial support specialist at the regional or country office level who would regularly visit sub-offices and offices to assess the environment and identify emerging issues to take preventative measures. In one agency, this specialist held a P5 ranking to be able to provide more senior-level inputs into the system.
126. Staff in the interviews often stated that they are unaware of how to access psychosocial support and cited concerns regarding whether accessing such support might lead to stigmatization in the organization – possibly to the point of preventing access to other positions. They also expressed some concerns regarding what to do if they perceived a colleague experiencing psychosocial needs and whether there was a mechanism to refer the colleague for diagnosis or counselling. National staff received relatively less guidance regarding psychosocial resources and had less contact with existing resources. A final dynamic mentioned related to the application of HR policies which were perceived as being inflexible and creating awkward conditions for staff trying to seek appropriate psychosocial support.

4.4 Dimension 3: Working Environment

127. This dimension includes not only specific workplace harassment cases, but also factors such as organizational culture, communication and mechanisms for reporting incidents. In the policy arena, this dimension has received increasing priority. There are policy documents that outline expected styles of communication, incident reporting systems and training for managers and staff on harassment (Annex 7). There are also ongoing initiatives at both the Secretariat and the inter-agency level for addressing sexual harassment in the workplace. However, despite such prioritization, respondents in the qualitative evaluation interviews often cited this dimension as the dimension most in need of strengthening – especially in high-risk environments.
128. In the online quantitative survey, respondents were asked to rate the quality of the working environment on six different dimensions. The following list profiles the percentage of respondents who rated each dimension as positive or very positive:
- Respectful environment: 66 per cent
 - Harassment Free: 62 per cent
 - Discrimination Free: 52 per cent
 - High Stress: 45 per cent
 - Women have opportunities: 41 per cent
 - Staff of all nationalities can advance: 27 per cent
129. The survey examined two dimensions of workplace environment: Respectful communication and harassment, and perceptions of discriminatory behaviour. In terms of respectful communication and harassment, more than 60 per cent of those who responded to the survey rated their work environment as respectful or harassment-free, and 45 per cent rated themselves as highly stressed. A little less than half the respondents felt that women had equal opportunities for advancement compared to men and very few believed that staff of all nationalities had equal opportunities for advancement. In the qualitative interviews and open-ended survey questions, many respondents commented that the entitlements for women were insufficient to support their duty of care needs – for both national staff and international staff. Responses related to supporting women in family roles including with young children or maternity leave policies. Some of the concerns about the advancement of national staff could be related to the management of their contracts through UNDP or to their status of national contracts in general. When they apply to similar positions in other countries, they are considered “external applicants” and consequently have a lesser chance for an internal posting even though the position they are applying for is the same as the one they are currently working in.
130. Although overall measures for respectful communication were more positive than negative, more than 35 per cent of the respondents reported witnessing or experiencing harassment, of which 41 per cent had reported these incidents and 12 per cent were satisfied with the measures taken in the case. Among the survey participants, 89 per cent knew the mechanisms for reporting harassment and 27 per cent believed that they would be protected from retaliation if they did report.
131. Interestingly, although the qualitative evaluation interviews emphasized the need to strengthen this dimension especially in HRE contexts, in the quantitative online data, the type of duty station did not correlate with the responses assessing work environment, meaning that respondents reported harassment to the same degree in all duty stations and did not disproportionately report more harassment in high-risk environments. Although type of duty station did not correlate with an assessment of a harassment environment, the gender of the respondent did influence the patterns of responses: Women were consistently more negative than men on their assessment of the environment in the workplace, opportunities for advancement, experiencing harassment or being protected if reporting an incident.⁵⁰ There was no difference between men and women on feeling stressed.

[50] $P < .05$, r between .1 and -.325 for cited dimensions.

