World Health Organization

Seventy-ninth World Health Assembly

Provisional agenda item 18.14 A79/21 Add.1

8 May 2026

Human resources: annual report

WHO's prioritization and realignment process in 2025–2026

Report by the Director-General

Introduction

1. This report provides an overview of the WHO prioritization and realignment process undertaken in 2025 and to date in 2026, including its implications for the Organization's projected staffing.[1] The figures provided are preliminary and a provisional projection of WHO's future Organizational shape as of 30 June 2026, based on preliminary data received from all major offices as of 13 March 2026; it should be noted that the prioritization and realignment process is ongoing. The report covers:

- elements of the prioritization and realignment process (section 1);
- outcomes of the prioritization and realignment process (section 2);
- WHO's projected composition of staff as of 30 June 2026 (section 3); and
- use of the Programme Support Costs fund balances related to the prioritization and realignment process (section 4).

Proposed action by the Health Assembly is given in paragraph 55.

[1] This report is presented as an exceptional contribution to ensure that the Executive Board and governing bodies are provided with sound and timely information, recognizing that the current situation requires an exception to the standard reporting modalities set out in WHO documents EB136/6, paragraph 9, and EB154/33 Add.1, paragraph 22.

1. Elements of the prioritization and realignment process

Process initiation

2. In February 2025, following deliberations among Member States in response to evolving global and financial pressures, the Executive Board recommended reducing the proposed budget for the 2026–2027 biennium from US$5.3 billion to US$4.9 billion. A subsequent reduction to US$4.2 billion was recommended based on the Secretariat's further assessment of the financing landscape, which was approved by the Seventy-eighth World Health Assembly, culminating in a 21% reduction from the original proposed budget. To operate within the reduced budget while preserving WHO's core mandate, the Secretariat undertook a strategic prioritization and realignment process to define essential functions and align financial and human resources accordingly.

3. As previously reported,[2] the Secretariat introduced early mitigation measures to proactively reduce the risk of overreliance on a narrow donor base. At the Seventy-fifth World Health Assembly in 2022, Member States agreed to gradually increase their assessed contributions to represent 50% of WHO's core budget by the 2030–2031 budget cycle.[3] Furthermore, the Secretariat has proactively pursued efficiency measures, including by leaving vacancies unfilled and reducing costs in anticipation of funding shocks.

4. In alignment with recommendations to reflect Member States' priorities and the recent country prioritization process, the Secretariat initiated a prioritization and realignment exercise to place WHO on a sustainable financial trajectory for 2026–2027 and beyond. With Member States' endorsement, the Programme Support Cost fund was deployed to cover indemnities and salary gaps for technical activities through 30 June 2026, ensuring continuity during the process and transition.

Guiding considerations

5. The Secretariat outlined a distinct methodology, operating on three foundational considerations to guide the design and implementation of the prioritization and alignment process:

(a) The prioritization of programmatic priorities, roles and responsibilities, was guided by a refocusing on WHO's core mandate. The Secretariat initiated a thorough review of all deliverables against the Proposed programme budget 2026–2027 (which is aligned with the Fourteenth General Programme of Work (GPW 14), 2025–2028) in order to determine what to sustain and strengthen, what to scale down or stop, and where to improve efficiency and impact. This resulted in the allocation of budget envelopes to all budget centres in every major office, covering both human resources and non-staff costs, which were considered when designing the new Organizational structures.

[2] The Secretariat implementation plan on reform (document A77/28) details actions to enhance performance, strengthen budgetary and financial processes and improve accountability. It explicitly references efficiency measures, alignment with Member State priorities and steps to address financial fragility. The Director-General and Secretariat have provided regular updates to Member States through dedicated information sessions.

[3] See decision WHA75(8) (2022), Annex 4, paragraph 39(e).

(b) Organizational realignment activities were implemented in accordance with the approved budget envelopes and applied comprehensively across all three levels of the Organization.

(c) The design of the human resources process was anchored in three core principles: transparency, fairness and humanity.

- Transparency was ensured through regular communication, inclusive dialogue, and clear, traceable methodologies and decisions.
- Fairness was realized by applying consistent and equitable standards across all levels of the Organization.
- Humanity was fundamental in acknowledging the personal and emotional impact of Organizational change, emphasizing empathy throughout the planning, communication and implementation stages. The Secretariat honours colleagues whose service concluded during this period and recognizes the additional responsibilities carried by those who remain.

Implementation of the prioritization and realignment process

6. The scope of the review included positions financed by the base budget, as this segment was most affected by the 2025 funding cuts. It covered all Organizational levels – headquarters, regional offices and country offices – and included all job categories and grades, from Professional staff to General Service staff. All contract types were considered: continuing, fixed-term and temporary.[4] The prioritization and realignment process was conducted in four phases, as set out below.

Phase 1: Structure definition

7. A high-level and detailed Organizational design exercise started by defining a new headquarters structure, restructured from 11 to six divisions and from 67 to 36 departments, by identifying significant opportunities for synergies through mergers, and then subsequently consolidating units, teams and positions to create a more efficient structure. This resulted in a substantially leaner leadership team (reduced by 50%). As part of the new core structure, division heads and a significantly reduced number of directors were appointed to prepare future Organizational structures for their respective divisions and departments, including position descriptions aligned with prioritized activities and approved budgetary envelopes. Each major office conducted the same prioritization exercise, setting out future Organizational structures to initiate the realignment process outlined in the next phase.

