

## Human resources: update

### Report by the Secretariat

1. This document provides an update on the human resources funded by the Global Polio Eradication Initiative (see Annex<sup>1</sup>), as requested by the Programme, Budget and Administration Committee of the Executive Board in its report to the Sixty-sixth World Health Assembly.<sup>2</sup>
2. An update on the workforce data for the period from 1 January to 31 July 2016 is available on the WHO website.<sup>3</sup>
3. The Secretariat has also prepared an update on the implementation of the Organization-wide human resources strategy,<sup>4</sup> which was noted by the Executive Board in January 2014.<sup>5</sup> This update, available on the WHO website,<sup>6</sup> recapitulates all the activities that have been undertaken for the period from January 2014 to October 2016 in a table that follows the three main pillars of the strategy (attracting talent, retaining talent – career management, and an enabling working environment) and the four cross-cutting principles (gender balance, diversity, collaboration, and accountability). In addition, an update on the human resources performance metrics of the WHO reform can be found in the WHO reform dashboard.<sup>7</sup>

### ACTION BY THE EXECUTIVE BOARD

4. The Board is invited to note the report.

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<sup>1</sup> See also document EB140/13.

<sup>2</sup> Document A66/60.

<sup>3</sup> See the document entitled “Human resources: workforce data (from 1 January to 31 July 2016)”, available at: <http://www.who.int/about/finances-accountability/budget/en/> (accessed 17 October 2016).

<sup>4</sup> Revised human resources strategy, document EB134/INF/2.

<sup>5</sup> See document EB134/2014/REC/2, summary record of the eleventh meeting, section 3, pp. 205–206.

<sup>6</sup> [http://www.who.int/about/who\\_reform/managerial/en/](http://www.who.int/about/who_reform/managerial/en/) (accessed 2 November 2016).

<sup>7</sup> [http://spapps.who.int/WHOREform/SitePages/View\\_PerformanceMetrics.aspx](http://spapps.who.int/WHOREform/SitePages/View_PerformanceMetrics.aspx) (accessed 17 October 2016).

## ANNEX

### WHO'S HUMAN RESOURCES FUNDED BY THE GLOBAL POLIO ERADICATION INITIATIVE – AN UPDATE

1. Following discussions in the Executive Board, an independent study was conducted in 2013 to gain a complete understanding of WHO's component of the human resources infrastructure funded by the Global Polio Eradication Initiative and the associated financial liabilities.<sup>1</sup> The Board's Programme, Budget and Administration Committee requested that future human resources reports should include an update on the situation, and the first such report was duly noted by the Health Assembly.<sup>2</sup>
2. In response to the sixth annual report of the Independent Expert Oversight Advisory Committee,<sup>3</sup> a new independent study was undertaken in September 2016 to provide specifically: an updated overview of the human resources at WHO funded by the Global Polio Eradication Initiative, highlighting major changes and trends since 2013; an updated projection of the financial liabilities under different scenarios; and recommended priorities to reduce liabilities and enhance polio-related human resource planning.
3. Recent developments in transition planning for the Global Polio Eradication Initiative and the main findings of the new independent study are set out in the following paragraphs.

#### PROGRESS IN TRANSITION MANAGEMENT

4. Several initiatives have been implemented since 2013 with the objective of further defining the post-eradication transition plan and limiting the scale of potential liabilities:
  - WHO's polio programme has had to increase the number of staff to implement simultaneously and successfully all four objectives of the Polio Eradication and Endgame Strategic Plan (2013–2018); however, it has also substantially increased the use of temporary contracts, thus ensuring enhanced flexibility of the human resources structure and minimizing additional liabilities.
  - A contingency fund to cover separation costs has been set up and US\$ 20 million have already been set aside (it is expected that a total of US\$ 40 million will be set aside within three years).
  - Budget targets for the period 2016–2019 provided to all regional offices include decreases for 2017–2019 in order to facilitate and advance human resources planning.