132. In the qualitative interviews, a number of interviewees reported perceiving OCHA's organizational culture as permissive of workplace harassment or abuse of authority and stated that there were few trustworthy mechanisms for limiting the spread of an abusive workplace environment or for addressing grievances. In this regard, interviews confirmed the importance of setting the right tone at the top and affirmed the work of very good and supportive managers, which is also demonstrated in the quantitative data. The respondents perceived that OCHA staff in senior level positions have a disproportionate influence on the emerging office culture due to the weak accountability mechanisms in place.
133. In the qualitative interviews, respondents described their perceptions of why this culture of harassment could emerge quickly in any given office. The responses cited four major themes that contribute to these problems. First, managers at senior positions were often not recruited with a consideration for their ability to manage duty of care issues. Second, managers received minimal induction and training on duty of care issues related to maintaining a positive workplace environment, standards of communication and relevant protocols related to harassment. Third, no accountability mechanisms were seen to exist for assessing a manager's performance related to duty of care. Fourth, and most importantly, reporting and grievance mechanisms were considered inadequate and widely distrusted.
134. Related to the final factor, there was widespread distrust expressed in the interviews concerning whether any reporting mechanism would be truly confidential, timely, or lead to change. A significant number of staff expressed concern that the person reporting was more likely to end up being punished than the person being charged. This was consistent with the survey results where fear of retaliation was most often cited as the reason for not reporting incidents.
135. In addition to the lack of trust in reporting mechanisms, staff also felt isolated. In some of the field visits, the lack of an OCHA staff association (or larger representative body for addressing grievances) limited their options for collective action. There are staff representatives in the OCHA system who have some mandate to address duty of care issues, but there are relatively few and they do not have the responsibilities (or resources) to respond to harassment grievances – especially if carried out by higher-level managers. Within the specific environment of peacekeeping or political missions, the previously noted reluctance of OCHA offices to fully access mission resources due to neutrality concerns created a distance from the mission structures and limited the options of OCHA staff for reporting grievances through non-OCHA channels.
136. Staff interviews also highlighted the perception that supervisors paid relatively little attention to communication regarding duty of care. The only OCHA group that reported receiving consistent inquiries on their wellbeing was surge staff who received this support and communication from the Surge Capacity Section in Geneva rather than from their posted field offices. The Surge Capacity Section is thus one entity that should be considered for best practices in duty of care. Interviewed staff on surge reported receiving a systematic induction prior to surge, as well as ongoing communications from the Section regarding their wellbeing while on assignment. Surge staff identified their most pressing duty of care issue as inadequate duty of care support upon their return from assignment. Despite working in high intensity situations for several months or longer, staff members were expected to return to their original post immediately with no R&R or re-integration process. The staff counsellor was cited as being a helpful resource for those returning to Geneva. Aside from the post-assignment phase, the surge process appears to have a higher level of duty of care support than other parts of OCHA.
137. During country visits, in interviews and in the survey, many said it was difficult to achieve a good work-life balance at OCHA. Some 45 per cent of survey respondents said they often felt stressed and overwhelmed. Both women and men said it was particularly hard and emotionally draining to work in non-family duty stations away from their families. A few survey respondents felt that the

standard 16 weeks of maternity leave and 4 weeks of paternity leave were insufficient. UNICEF, WHO and WFP allow for an additional 8 weeks of maternity leave.⁵¹

138. Gender considerations are more systematically addressed in the policy environment related to harassment – especially sexual harassment. However, interviewees frequently commented on the additional potential harassment women experienced in the workplace. Female national staff in conservative cultures frequently commented on verbal or other types of harassment by male colleagues but did not consider reporting these incidents for fear of retribution. Both national and international staff expressed some concern over male-dominated environments – whether isolated duty stations or peacekeeping mission contexts – that potentially increased vulnerability and perceived heightened risk for women.
139. The high-stress conditions were often ascribed in interviews to the heavy workload obligations, rotating staff and shortfalls in staffing. Staff often found themselves working in such an environment for long periods of time with few opportunities for rotation or leave. Interviewees highlighted this as a key factor for that undermined a positive culture in the workplace.
140. In addition, relatively little emphasis is placed on either training or accountability for managing workplace environments. Neither staff nor managers interviewed reported receiving systematic training in workplace communication or for handling an abusive environment. Many Heads and Deputy Heads of Offices interviewed had participated in the Management Development Programme provided by the UN system. In the Country/Regional Results framework, in 2015, 77 per cent of P4s and P5s had attended the required management training. However, those interviewed during the field phases who had participated in the training felt that the duty of care component in the management training was not emphasized enough and should be expanded.
141. As with the other dimensions, staff interviews noted that there were few accountability mechanisms in place. Duty of care conditions related to the working environment were not usually included in job descriptions, integrated into performance review, or assessed in a 360-degree manner. The planned 360-degree reviews in the Secretary-General’s management reform plans may help in this regard.
142. The final section of the survey asked Heads and Deputy Heads of Offices to rate the significance of six factors for impeding their provision of duty of care. More than three-quarters of respondents rated each of these factors as significant or very significant barriers:
- Insufficient training on duty of care for managers: 94 per cent
 - Insufficient budget for duty of care: 85 per cent
 - Administration processes not supportive for duty of care: 85 per cent
 - Policies for duty of care are unclear: 82 per cent
 - Procurement process are not supportive for duty of care: 80 per cent
 - Roles and responsibilities for duty of care are unclear: 76 per cent
143. **Additional surveys and supplementary information:** Several other recent surveys of UN personnel provide supplementary information on the perceptions among staff regarding work environment. The supplementary data points from these UN system surveys are aligned with the patterns identified in the evaluation interviews and online survey.
- Accountability. Overall, OCHA staff showed pride in their work and a strong belief in the UN’s values, yet only 39 per cent of OCHA respondents believed there were consequences for non-adherence to these values.⁵²
 - Protection when Reporting Grievances. Whereas 79 per cent claimed to know how to report unethical behaviour or wrongdoing, less than half of the respondents across the UN believed