Phase 2: Mapping and matching realignment exercise

8. A mapping and matching realignment exercise began once the organigramme and associated human resources plan for a given level (division, department or unit/team) had been approved by the Director-General for headquarters and by the regional directors for their respective major offices. Individuals were then either: (a) unmapped/unmatched; or

[4] Temporary appointments were excluded from the mapping and matching phase as they were separately reviewed.

(b) mapped/matched to positions based on role alignment with their current functions.[5] This process was applied to all staff in active service holding continuing appointments or fixed-term appointments.

9. Each division/regional office convened an ad hoc review committee[6] to review all mapping and matching proposals. Those meetings included an independent member and a Staff Association representative. Beyond the committee work throughout the mapping and matching phase, staff members were invited to direct any concerns to a transparency and fairness committee established in each major office. Once ad hoc review committee reports were signed by all committee members (including the Staff Association representative) and approved by the Director-General or Regional Director, a structured 1:1 communication process was launched to inform impacted staff of the outcomes.

Phase 3: Individual communications

10. Individual meetings were conducted with staff members who had not been mapped or matched to a position, or where their position was relocated to another duty station.

Phase 4: Reassignment process

11. Reassignment committees were activated for those who were not mapped or matched to a position in the new structure yet were eligible for the formal reassignment process.[7] These individuals were supported in identifying suitable vacancies across the Organization during the reassignment period, in accordance with Staff Rule 1050. The reassignment process has been centrally managed by headquarters for international staff and by major offices for local staff. It was designed to last up to six months, during which eligible staff received support in finding suitable vacancies across the Organization. This step has been finalized and impacted staff are entering their final separation period, leading to the conclusion of the process.

Staff engagement and support throughout the process

12. The Staff Associations were systematically consulted throughout the process, from process development to implementation. Staff Association representatives were full members in ad hoc review committees, transparency and fairness committees, and local and global reassignment committees. Leadership engaged in regular meetings throughout the year with the Staff

[5] "Mapping" means that staff holding continuing or fixed-term appointments and encumbering positions that are not changing, or with less than 50% change, were considered for the positions identified for "mapping"; "matching" means that staff holding continuing or fixed-term appointments, and encumbering positions that were changed by 50% or more, were considered for the positions identified for "matching".

[6] Ad hoc review committees comprised the following: the division head, a human resources specialist; a Staff Association representative (not from the same division); an independent member from another division; and a management/administrative officer acting as Secretary.

[7] Staff members were eligible for the formal reassignment process if they met the criteria outlined in Staff Regulation 1050.2, specifically, if they held a continuing appointment or held a fixed-term appointment with at least 10 years of continuous, uninterrupted and certified satisfactory service.

Associations.[8] A total of 30 weekly newsletters have been released, sharing milestones, upcoming events, support services and the top FAQs received from staff. Two pulse surveys were organized to establish feedback loops. This unprecedented level of engagement and consultations, articulated around two global and more than 25 regional town hall meetings, reflected a deliberate effort to foster communication and trust, while supporting the pace of transformation that was imposed on WHO.

13. Special measures were introduced for staff regarding parental leave, home leave, repatriation travel, shipment of household effects, settling-in grants, relocation and education grants. To minimize disruption, a voluntary early retirement package was offered; a one-month extension of notice periods for temporary appointments was provided; and a separation by mutual agreement option for earlier exits was provided. Additional arrangements for special leave without pay were implemented to maintain Staff Health Insurance (SHI) and pension coverage.

14. To support staff careers and well-being, WHO enhanced clinical and psychosocial services by introducing a staff counsellor and an occupational health physician for surge support at headquarters. Globally, respectful workplace and leadership support was expanded by holding tailored sessions to address leadership training and mental health concerns.[9] The Ombudsperson and mediation teams delivered cross-regional training on managing bias, conflict coaching, psychological safety and resilience.

15. Staff were given 24/7 confidential access to the Employee Assistance Programme, along with guidance from the United Nations System Staff Counsellors Group for leaders and teams navigating change. Counselling sessions were provided and critical guidance for directors was developed, complemented by dedicated sessions to ensure consistent implementation of the process.

16. In April 2025, WHO launched the Workforce Transition Support Hub, a single source for mental health support, career coaching and upskilling, CV and job search guidance, pensions and SHI briefings and workplace tools.[10] Three global human resources webinars were conducted on staff entitlements; internal justice; and a human resources process update for locally recruited staff at headquarters.

[8] The following meetings were convened by WHO leadership since January 2025 (as at April 2026): 38 meetings between human resources leadership and the headquarters Staff Association President; 59 meetings between human resources leadership and the headquarters Staff Association; 27 meetings between human resources leadership and the Global Executive Office of the WHO Staff Associations; nine meetings between the Director-General and the headquarters Staff Association; and five meetings between the Director-General and the Global Executive Office; plus 11 formal multi-party meetings between the headquarters Staff Association, human resources leadership, the Assistant Director-General/BOS, and the Chef de Cabinet.

[9] This included 26 sessions promoting a respectful workplace with more than 7250 participants, plus five leadership briefings reaching more than 200 leaders and supervisors. To address mental health concerns, WHO provided nine well-being webinars (more than 550 participants), 16 team sessions for HR, SHI, and other key functions, and 30 mindfulness sessions (more than 350 participants).

[10] Since its launch, the Workforce Transition Support Hub delivered 137 career transition workshops, reaching over 10 250 participants; 167 individual career counselling sessions; 21 SHI briefings (more than 2600 participants); and 26 pension briefings (more than 3100 participants); alongside over 4500 individual pension support requests.