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<sup>1</sup> See documents EB132/2013/REC/2, summary record of the fifteenth meeting, section 1 ([http://apps.who.int/gb/ebwha/pdf\\_files/EB132-REC2/B132\\_REC2-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB132-REC2/B132_REC2-en.pdf), accessed 17 October 2016) and A67/47, Annex.

<sup>2</sup> See documents A66/60 and WHA67/2014/REC/3, summary record of the second meeting of Committee B, section 4 ([http://apps.who.int/gb/ebwha/pdf\\_files/WHA67-REC3/A67\\_REC3-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA67-REC3/A67_REC3-en.pdf), accessed 17 October 2016).

<sup>3</sup> See document EBPBAC24/2 ([http://apps.who.int/gb/pbac/pdf\\_files/pbac24/PBAC24\\_2-en.pdf](http://apps.who.int/gb/pbac/pdf_files/pbac24/PBAC24_2-en.pdf), accessed 19 October 2016).

- A WHO-wide Post-Polio Transition Planning Steering Committee has been established in order to ensure common understanding at all levels of the Secretariat of the significant programmatic, organizational and financial risks associated with the decreasing budgets and eventual closure of the Global Polio Eradication Initiative; to identify mitigating factors; and to consider the potential integration of functions and resources of polio eradication work into other programmes (for example, emergencies, immunization and health systems/universal health coverage).
- Transition guidelines have been provided to the 16 priority countries that account for more than 90% of Initiative-funded assets and which have been identified for fast-track development of national post-eradication transition plans. These countries are being supported and their progress monitored by the Secretariat at headquarters and regional levels.<sup>1</sup>
- The Polio Strategy Committee of the Global Polio Eradication Initiative has initiated the development of a post-certification strategy to define the essential polio-related functions that will need to be sustained post-certification in order to maintain a polio-free world.

## **MAPPING OF HUMAN RESOURCES FINANCED FROM GLOBAL POLIO ERADICATION INITIATIVE FUNDS (AS AT AUGUST 2016)**

5. In close collaboration with the Secretariat, from August to September 2016, the independent study team collected and analysed data from the Global Management System, and refined them on the basis of inputs received from focal points in headquarters and the regional offices for Africa, South-East Asia and the Eastern Mediterranean.

### **Overall composition of the WHO polio-funded workforce**

6. There are 1325 WHO staff positions funded through the Global Polio Eradication Initiative, of which 1112 are currently filled.<sup>2</sup> Highlights of the overall composition include:

- the 1112 filled positions cost US\$ 97.3 million annually;
- most staff (826, 74%) are in the African Region, followed by the Eastern Mediterranean Region (14%), headquarters (7%) and the South-East Asia Region (4%) (Appendix 1);
- within filled positions, 24% of staff are women and 94 nationalities are represented, with just four nationalities accounting for about half the total staff (Angola, Democratic Republic of the Congo, Ethiopia and Nigeria);

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<sup>1</sup> Polio legacy planning: guidelines for preparing a transition plan, revised 1 June 2015, available at: <http://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf> (accessed 17 October 2016).

<sup>2</sup> Source for all staff data: Global Management System database, mid-August 2016. Data are changing continuously and a further refinement of the baseline with each Regional Office's human resource department is ongoing (for the regional offices for Africa, South-East Asia and the Eastern Mediterranean).

- most WHO staff funded by the Global Polio Eradication Initiative (56%) work in operations support,<sup>1</sup> the rest on immunization and surveillance activities (23%), technical support (19%) and coordination of activities (2%). The mix of roles does not appear to be correlated to the polio status of the country;
- staff contracts are divided between temporary (20%) and longer-term (fixed-term and continuing appointments, 80%).