[51] Devex (9 May 2017). Push to reform parental leave gains speed at UN. Retrieved from <https://www.devex.com/news/push-to-reform-parental-leave-gains-speed-at-un-90092> (accessed 5 April 2018).

[52] OCHA (June 2016) OCHA Functional Review – Organizational Culture Survey: Results Overview. The response rate was about 50 per cent of OCHA personnel.

that misconduct could be reported without retaliation.⁵³ Although low for the whole system, this percentage was still higher than the percentage of OCHA respondents who felt that they would be protected from retaliation (27 per cent).

- c. **Harassment.** In OCHA, on average, respondents in the UN system surveys neither agreed nor disagreed that their work environment was free from harassment or abuse of authority.⁵⁴ This correlates with the patterns in the online survey where a significant plurality (35 per cent) reported experiencing or witnessing harassment.
- d. **Stress.** OCHA staff in this evaluation's survey reported significantly lower levels of wellbeing and perceived fair and equitable treatment compared to the UN personnel in general from the UN staff satisfaction surveys. Across the UN, 63 per cent felt they were able to maintain a healthy work-life balance (OCHA personnel were at 33 per cent), and 24 per cent of all UN personnel experienced unacceptable levels of job stress (much less than the 45 per cent reported in OCHA's online survey for this evaluation).
- e. **Equitable Treatment and Diversity.** In UN System surveys, 83 per cent of respondents answered favourably to the question of whether staff of diverse racial, cultural and religious backgrounds were respected in the UN,⁵⁵ and 72 per cent believed that men and women were treated equally in the workplace (compared to 41 per cent in OCHA's online survey for this evaluation).⁵⁶

5 Conclusions

5.1 Cross-Cutting Themes

144. **Conclusion 1.** Recognizing the importance of the HLCM Duty of Care Task Force, it will be necessary to better define what duty of care means for OCHA in order to contribute to the overall discussion and develop a duty of care framework to address the most pressing concerns for personnel. In the absence of a duty of care definition and agreed framework, there is, with the partial exception of security risk management, a lack of clarity regarding accountability and responsibility for implementing actions related to duty of care. There is a need for greater delineation of responsibilities within the organization at different levels and clearer mechanisms for accountability. This is particularly pressing for high-risk environments and deep-field postings. These gaps in guidance, policies, and induction have particularly profound effects for the delivery of duty of care for national staff and women.
145. **Conclusion 2.** Some duty of care concerns relate to OCHA's position within the Secretariat requiring administrative support provision from the Secretariat but having operational needs beyond those of most other UN Secretariat entities. This ambiguity between structures and mandate can impede the organization in providing adequate duty of care to its personnel. In addition, in some high-risk environments, the interpretation of OCHA's humanitarian mandate for neutrality can create reluctance to fully use peacekeeping mission resources because of perceived compromised humanitarian principles. This can affect personnel's access to resources that affect duty of care considerations. Although OCHA could invoke special measures for duty of care consideration, it has not used these special measures, including for duty of care conditions.
146. **Conclusion 3.** OCHA must strengthen its accountability framework for duty of care, clearly define the responsibilities at different levels and provide clearer mechanisms for accountability. There is limited articulation of senior managers' responsibilities for delivery of duty of care. This spans the organization, but is particularly critical at the level of Heads and Deputy Heads of Office in high-

[53] United Nations (February 2018) United Nations Staff Engagement Survey: UN Secretariat Survey Results. The response rate was 39 per cent across the UN and about 28 per cent for OCHA.