2. Outcomes of the prioritization and realignment process

17. The outcomes of the 2025 prioritization and realignment process are framed across five key dimensions that have informed WHO's strategic orientation across major offices: "protect and enhance the core"; "scale down and stop"; "consolidate"; "collaborate"; and "digitize". Together, these dimensions reflect the Organization's commitment to safeguarding and enhancing its core mandate, streamlining and concentrating its work, and modernizing its operating model to respond to evolving global health needs. They have collectively shaped the foundation for operational planning for the 2026–2027 biennium, ensuring alignment between strategic choices, resource realities, expected deliverables and workforce requirements. They also inform WHO's engagement in broader reform processes, including preparations for the 80th anniversary of the United Nations, and they will continue to guide adaptation as the external context evolves.

18. These outcomes should be seen as part of a continuous and iterative process rather than a one-off exercise. As we move forward in this process, priorities will be further nuanced and refined through adaptive management, informed by evolving external conditions, operational learning and ongoing dialogue across the Organization.

19. The transition from strategic intent to operational delivery represents the most complex phase of this effort and requires paying sustained attention to portfolio management, change management and expectation-setting. This includes balancing the strong and diverse set of mandates and expectations provided by Member States, while supporting staff through adjustments in ways of working, sequencing of activities and the practical translation of prioritized outcomes into day-to-day delivery across all levels of the Organization.

Protect and enhance the core: safeguarding WHO's core functions and its unique mandate in the global health system

20. Protecting and enhancing the core anchored the Organization's effort to reaffirm the functions that are part of WHO's unique mandate. This encompasses: WHO's leadership in norms, standards-setting and essential global public health goods; its role in advancing universal health coverage and quality of care; its role in convening Member States and stakeholders; its core role in global health security, including International Health Regulations (2005) implementation, preparedness and response; its stewardship of data monitoring and surveillance for epidemic intelligence, burden, equity and impact; its responsibilities in the prequalification and quality assurance of vaccines, medicines and diagnostics; its role in health systems strengthening and capacity-building for sustainable financing, accountable governance, data and digital transformation; and its research and science agenda supporting the development and deployment of effective interventions.

21. To provide just a few illustrative, yet non-exhaustive examples, WHO is reinforcing its normative leadership by maintaining and updating essential global public health goods – for example through its stewardship of the International Health Regulations (2005) and its technical support for the intergovernmental Pandemic Agreement process – and by ensuring the availability of up-to-date science-based guidance for disease-specific areas and their increasing integration, including through the WHO Living and SMART Guidelines, the WHO Model List of Essential Medicines and the WHO model list of essential in vitro diagnostics.

22. In the area of global health security, WHO is preserving its capacities for early detection and coordinated response, for example through event-based surveillance systems and public health

intelligence tools to strengthen decision-making, such as through Epidemic Intelligence from Open Sources (EIOS), and is ensuring emergency preparedness and response, such as incident management structures and surge deployments.

23. WHO also maintains front-line coordination in acute emergencies, such as through its role as the United Nations' Inter-Agency Standing Committee Global Health Cluster Leader, the Global Health Emergency Corps framework, emergency medical team coordination, and facilitating critical supplies and logistics. Data collection, monitoring and surveillance continue to serve as essential global public goods, for example through standardized systems that enable comparable assessments of burden and equity within and across countries. Product quality assurance also remains a core capability, such as through WHO prequalification pathways that support access to quality-assured vaccines, medicines and diagnostics. Processes for the development of WHO guidelines and prequalification are now aligned and proceed in parallel, not in sequence, which anticipates and accelerates equitable access and updates to innovation. The first example of this was for lenacapavir, a transformative intervention against HIV.

Scale down and stop: stopping or sunsetting activities at the divisional/departmental levels against defined criteria

24. This dimension ensured that resources are focused on WHO's highest-value functions. Activities have been reduced or discontinued where they were obsolete, duplicative, better delivered by others, primarily operational/implementation in nature or of minimal strategic utility. **Where work was no longer strategically relevant, WHO has stepped back, for example by:**

- discontinuing direct scientific leadership of selected clinical trial platforms, such as tuberculosis trial platforms and multicountry newborn-health trials, while reinforcing its normative role on trial standards, ethics and inclusion;

- discontinuing selected legacy technical platforms, tools, assessments and stand-alone initiatives whose original purpose has been fulfilled, with WHO retaining a standards-setting, guidance and quality-assurance role rather than direct operational ownership; and

- rationalizing disease- or event-specific response tools developed for earlier emergencies, as capacities are integrated into more sustainable, cross-cutting preparedness and surveillance architectures.

25. **Where mandates lie more clearly with other United Nations agencies, WHO has reduced overlap, for example by:**

- scaling back Secretariat support to external multipartner United Nations mechanisms in which mandates and coordination functions are now more clearly anchored elsewhere, such as in selected inter-agency platforms and trust-based coordination structures, allowing WHO to focus on its comparative normative and technical roles; and

- clarifying lead roles in protection-adjacent or protection-linked thematic areas, with WHO stepping back from parallel delivery, while continuing to provide technical guidance and standards where health mandates remain relevant – for example, in selected areas of menstrual health, sexual and reproductive health in humanitarian settings, and related protection work now led by the United Nations Population Fund and the United Nations Children's Fund.

26. **Where other partners can deliver more effectively at scale, WHO has transitioned work, such as by:**

- handing over logistics functions to operationalize appropriate transfer of innovative technologies and support geographically diversified health product manufacturing capacity;

- transitioning selected training, learning and operational-innovation activities – including selected innovation hub initiatives (demand Catalyst and LEAD) – to the WHO Academy and WHO collaborating centres, thereby consolidating delivery while maintaining WHO stewardship over quality and normative alignment; and

- refocusing community-level or country-level implementation activities towards policy guidance, advocacy and partnership enablement, where national authorities and implementing partners are better placed to deliver at scale.