7. Many personnel working on polio eradication have non-staff contracts,<sup>2</sup> particularly in the African, South-East Asia and Eastern Mediterranean regions:<sup>3</sup>

- the number of non-staff contracts in the Eastern Mediterranean Region has doubled since 2013, from 1172<sup>4</sup> to 2352, with the increase largely driven by surveillance and immunization roles in Pakistan;
- the African Region identified 2752 non-staff contracts, up from 2449<sup>5</sup> in 2013, driven mainly by growth in Nigeria.

8. However, the current analysis has focused on workforce holding staff contracts as it represents the most significant driver for liabilities and human resources planning.

### Evolution of polio-funded staff since 2013

9. The number of WHO staff funded by the Global Polio Eradication Initiative has grown by 10% (about 100 positions) since the most recent study in 2013. The reasons for the increase globally between 2013 and 2016 are:

- the continued support to Objective 1 of the Polio Eradication and Endgame Strategic Plan (2013–2018): detect and interrupt poliovirus transmission – for example the strengthening of country offices in the countries endemic for poliomyelitis (Pakistan, Afghanistan and Nigeria), and the build-up of the regional centre for health emergencies and polio eradication in Amman for Eastern Mediterranean countries, in particular to respond to the multicountry outbreak of poliomyelitis in the Middle East in 2014;
- the simultaneous increase in focus on Objectives 2, 3 and 4 of the Polio Eradication and Endgame Strategic Plan: global withdrawal of type 2 component in oral polio vaccine and strengthening immunization systems, poliovirus containment and certification, transition planning – for example, by strengthening and adding functions at headquarters to coordinate

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<sup>1</sup> Drivers and administrative staff (e.g. finance, human resources and information technology).

<sup>2</sup> Non-staff contracts include: agreements for performance of work, special services agreements and local individual contractor agreements.

<sup>3</sup> Data on non-staff contracts are collected from focal points in regional offices' human resources teams; data for the South-East Asia Region are not presented as they are still being collected.

<sup>4</sup> Data for South Sudan were excluded from the data for the Eastern Mediterranean Region also in 2013 to allow comparability; for that reason the total figures for the Region differ from those in the 2013 report.

<sup>5</sup> Non-staff data for South Sudan are not included in the data for the African Region for 2013 in order to allow comparability: nor are they included in the data for 2016 as they are not available.

the global withdrawal of vaccines containing the type 2 component and introduction of inactivated poliovirus vaccine, additional staff to increase containment capabilities, and enhanced administrative support for the governance structures of the Global Polio Eradication Initiative.

10. Since 2013, 45% of the new positions created and filled have been occupied by temporary contracts, increasing the overall flexibility of staff contracts. The share of temporary contracts is now 20% of the total (up from 11% in 2013).

### **Reliance on the Global Polio Eradication Initiative's funds in regions and countries**

11. The degree of reliance on the Global Polio Eradication Initiative's funds varies by region: the African Region has the highest share of such-funded staff as a percentage of their total staff (31%), followed by the Eastern Mediterranean Region (15%) and the South-East Asia Region (6%).

12. The reliance of the African Region has decreased (down from 37% in 2013), although actual numbers of staff in the Region funded by the Global Polio Eradication Initiative have not fallen significantly (the decreased reliance comes from an increase in the overall headcount of staff in the Region). In the Eastern Mediterranean Region, the degree of reliance has increased (up from 11% in 2013), whereas in the South-East Asia Region it has remained stable.

13. Countries that rely the most on the Global Polio Eradication Initiative's funding include Angola, Chad, the Democratic Republic of the Congo, Niger and Nigeria; in these countries more than 50% of staff are funded with polio-specific funds. Additionally, there are countries that have been polio-free for more than 10 years which still have 20% to 50% of all staff positions in the country office supported by funding from the Global Polio Eradication Initiative (e.g. South Africa, United Republic of Tanzania and Zambia).

14. Of country office staff funded by the Global Polio Eradication Initiative, 43% are currently located in countries that have had no wild poliovirus in the past four years.<sup>1</sup> This proportion is significantly higher than in 2013, owing mainly to an increase in the number of polio-free countries since then.