[54] United Nations Staff Unions (2017) United Nations Unions Global Staff Satisfaction Survey 2017. Retrieved from <https://www.unfsu.org/global-staff-survey-2017-results/> (4 April 2018). Only 105 OCHA personnel responded to this survey for a response rate of about 5 per cent.

[55] The UN survey and the online survey asked slightly different questions here regarding gender treatment. The UN survey asked if diversity was "respected" (83%) while the OCHA online survey asked if people from different ethnicities "could advance" (27%).

[56] United Nations (February 2018) United Nations Staff Engagement Survey: UN Secretariat Survey Results.

risk environments. Managers receive minimal induction on the expected roles and responsibilities for duty of care towards staff and few guidance documents or manuals exist to provide them with the appropriate knowledge of expectations, protocols or processes related to duty of care. This has resulted in a patchwork of responses dependent on the discretion and interest of the Head of Office. When managers do not receive sufficient guidance and accountability support, it can lead to the creation of a field culture that under-prioritizes duty of care considerations – especially in high-risk environments and deep-field postings. To get the support the managers need, accountability mechanisms also must be in place for all those engaged in supporting duty of care issues including administration (HR, finance and procurement). In addition, it is important for these policies and frameworks to be shared with all staff to provide a common and shared understanding for duty of care provision.

5.2 Security

147. **Conclusion 4.** Security as a dimension has a more centralized policy system and a clearer articulation of roles and responsibilities compared to other dimensions of duty of care. The most pressing security concerns appear within the context of high-risk environments. The current support from UNDSS is not sufficient to cover OCHA's security needs, adversely affecting and creating gaps in OCHA's duty of care to its personnel.
148. **Conclusion 5.** OCHA national staff have additional security needs distinct from national staff in other Secretariat entities in high-risk environments. But the level of security support is often not commensurate with these extra duties. In some high-risk environments or deeply conservative cultures, insufficient attention is often given to the extra gender considerations for security.
149. **Conclusion 6.** The provision of armoured vehicles and personal protective equipment was not generally cited as a major gap by field staff though there have been cases where equipment was inadequate. The concerns over AVs and PPE related more to the standard processes of the Secretariat which would include OCHA's use of DFS systems contracts. Managers were reported as often not being aware of the implications of the systems and processes for procurement or lacked the necessary permissions and delegated authorities provided to enable OCHA to use the right service providers depending on the context. The lack of awareness and permissions can lead to both extensive delays and to the supplying of equipment that is perceived to be of lower quality.

5.3 Staff Health and Welfare

150. **Conclusion 7.** The HR support provided by UNOG is not fit for purpose to respond to the particularities of OCHA HR needs. This leads to two separate challenges. First, the automated system and lack of identified focal points for handling cases creates a situation where field staff increasingly feel like they are dealing with an anonymous and unaccountable HR system which makes it difficult to track progress of how their concerns are being handled. There is also lack of a monitoring mechanism within OCHA for proactively tracking personnel movements and for proactive case management in general, which creates high risk for frustration and burnout, as well as unintentional discriminatory outcomes in terms of staff distribution across offices and categories. Currently, a case review committee convenes for security-related incidents but there is no ongoing tracking of psychosocial or other trauma incidents.
151. **Conclusion 8.** Staff health and welfare considerations are especially prominent in high-risk environments. In many ways, national staff face the same difficulties that international staff face – especially when posted in duty stations away from their homes – but without the welfare provisions enjoyed on international contracts (e.g. leave provisions, R&R and mental health support). High-risk environments often lack healthcare providers including hospitals, clinics, doctors and pharmacies with an agreement with Cigna, the insurance company. This severely limits national staff members' access to healthcare – especially considering that their travel to a location with better healthcare is not covered.