27. **Where WHO can step back, while stepping up where it must, WHO has refocused its resources as follows**:

- in acute emergencies, WHO differentiates between roles best performed through coordination and normative guidance and those best performed through direct delivery, stepping back from operational functions where countries and partners are able to lead, while stepping up its unique convening, standard-setting and operations role where gaps in knowledge are clear or emerge and no alternative capacity exists; and

- WHO's technical assistance to countries is increasingly differentiated, with more intensive engagement concentrated on priority and fragile contexts, while lighter-touch, demand-driven support, including to coordinate contributions of other partners, is applied elsewhere.

28. **Where strategic utility was limited, WHO has streamlined internal outputs, for example by**:

- streamlining or discontinuation of publishing, reporting and internal knowledge products, reducing volume and frequency (e.g., stopping non-mandated publications in the WHO Health Emergencies Programme), while safeguarding the quality and integrity of WHO's normative and flagship outputs;

- decommissioning selected in-house digital platforms, tools, apps and analytical products, where equivalent or superior solutions are available through partnerships, academic institutions or shared platforms, with WHO shifting to stewardship and validation roles; and

- reducing the number of stand-alone technical products (e.g., technical products in the areas of environment, climate change, One Health and migration), while prioritizing fewer, more integrated, higher-impact guidance outputs aligned with the GPW 14 and country demand.

29. These examples are illustrative and non-exhaustive, reflecting the application of consistent criteria across diverse technical and functional areas, while preserving WHO's core normative, convening and stewardship roles.

Consolidate: streamlining efforts across WHO to use synergies for new realities and overcome legacy structures

30. The dimension of consolidation focused on strengthening coherence and reducing fragmentation across the Organization by realigning Organizational structures and the consolidation of activities. Organizational structures have been simplified to better align related functions, for example by integrating health promotion, disease prevention and care functions into a single divisional configuration; strategically aligning core health systems, health products, antimicrobial resistance, traditional medicine and data/digital portfolios in a coherent division; consolidating surveillance and laboratory functions in the WHO Hub for Pandemic and Epidemic Intelligence in Berlin; and consolidating operations support and logistics functions in Dubai at the WHO Hub for Global Health Emergencies Logistics. Increased alignment and active use of common corporate platforms for data capture, validation, analysis and sharing across the Organization are being pursued. Regional operating models have been adapted to ensure flexibility, for example with subregional administrative hubs being replaced by regional surge capacity available for country office deployment. Finally, shared activities have been streamlined to improve efficiency, such as consolidating work on cancer at headquarters and the Regional Office for Europe in the form of selected training exercises, meetings and hub-related functions into unified delivery models.

Collaborate: leveraging WHO's convening power and increasing collaboration both internally and externally and anticipating innovation

31. This dimension strengthens the mechanisms that enable WHO to deliver effectively across a distributed health ecosystem: collaboration across WHO's three levels, United Nations-wide coordination, and ecosystem partnerships with technical institutions. Internal collaboration has been reinforced, for example, through strengthened cross-divisional, cross-regional and cross-country task forces in areas such as surveillance, digital and data, guidelines and prequalification, One Health, and finance and economics. United Nations-wide engagement has been deepened to support system-wide reform, for example through closer alignment with partners in the context of the 80th anniversary of the United Nations to clarify complementary roles and joint approaches. Ecosystem collaboration continues to strengthen and expand, such as through the diversification of WHO collaborating centres and strengthened WHO Academy platforms to meet emerging needs areas, including One Health, digital and artificial intelligence (AI), regulation, horizon scanning, ageing, multimorbidity and clinical trials, occupational health, eye health and others. In April 2026, the First Global Forum of WHO collaborating centres brought together global experts from a total of 842 institutions designated as WHO collaborating centres across more than 80 countries to strengthen scientific and technical collaboration in support of the GPW 14 and promote coordinated actions to address global health priorities.

Digitize: adopting and scaling new technologies

32. This dimension advances technology-enabled transformation through two reinforcing streams: the integration of new technologies, including AI, to support evidence synthesis and operational efficiency; and the strengthening of data quality, access and analytics to improve foresight and decision-making. New technologies are being integrated across surveillance and analytics, for example through AI-enabled workflows in early warning and situational analysis, including EIOS and collaborative data access and analysis, including the new collaboratory initiative in Berlin. Health system digital transformation strategies and blueprints help to move

disconnected analogue systems into a digital reality connecting programmes, from immunization to non-communicable disease prevention.

33. Scientific advances are also being applied in laboratory and surveillance functions, such as by using genomics and metagenomics for the earlier detection of emerging threats. Through leadership in driving interoperability standards and the hosting of global digital infrastructure, WHO is helping countries to digitally strengthen health systems for routine service delivery and emergency preparedness.

34. Corporate processes are being progressively modernized to support WHO's evolution towards becoming a more digital- and AI-enabled Organization. Beyond automating selected repetitive tasks to sustain a leaner workforce, this transformation focuses on embedding advanced digital and AI-supported capabilities into everyday work and core business operations. Corporate solutions such as Microsoft Copilot, complemented by the responsible adoption of additional large language model technologies, enhance content development, meeting and workflow management, information retrieval and real-time reporting. Use-case-driven applications further strengthen human resources, supply and procurement, programme management, donor reporting, data stewardship and multilingual translation, while user-developed and region-specific solutions respond to concrete operational needs at the country and regional levels.