### **FINANCIAL LIABILITIES ASSOCIATED WITH WHO'S STAFF FINANCED WITH FUNDS OF THE GLOBAL POLIO ERADICATION INITIATIVE**

15. For the updated study, analyses of the terminal indemnity costs were based on scenarios used in the previous study of 2013 and a new "more likely" scenario based on new information.

#### **Updated maximum indemnity forecast**

16. Based on the worst case scenario developed in 2013, updated maximum indemnity costs upon programme closure in 2019 associated with current staff<sup>2</sup> positions are estimated to be

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<sup>1</sup> Last isolation of wild poliovirus before or during 2012.

<sup>2</sup> Staff positions as per the current baseline analysis, with data from mid-August 2016; non-staff contracts could potentially generate expenses at the end of the Initiative (estimated up to US\$ 7–10 million, depending on data for the South-East Asia Region), but can be fully managed through synchronization of contracts and duration of the eradication work.

US\$ 109 million. This estimated figure does not represent a significant change from the 2013 estimate (US\$ 105 million) despite the increase in the number of staff by 10%, mainly because of:

- the increased flexibility of contracts, which reduces potential liability in the worst case scenario by US\$ 4 million compared to a scenario where the share of temporary contracts would have stayed the same as in 2013;
- the strengthening of the US dollar against local currencies; at a constant exchange rate indemnities would have been US\$ 9 million higher in the worst case scenario.<sup>1</sup>

### New indemnity forecast

17. A more detailed indemnity forecast was made in this study that allows for manageable mitigating measures and a progressive decrease of resources in the period 2017–2019 (information that was not available in 2013). The new forecast gives an estimate of US\$ 55 million in indemnity payments over three years (Appendix 2).<sup>2</sup> Key elements of this scenario include:

- the assumption that the programme will close at the end of 2019 and resources will fall in line with the Global Polio Eradication Initiative Financial Resources Requirements document<sup>3</sup> for 2016–2019; it requires the regional offices to adapt their budget for 2017, initiate the decrease and include the proposed fall in the budgets in their submission for the Proposed programme budget 2018–2019;<sup>4</sup>
- partial synchronization of contract end dates with programme closure and the possibility of reassigning some international Professional-grade staff on longer-term contracts;<sup>5</sup>
- the indemnity cost is spread across the intervening years to programme closure (US\$ 6 million in 2017, US\$ 7 million in 2018 and US\$ 42 million in 2019);
- the budget decline affects the programme running costs for personnel, and represents cumulative savings in 2017–2019 of more than US\$ 60 million;
- the largest share of liabilities is associated with the African Region (73% of the total);

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<sup>1</sup> It includes the effect of updated salary scales and post adjustments. Other major factors affecting the change in indemnity cost are “systemic” factors such as: changes in human resources rules and better data available in the systems.

<sup>2</sup> Based on current Staff Rules; if a change in policy is approved that postpones the retirement age to 65 years, the indemnity cost would be US\$ 3–4 million higher.

<sup>3</sup> Global Polio Eradication Initiative Financial Resources Requirement for 2016–2019, Annex E ([http://polioeradication.org/wp-content/uploads/2016/07/FRR2013-2019\\_April2016\\_EN\\_A4.pdf](http://polioeradication.org/wp-content/uploads/2016/07/FRR2013-2019_April2016_EN_A4.pdf), accessed 19 October 2016).

<sup>4</sup> On the assumption that the number of staff decreases at the same rate as the budget for the technical assistance category as in Annex E of the Financial Resources Requirement for 2016–2019; with respect to budget decrease compiled in May 2016, the estimate assumes a delay by one year of decline for the five countries of the Lake Chad subregion.

<sup>5</sup> The main assumptions used are: 75% of temporary contracts can be synchronized to the end of the programme, longer-term contracts can be synchronized in 50% of the cases as of 2018 (no synchronization is possible in 2017 given that the lead time required is 9–12 months in advance); 25% of international Professional-grade staff can be reassigned; retirements do not generate terminal indemnity costs (assumption may change in case retirement age is postponed to 65 years).