152. **Conclusion 9.** Psychosocial support receives few resources and it is therefore difficult to address needs in a proactive, strategic or appropriate manner. This has led to the evolution of a system of psychosocial support that is less proactive in mitigation measures, limited to reactive responses to critical incidents and with little access to outsourced resources which limits the appropriateness of the services for staff.
153. **Conclusion 10.** Accommodation (office and personal) is one of the elements of concern cited by OCHA personnel in high-risk environments. There exists a perception in countries with peace operations that OCHA's needs are not prioritized leading to sub-optimal conditions. In other operational contexts, there is a general concern that many deep-field locations do not meet minimum standards and pose long-term health and burnout risks.
154. **Conclusion 11.** Procedures around critical incidents do exist but those affected by critical incidents often require holistic support from incident to resolution which are not met by the current structures and systems. The amount of resources available to support personnel, and the sometimes-isolated communication between medical, HR, psychosocial and administration services at field and HQ offices frequently results in slow and inadequate responses. In addition, the segregation of relevant departments obscures a clear understanding of the range of resources available to them.

5.4 Working Environment

155. **Conclusion 12.** There is a consistent pattern of responses from staff that the mechanisms for addressing harassment in any form including sexual harassment, discrimination or abuse of authority in the workplace are insufficient – especially with respect to induction, guidance, and accountability processes. Staff in interviews and in the survey expressed a lack of confidence that persons filing complaints or grievances would be protected from retaliation or that appropriate action would be taken as a result.
156. **Conclusion 13.** The current OCHA duty of care practices are not appropriately gender-sensitive nor consider the specific concerns of women working in deeply conservative cultures, high-risk environments or emergency contexts. Living within a peacekeeping mission culture in extreme environments creates a heightened state of anxiety and puts OCHA personnel – especially women – at greater risk.

6 Recommendations

157. The Change Implementation processes and in particular the People Strategy are already implementing a wide range of actions intended to promote an enhanced duty of care environment even as this evaluation was being conducted. The following recommendations, some of which are already being considered within the frame of these ongoing initiatives, are intended to affirm existing processes and to complement or strengthen ongoing duty of care activities.
158. The recommendations are divided into four sections: a) overall approach to duty of care; b) security; c) staff health and welfare; and, d) working environment. Each section begins with a summary rationale for the included recommendations. Some recommendations require a set of interconnected steps for achievement, which are categorized as sub-recommendations. The recommendations are prioritized with the terminology used by OIOS (Critical, Important, Opportunity for Improvement). However, in the course of enhancing duty of care, some steps need to be taken before others can happen. For this reason, the terms also reference sequential considerations. 'Critical' would imply addressing these issues within the next six months. 'Important' would imply addressing issues over the course of 12 months, and 'Opportunity for Improvement' within the next 18 months. Many of these recommendations contains a large number of sub-steps and components that need to be implemented to achieve the overall recommendation. A more detailed description of the individual components in each recommendation and actions are found in Annex 6.

6.1 Overall Approach to Duty of Care

159. **Rationale:** OCHA needs to strengthen a systematic approach to duty of care that is comprehensive and integrated. This approach would include the establishment of **accountability mechanisms** which would include a definition of **standards**, and a clarification of **roles and responsibilities**.

Table 2: Recommendations for Overall Approach to Duty of Care

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
1	<p>Drawing on the existing Secretariat policies and the work of HLCM Task Force, and linked to the People Strategy, OCHA should develop a duty of care framework. The framework plan should:</p> <ul style="list-style-type: none"> • Operationalize a definition of duty of care that enables OCHA to interpret the existing HLCM definition • Include a statement on how the organization will manage and minimize the risks to the physical and psychological health, safety and security of its personnel • Outline the minimum standards in the different areas of duty of care such as security management, staff welfare and entitlements, health support, wellbeing and a working environment free from harassment (or refer to existing UN or Secretariat standards) • Establish responsibilities for duty of care, including for ensuring a respectful work environment, as part of the job descriptions of senior management for the USG/ERC, ASG/DERC, specified directors, branch chiefs, and all Heads of Offices and their deputies. Duty of care responsibilities will need to be incorporated into the performance management system. <ul style="list-style-type: none"> - USG/ERC: Responsibility for representing duty of care issues for the humanitarian community at the highest levels of the UN and addressing key issues of principle at the higher levels of the Secretariat. - ASG/DERC: Responsibility for overall duty of care management within OCHA. - HCs: Should be considered as a resource to Heads of Office in assessing the OCHA duty of care delivery and to ensure overall duty of care in the humanitarian community. - Managers: Those responsible for personnel in high-risk environments which may include: OAD, Director of the Coordination Division (for surge), the Executive Office, specified HQ staff and HOOs and Deputies. 	Critical	USG/ASG with EMC, OAD and SPEGS	<p>Overview par. 85-87, Security par. 95, Staff Health and Welfare par. 111, Working Environment par. 149</p> <p>Security par. 101-102, Staff Health and Welfare par. 110-111, 124. Working Environment par. 149-153, 155, 158-163</p>