35. These efforts are guided by a clear vision to build a future-ready WHO – one that anticipates the future to help to drive access to innovation, rather than reacts to it, and combines workforce upskilling with access to advanced tools, modernized technology and data architectures, and harmonized data lifecycle management and governance. Together, this will enable more informed decision-making, greater operational agility, cost-efficient delivery, and more seamless collaboration across the Organization, while safeguarding quality, accountability and trust. Data infrastructure is being strengthened, such as through the World Health Data Hub 2.0 to enhance data capture, validation, access, interoperability and analytics – thereby increasing operational efficiency and reducing duplicative costs.

36. Taken together, the five dimensions detailed in paragraphs 19 to 34 above provide a coherent framework for WHO's reorientation and operating model evolution. They underpin operational planning for 2026–2027 and beyond, clarify strategic choices within resource constraints, and provide a basis for ongoing adaptation as the external context evolves, including in the context of discussions in the global health architecture and the 80th anniversary of the United Nations.

3. WHO's projected composition of staff as of 30 June 2026

Overall impact on the Organization

37. Since the beginning of 2025, WHO has pursued a deliberate and balanced approach to the prioritization and realignment process, underpinned by a range of preventive workforce measures. Through comprehensive workforce planning – including natural attrition, retirements, and voluntary early retirement arrangements – the Organization was able to manage workforce adjustments in a measured manner, resulting in 1275 voluntary separations across WHO. In parallel, the increase in assessed contributions enabled the preservation of approximately 600 posts. Taken together, these efforts have allowed the Organization to mitigate the overall impact of the realignment process, while proceeding with 1232 post abolitions.

38. The primary objective throughout this process was to safeguard the core functions of the Organization and align financial and human resources accordingly, while minimizing separations to the greatest degree possible. Overall, through this approach, approximately 51% of all global separations were managed through preventive measures, while the remaining 49% of separations between January 2025 and June 2026 required termination.

39. In practice, preventive measures involved sequencing actions to avoid forced reductions and implementing measures such as the voluntary early retirement package with enhanced financial terms and transition support; non-replacement of vacated positions; and leveraging broader natural attrition, including the expiration of fixed-term contracts and retirements. By prioritizing these levers first, WHO aimed to achieve the required efficiencies while reducing uncertainty, preserving morale and maintaining operational continuity.

40. Nevertheless, preventive measures alone were not sufficient to fully realign the Organization with its new operational and financial realities. Consequently, WHO had to complement these efforts with more active separation measures, applied carefully and only as a last resort, to ensure sustainability and continuity. Additional measures included separation by mutual agreement to enable early exits under mutually agreed conditions, as well as an extended one-month notice period for temporary staff. All actions were implemented with a strong emphasis on fairness, transparency and support for affected staff, in deliberate efforts to balance Organizational needs with the commitment to minimizing disruption, wherever possible. In the context of prevailing financial uncertainty, the Organization is taking further preventive steps to maintain a level of contractual and budgetary flexibility, while continuing to work with Member States to increase assessed contributions in the 2027–2029 and the 2029–2031 bienniums.

Guidelines on data

41. The following section provides provisional projections of WHO's headcount as of 30 June 2026, based on preliminary data received from all major offices before or on 13 March 2026. These projections reflect the ongoing restructuring of WHO's human resources and separations associated with the 2025 prioritization and realignment process. In particular, the following considerations apply.

- Included in this data, in line with annual human resources reports, are the following: programme budget positions and non-programme budget positions; the Business Management System; all special programmes; hosted partnerships; and secondments. It includes the following appointment types: fixed-term; continuing; temporary under Staff Rule 420.4; temporary of 60 days or less.

- Excluded from this data, in line with annual human resources reports, are the following: short-term translators, revisers, editors and précis-writers; and short-term Conference interpreters; as well as Unitaid.

- The data for headquarters consistently includes the headcount related to Global Shared Services. Please note that in May 2025, the Indonesia Country Office was transferred from the South-East Asia Region to the Western Pacific Region. As a result, the 74 staff members recorded as at 1 January 2025 are included in the Western Pacific Region figures for comparison with January 2025 levels. They are also reflected under the Western Pacific Region in the 2026 projections, in line with the current human resources database.

- Staff members whose nationalities are classified as stateless are listed under “Others”. Only absolute figures of projected headcount by nationality are provided; no analysis of underrepresentation or overrepresentation has been conducted at this juncture, given the expected variances until 30 June 2026. These aspects will be addressed in the next human resources report, which will be presented to the Executive Board in 2027, based on actual data.

- The projected data refers to the 30 June 2026 at 24:00 in order to reflect all final separations that will be effective in the system as of that time.

- All comparisons reported in terms of “from” and “to” in the following section regarding the evolution of staff distribution are made against the human resources database as of 1 January 2025.

- All age data reflect staff members’ ages as at 1 July 2026 to ensure comparability. The grades are derived from the WHO human resources database. The grades as at 1 January 2025 are based on the actual data from that date; the grades as of 30 June 2026 are based on the latest data available, i.e. 13 March 2026.

- Percentages may not add up due to rounding.

- Please note that the figures on regional representation are based on the comprehensive data set used for the analysis presented here, as outlined above. This data set includes seconded staff and staff working in partnerships. Therefore, it may not be directly comparable to the previous human resources update as at 31 December 2024. For reference, we have included regional and national representation data as at 1 January 2025, using the same baseline applied for 30 June 2026 to ensure the consistency of comparisons.