- staff holding continuing and fixed-term appointments contribute 93% of the total indemnity cost.

## **WHO'S PRIORITIES TO REDUCE LIABILITIES AND ENHANCE POLIO-RELATED HUMAN RESOURCE PLANNING**

18. Based on the current independent analysis and the outcomes of the meetings of WHO's Post-Polio Transition Planning Steering Committee, the following next steps have been identified for urgent implementation (in the next 2–3 months).

### **Human resource management**

19. An ad hoc human resource planning working group, with representation from headquarters and relevant regional offices, has been established to plan for, and proactively manage, the eradication programme's human resources in order to reduce indemnity exposure.

20. Further to collaboration between the working group and the Department of Polio Eradication in the Secretariat, the following new measures will be taken to oversee closely and review decisions about staff funded by the Global Polio Eradication Initiative:

- introduction of a monthly dashboard for review by Director, Polio Eradication and Director, Human Resources, which highlights upcoming contract expirations and retirements across WHO's programme, and new positions, to enable better planning and readjustment of resourcing levels (for instance, to give advance notice as needed, to ensure that retirees are replaced by staff with more flexible contracts only where necessary, and to ensure that budget decreases are being respected);
- proactive management of vacancies, with review of existing vacancies to eliminate unnecessary positions and limits to further increases in the staff size;
- introduction of tools to enhance oversight and tracking of non-staff contracts given their importance for polio transition planning – currently, access to non-staff data relies on manual collection from procurement system at country or regional level;
- engagement with the programme area network in the Secretariat to identify crucial polio-funded functions that could be integrated into other programmes, to assess and maximize opportunities for internal reassignments for international Professional-grade staff impacted by the polio transition, and to facilitate retention of skilled staff.

21. Additional new measures are also being considered and will be further evaluated in the next few months. These are:

- introduction of a review and approval process by Director, Polio Eradication (with regular updates to the ad hoc human resources working group) for all new longer-term<sup>1</sup> contracts being considered globally using Global Polio Eradication Initiative funds, and, additionally,

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<sup>1</sup> Fixed-term and continuing appointments.

for all new proposed such-funded positions (including any filled by temporary contracts) created at headquarters and in the European and Western Pacific regions;

- review of functions/teams that are currently in high-cost locations, and potentially consider different locations with lower post adjustment to minimize operating and ultimately indemnity costs.

### **Budget management**

22. WHO's Polio Eradication Department is working closely with regional offices and the Department of Planning, Resource Coordination and Performance Monitoring to ensure that the lowered polio budget targets for 2017–2019 are accurately reflected in regional and headquarters submissions for the Proposed programme budget 2018–2019.

23. Given that 43% of the staff funded by the Global Polio Eradication Initiative are located in countries that have been polio-free for several years, headquarters will work with regional offices to review the budgets of low-risk polio-free countries and explore opportunities to accelerate human resources planning; linking resource allocation processes to countries' polio status and risks will help to reduce indemnity costs.

24. Given that many country offices and other health programmes rely heavily on staff funded by the Global Polio Eradication Initiative and its resources, the Post-Polio Transition Planning Steering Committee has called for a “consequence analysis” within critical country offices and health initiatives in order to understand the impact of the loss of staff funded by the Global Polio Eradication Initiative and associated resources after its closure, and help clearly to identify and develop core capacity requirements.