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
1a	As part of the duty of care framework, and under the auspices of the OCHA People Strategy and Management Committee, OCHA should integrate into the organizational workplan elements pertaining to duty of care . Specifically, field offices in High-Risk Environments should have in their annual work plans a section related to duty of care which identifies measures to meet basic standards of security, accommodation (office and living), medical provision and administration processes including leave management. Progress in the implementation of the annual work plans' components related to duty of care should be reported twice a year to the People Strategy and Management Committee.	Critical	ASG with Change Implementation Team and SPEGS	Current duty of care context par. 59-62, 65. Security par. 95-97, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-136, 139,144, Working Environment par. 149, 155-157, 158, 162-163
1b	OCHA should also collect concerns on duty of care when conducting regular staff engagement surveys and follow up with a report on actions taken in response to the survey. This should be integrated into the annual reporting on duty of care.	Opportunity for Improvement	ASG with EO or SPEGS	
2	Personnel at all levels need to be more involved in the provision of duty of care. At HQ level, the People Strategy and Management (PS&M) Committee should either establish a sub-group to review and develop the annual duty of care workplan, or hold twice-annual meetings dedicated to duty of care. At field level, country and regional offices should either establish a working group that meets regularly to review and contribute to the duty of care workplan or existing groups should hold twice-annual meetings dedicated to duty of care.	Important	ASG with PS&M Committee, OAD and HOOs	Current duty of care context par. 59-62, 65. Security par. 95-97, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-136, 139,144, Working Environment par. 149, 155-157, 158, 162-163

Recommendations and Sub-Recommendations		Priority	Responsible	Links to Report
3	OCHA should draw on the best practices of duty of care systems from other organizations to improve guidance, training and awareness raising on duty of care considerations, especially for managers, including a respectful work environment free from harassment.	Important	ASG with PS&M Committee, OAD and HOOs	Current duty of care context par. 59-62, 65. Security par. 95-97, 101-102. Staff Health and Welfare par. 115-117, 119-120, 124, 135-136, 139,144, Working Environment par. 149, 155-158, 158, 162-163
3a	Create internal policy documents such as SOPs and guidance , and accompanying training materials for guidance, including on duty of care responsibilities of managers. All duty of care-related SOPs, guidance and other information should be available in one place, e.g., a page on OCHA's intranet. The OAD Security Advisors could be important resources for the development of the necessary guidance, training and awareness raising.	Important	USG/ASG with EO and SPEGS	Current duty of care context par. 59-62, 66, Staff Health and Welfare par. 116, 123-124, 132, 134, 141, 144, Working Environment par. 152-154, 162-165. Annex 7, Annex 8
3b	Staff induction should integrate duty of care modules with descriptions of rights and responsibilities. Specific induction modules on duty of care should also be provided to managers to discharge their responsibilities. The OAD Security Advisors could be important resources for the development of the necessary guidance, training and awareness raising.	Important	EO	
3c	Consideration should be given to incorporating duty of care discussions and briefings into the annual Heads of Offices meeting and Global Management Retreat and provide staff involved with the duty of care appropriate policy guidelines and documents.	Important	OAD	

6.2 Security

160. Rationale: OCHA's role and work requires that it works predominantly in high-risk environments and is extensively involved in deep field operations. This creates a different set of security requirements beyond the current capacity and resources of the Secretariat systems in UNDSS to support. Adjustments to protocols should be made to ensure better attention to high-risk environments and national staff.