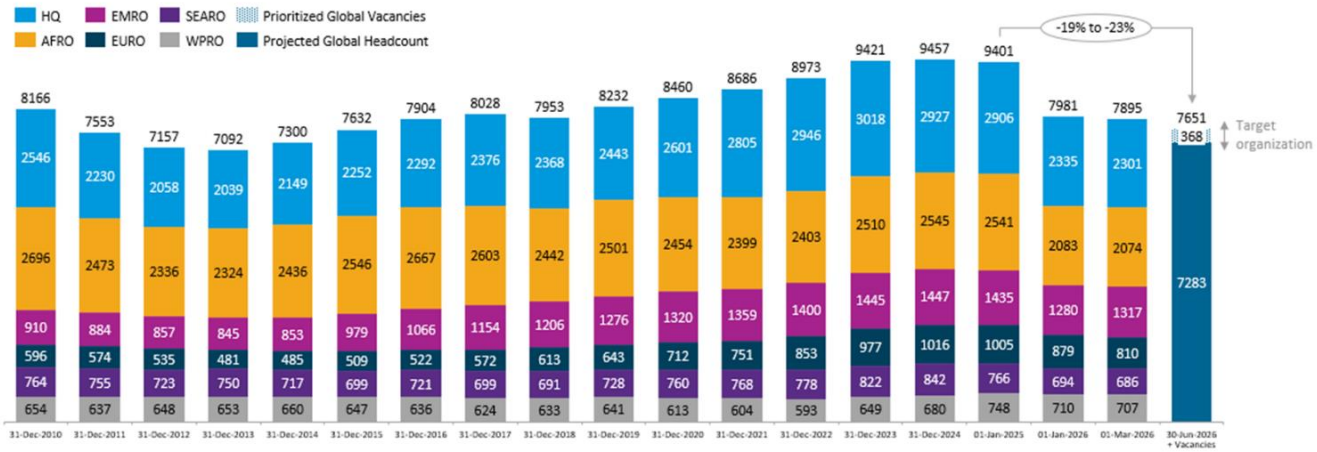
Projected composition of WHO staff as of 30 June 2026

Global

Projected global staff

42. By 30 June 2026, the number of WHO’s global staff is projected to reach 7283 – a 23% reduction compared to the number of global staff as at 1 January 2025 (9401) – based on remaining staff members. It should be noted that approximately 368 additional vacant positions are being prioritized. If these prioritized vacant positions were filled, the headcount by June 2026 would be about 7651, representing a 19% reduction from January 2025 levels. Overall, this reduction (-23% to -19%) reflects a strategic shift towards a leaner, more agile Organization, better equipped to respond rapidly to emerging health challenges, allocate resources where they have the greatest impact, and reinforce WHO’s leadership in an evolving global health landscape (Fig. 1).

Fig. 1. Evolution of global headcount from 2010 to 2026: historic headcount evolution, projected and provisional global headcount as of 30 June 2026, indicating a range based on the level of vacancies to be filled



Projected global staff, by major office

43. WHO's global staff is strategically distributed across its major offices, with the following projections: headquarters and Global Shared Services are expected to account for 2066 staff members, representing the most significant staff reduction (29%) compared to January 2025 levels of 2906. The second largest major office, the Regional Office for Africa, is projected to decrease staff by 25%, from 2541 to 1904. The Regional Office for Europe will reduce its staff by 26%, from 1005 to 745. The Regional Office for the Eastern Mediterranean is expected to reduce its staff by 14%, from 1435 to 1239, while the Regional Office for South-East Asia will also reduce its staff by 16%, from 766 to 646, excluding Indonesia. The Regional Office for the Western Pacific is projected to reduce its staff by 9%, from 748 to 683, including the Indonesia Country Office (Fig. 2).

44. When examining the overall composition of global staff by major office, headquarters and Global Shared Services will account for 28.4% of total global staff, a reduction of 2.5 percentage points from 30.9% in January 2025. The Regional Office for Africa remains the second largest major office, at 26.1% compared to 27.0% in 2025. The third largest major office is the Regional Office for the Eastern Mediterranean, with 17.0% compared to 15.3% in 2025. The Regional Office for Europe follows, with 10.2%, down slightly from 10.7%. The Regional Office for the Western Pacific will represent 9.4% of global staff by January 2026, compared to 7.2% in 2025 – the largest increase, of 2.3 percentage points. The Regional Office for South-East Asia remains the same as previously, at 8.9% (Fig. 3).

Fig. 2. Global headcount projections, by major office: headcount reduction by major office (net impact; % of total headcount reduction; projected major office % of global staff (percentages may not sum to 100% due to rounding)