## Appendix 1

**DISTRIBUTION OF STAFF ACROSS REGIONS AND EVOLUTION SINCE 2013**

WHO staff headcount totalling about 1110 occupied positions

WHO's polio-funded personnel  
(staff-occupied positions<sup>a</sup> only)

## Observations

Office/Region	Headcount		
	2013	2016	Δ 2013–2016
Headquarters	50	77	+54%
African	837	826	-1%
South-East Asia	41	39	-5%
Eastern Mediterranean	76	155	+104%
European and Western Pacific	10	15	+50%
<b>Total</b>	<b>1014</b>	<b>1112</b>	<b>+10%</b>

- The polio programme has personnel across multiple regions.
- Most are in the African, South-East Asian and Eastern Mediterranean regions; of these regions, the African Region has the largest proportion.
- However, the European and Western Pacific regions still have Global Polio Eradication Initiative-funded staff and the number has increased since 2013.
- In the past three years, the increase was mainly driven by growth in:
  - headquarters: increased administrative support, increased support to Department of Immunization, Vaccine and Biologicals for the polio vaccine switch, and additional staff across functions, particularly to increase containment capabilities (e.g., data unit and research);
  - Jordan: build-up of Regional Office staff in Amman (although there was no significant change in Regional Office staffing);
  - increase in country office staff in endemic and transition countries (Pakistan, Afghanistan and Nigeria).

<sup>a</sup> Including new positions

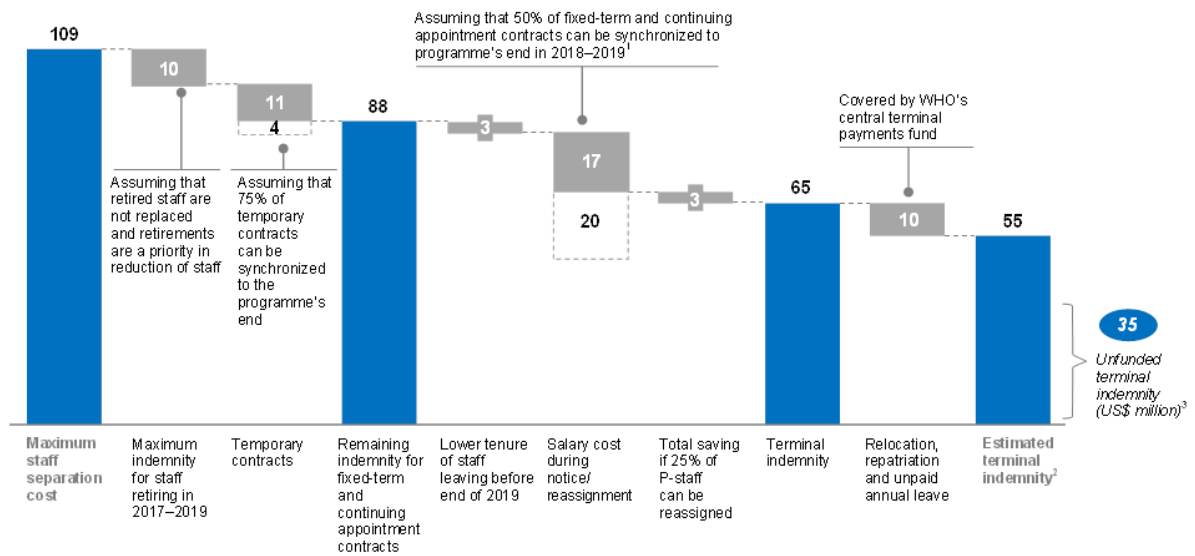
Source: WHO Global Management System August 2016, Global Polio Eradication Initiative human resources map, August 2013.

Appendix 2

**MAXIMUM AND “PLANNED” SCENARIOS FOR INDEMNITY EXPOSURE ESTIMATE**

Evolution from maximum estimated terminal indemnity to scenario with proactive planning and progressive decreases

US\$ million, 2016 estimate for separation costs by end of 2019



<sup>1</sup> No synchronization assumed in 2017.

<sup>2</sup> Of which, US\$ 6 million in 2017, US\$ 7 million in 2018, US\$ 42 million in 2019. Based on current human resources rules; if a change in policy is approved that postpones the retirement age to 65 years, the indemnity cost would be US\$ 3–4 million higher.

<sup>3</sup> US\$ 20 million have already been set aside for terminal indemnity.

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