Table 3: Recommendations for Security

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
4	In specific high-risk environments with a large OCHA presence, OCHA should ensure the provision of a <i>dedicated international security officer, supported by a local security assistant.</i>	Critical	OAD	Security par. 97-99
5	OCHA should undertake a corporate review with relevant stakeholders (UNDP, DM) to determine what <i>additional measures can be put in place for national staff</i> to enhance their security support, to address their increased risks resulting from inadequate accommodation, to travel to and from work, to travel in deep-field operations, to assess their work and leave arrangements, and to support their health and well-being needs. Heads of Offices will need to consider appropriate working modalities that help to mitigate these security risks.	Important	EO, OAD and HOO	Security par. 95-97
6	6a OCHA should carry out a <i>review of procurement-related processes</i> which apply to accommodation, security and communications equipment to make them more efficient, faster and more attuned to field needs. This should include the issuance of guidance and checklists and securing permission and/or delegating authority for the use of the most effective options for service provision, given contexts, so that relevant staff, including Heads of Offices, are better informed about and engaged in options, required processes, focal points and obligations.	Important	EO	Security par. 106-109
	6b OCHA should review sister agency processes and suppliers to identify best placed suppliers and standards to be utilities and OCHA should <i>ensure that it has consistent, easy and quick access to UN system contracts</i> to procure security equipment, in particular armoured vehicles, of the required quality.	Important	EO and OAD	

6.3 Staff Health and Welfare

161. Rationale: The recommendations cover the five major themes raised in the findings related to staff welfare: a) an impersonal approach to the administration; b) the overuse of temporary job openings (TJOs); c) living and working conditions and accommodation; d) medical support; and, e) lack of effective case management for critical incidents and other HR considerations. The recommendations focus on establishing a case management process and a more proactive oversight for accessing quality medical and psychosocial provision.

Table 4: Recommendations for Staff Health and Welfare

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
7	<p>Linked to the People Strategy, and as part of the OCHA Duty of Care framework, OCHA should develop a policy on a case management process for staff. This should include:</p> <ul style="list-style-type: none"> - a systematic case management system with a broader mandate to include not only those affected by critical incidents, but also those affected by burnout, prolonged periods in extreme hardship postings and those suffering from a debilitating sickness - a standard definition for what constitutes a critical case and a typology of incidents that require this type of case management support - the appointment of a staff member with sufficient authority to manage critical case processes, including any fast-track procedures that may be required - quarterly dedicated discussions in People Strategy and Management Committee meetings to review critical cases and to ensure that appropriate actions have been taken both in OCHA and by external parties. 	Critical	OAD (Security Advisors), PS&M Committee and EO	Staff Health and Welfare par. 131-134, 136, 139-144
8	<p>Building on the existing tracking efforts among OAD section chiefs, OCHA should institute a more systematic and transparent process for tracking and reviewing the periods of duty undertaken by both national staff and international staff in hardship and in particular deep-field hardship locations (while maintaining staff confidentiality) and periodically report to senior management. Taking into account budget implications or contextual sensitivities, Heads of Offices and their deputies should be encouraged to be proactive in considering rotation of staff, especially national staff, amongst sub-offices and main offices that are more or less severe when feasible.</p>	Critical	EO	Staff Health and Welfare par. 135-139

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
9	OCHA should develop processes for the regular assessment of work and leave arrangements of staff in high-risk environments to accommodate their security challenges and to support their health and well-being.	Important	HOO	Security par. 96 Staff Health and Welfare par. 131-132, 147
10	OCHA should appoint a dedicated officer to provide oversight of OCHA's property portfolios – particularly office space, but also housing when staff live in guesthouses or compounds. The property officer would proactively promote a common premises approach for both accommodation and office space in high-risk environments and develop a work plan with objectives to increase the numbers of staff living in accommodation that reach minimum standards. Particular attention should be paid to additional issues of harassment that affect women and the gender aspects of duty of care.	Critical	OAD (Security Advisors), EO	Security par. 102 Staff Health and Welfare par. 138-140
11	As an issue of priority, OCHA should discuss the management of the Cigna contract with UN Medical Services to improve the claims processes including online tracking of claims, and in high-risk environments, to ensure that Cigna services are accessible and that more recognized medical providers are available especially for the needs of national staff.	Critical	EO with DM	Staff health and Welfare par. 133-135, 144, 147 Annex 6
11a	OCHA should adapt the recommendations from the HLCM Task Force to incorporate national staff's access to health, medical referral and medevac services in capital cities or neighbouring countries for the treatment of chronic illnesses and regular medical checks. This may require altering contract agreement phrasing with medical services or UNDP contracts used by OCHA.	Critical	EO with DM	
11b	OCHA should develop mandatory SOPs on medical and insurance issues that ensure the appropriate HR administration of medical insurance (to reduce gaps) and outline the reporting requirements, enabling staff to submit and track their claims and ensuring swift responses to longstanding medical conditions such as PTSD.	Important	EO and DM	