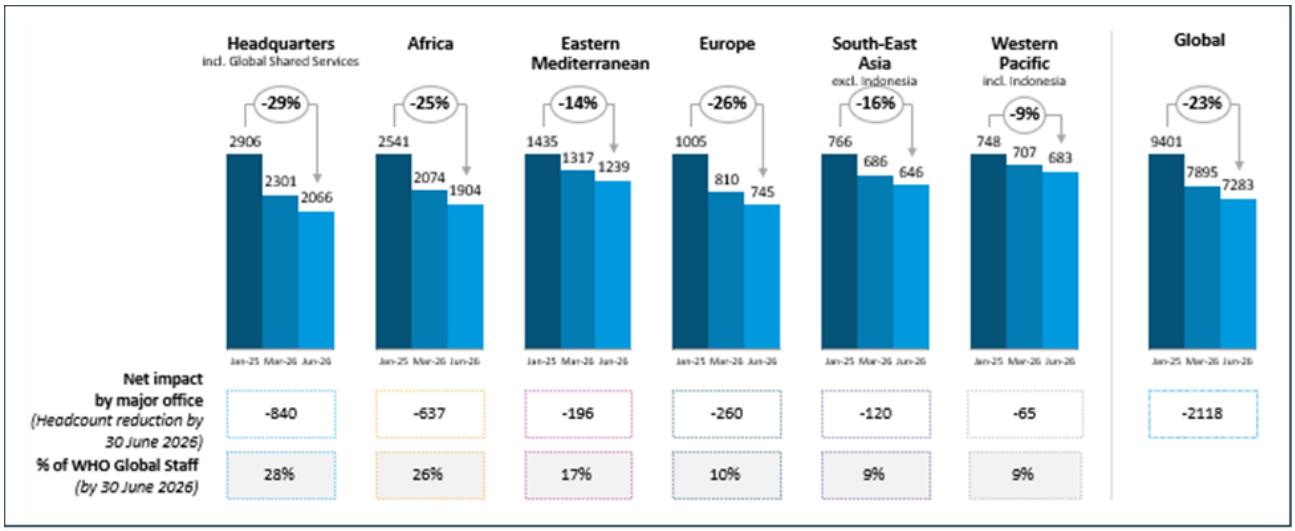
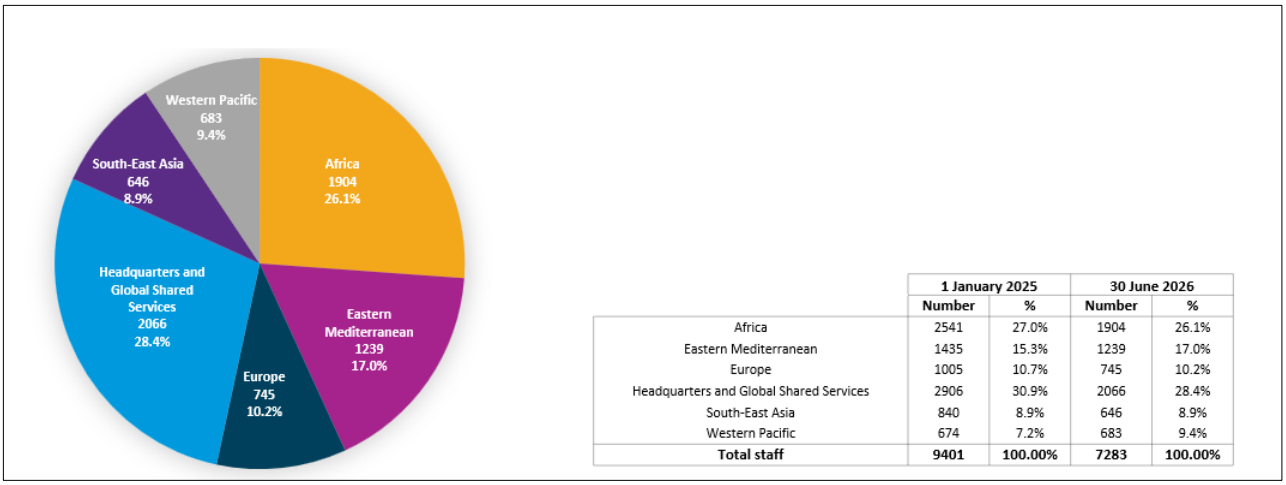


Fig. 3. Preliminary, projected distribution of WHO staff as of 30 June 2026, by major office (percentages may not sum to 100% due to rounding)

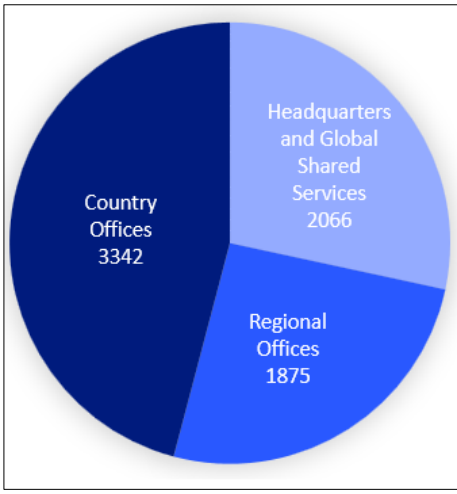


	1 January 2025		30 June 2026	
	Number	%	Number	%
Africa	2541	27.0%	1904	26.1%
Eastern Mediterranean	1435	15.3%	1239	17.0%
Europe	1005	10.7%	745	10.2%
Headquarters and Global Shared Services	2906	30.9%	2066	28.4%
South-East Asia	840	8.9%	646	8.9%
Western Pacific	674	7.2%	683	9.4%
Total staff	**9401**	**100.00%**	**7283**	**100.00%**

Projected distribution of global staff, by level

45. By 30 June 2026, the projected distribution of staff across WHO levels is expected to be 45.9% in country offices (+1.2 percentage points compared to January 2025), 25.7% in regional offices (+1.3 points), and 28.4% at headquarters and Global Shared Services (-2.5 points). This aligns with the objective set at the start of the transformation to rebuild a leaner headquarters while limiting the impact on country-level delivery (Fig. 4).

Fig. 4. Preliminary, projected distribution of WHO staff as of 30 June 2026, by level (percentages may not sum to 100% due to rounding)



	1 January 2025		30 June 2026	
	Number	%	Number	%
Headquarters and Global Shared Services	2906	30.9%	2066	28.4%
Regional offices	2293	24.4%	1875	25.7%
Country offices	4202	44.7%	3342	45.9%
Total	9401	100.00%	7283	100.00%

Projected distribution of global staff, by appointment type

46. The projected total number of global staff holding long-term appointments is 6129, representing 84.2% of the total projected workforce, up from 79.1% in January 2025. Of these, 3897 (53.5%) hold fixed-term appointments, while 2232 (30.6%) hold continuing appointments. The projected number of staff on temporary appointments is 1154 (15.8% of the total, compared to 20.9% in 2025), including 1149 temporary appointments under Staff Rule 420.4 and 5 temporary appointments of 60 days or less.