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
12	OCHA should establish a proactive and strategic approach to the development of a psychosocial support system , particularly in high-risk environments and for staff recognized as working in a highly stressful environment, e.g. in surge capacity. As part of this strategic approach, OCHA should review its own practices and approaches (including procedures for appropriate leaves to enable access) to align with the UN Mental Health Strategy currently being finalized. The approach should prioritize offices where support is most needed and provide input to the People Strategy on the issues where psychosocial support is required.	Critical	EO	Staff Health and Welfare par. 145-148
12a	The OCHA psychosocial staff should ensure that all country offices have guidance on outsourced mental health and psychosocial support services that can be accessed locally, and medical insurance to facilitate this.	Critical	EO	
13	For security and critical incident cases, security-related procurement and other duty of care-related administrative requests, a special fast-track should be created in OCHA – with agreements from DM including OHRM – to ensure priority is given to addressing this issue. For HR issues, this special track should include a case-designated HR focal point assigned to each critical incident case as stated in the People Strategy. A single HR case manager at a senior and authority level should support the case from initiation to completion with the authority and capacity to take the necessary actions. This would include (but not be limited to) administration of insurance, medical, pay and entitlements, claims and compensation support, liaison with medical providers, accommodation, medical and psychosocial support, leave and travel arrangements, and role transition.	Critical	EO	Staff Health and Welfare par. 139-148

6.4 Working Environment

162. Rationale: In a number of field operations, OCHA works within a background culture that is male-dominated and militarized with poor cultural sensitivity, and where there is a risk of accepting a more abusive culture. In combination with high-stress environments, this can create a pathology of abuse or harassment in the workplace. Currently, there are inadequate processes to deal with the issues arising from this internal and external culture. Recommendations relate to establishing or strengthening mechanisms for addressing and mitigating abuse.

Table 5: Recommendations for Working Environment

Recommendations and Sub-Recommendations		Priority	Responsible	Links in Report
14	OCHA should actively promote a culture of respectful communication that builds on the online courses and trainings provided by the Secretariat.	Critical	PS&M Committee and EO	Working Environment par. 153-158, 162
14a	This should include a strong training component , constituting of the following: <ul style="list-style-type: none"> - Integrate a respectful communication module into staff induction and ensure the completion of mandatory online trainings on this issue - Develop additional staff training opportunities on topics such as stress management, resilience and self-awareness, equality and diversity 	Important	EO	
14b	In annual retreats – country, regional and global – include a refresher topic on harassment and workplace communication.	Opportunity for Improvement	HOO and USG/ASG	
14c	In management training for Heads of Offices, strengthen the module on respectful communication.	Critical	EO	
15	OCHA should develop a detailed internal guidance note to managers and staff describing the process to handle cases in response to allegations of sexual misconduct and abuse. This process should prioritize the need for timely response and the importance of ensuring protection from retaliation, establish a mechanism for sanctions, outline support available for victims, and mechanisms to support those who are the subject of allegations – particularly in instances where allegations are proved to be false.	Critical	EO	Working Environment par. 149-152, 156-161

	Recommendations and Sub-Recommendations	Priority	Responsible	Links in Report
16	In high-risk environments, there are additional issues concerning <i>harassment that affect women</i> and OCHA should operationalize the gender aspects of duty of care in these contexts by providing appropriate accommodation standards, special trainings, contextualized policies, and special procedures for women's personal safety and security while operating in high-risk environments.	Critical	EO and OAD	Security par. 89-90 Working environment par. 136, 138, 145