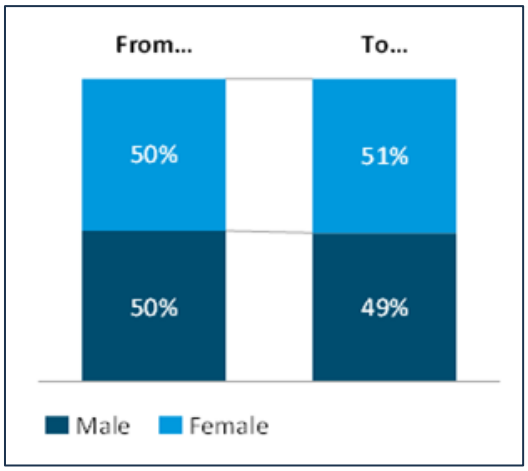
Projected distribution of global staff, by job category

47. The projected global distribution of staff by job category across all locations is as follows: staff in the Professional and higher categories are expected to constitute approximately 41.3% (+0.23 percentage points compared to 2025) of the total workforce, National Professional Officers will represent about 17.4% (-0.16 percentage points), and General Service staff about 41.3% (+0.39 percentage points).

Projected distribution of global staff, by gender

48. Gender parity remained a priority throughout the realignment process. As of June 2026, projections indicate a total of 3696 female staff and 3587 male staff, representing a 50.7% female and a 49.3% male total workforce – which represents a slight increase of 0.6 percentage points in the proportion of female staff members compared to January 2025 levels (Fig. 5).

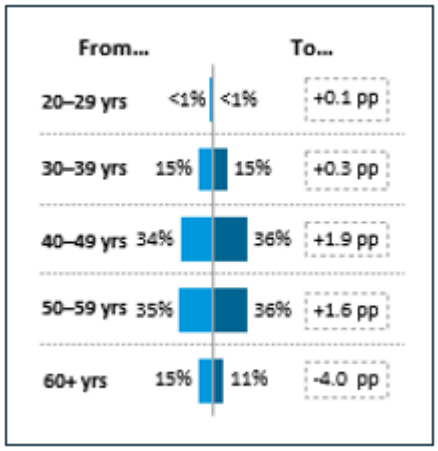
Fig. 5. Evolution of Organizational composition, by gender (percentages may not sum to 100% due to rounding)



Projected distribution of global staff, by age

49. The age profile reflects a subtle but meaningful shift towards a younger workforce. The highest staff distribution remains in the 40–49 and 50–59 age groups, while the over-60 age group has experienced the most significant decline. Across key age brackets: 20–29 years account for 0.6% (+0.1 percentage points), 30–39 years for 15.1% (+0.3 percentage points), 40–49 years for 36.4% (+1.9 percentage points), 50–59 years for 36.5% (+1.6 percentage points), 60+ years for 11.4% (-4.0 percentage points) of the global workforce (Fig. 6).

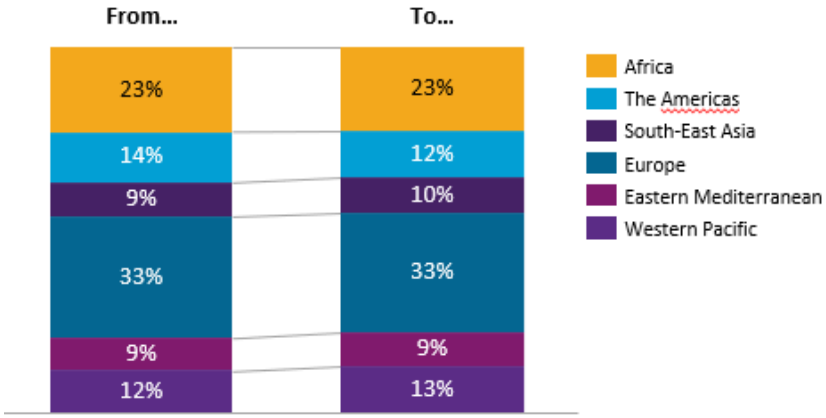
Fig. 6. Evolution of age distribution across the global Organization (percentages may not sum to 100% due to rounding)



Projected regional representation of global staff

50. The composition of regional representation across the Organization has remained largely stable compared to January 2025, reflecting continuity in regional diversity. Among Professional and higher-level staff, the Regional Offices for Africa, Europe and the Eastern Mediterranean remain at the same levels, at 23%, 33% and 9%, respectively, while the Regional Offices for the Western Pacific and South-East Asia have each increased by 1% to reach 13% and 10%, respectively. The Regional Office for the Americas shows a slight decrease, from 14% to 12%. A "from … to" comparison between January 2025 and January 2026 levels is given in Fig. 7.

Fig. 7. Evolution of regional representation among Professional and higher staff (percentages may not sum to 100% due to rounding)



4. Use of the Programme Support Costs fund balances related to the prioritization and realignment process

51. At the Seventy-eighth World Health Assembly, Member States decided to partially suspend Financial Regulation VIII, 8.2, on a temporary basis to allow for the Programme Support Costs fund balances to be used to reimburse expenses beyond indirect costs up to a maximum amount of US$ 410 million, to cover the indemnity costs and salaries needed to ensure the financial sustainability of the Organization.[11]

52. To date, the projected utilization of the Programme Support Costs fund balances stands at US$ 206.2 million (approximately 50%). The Secretariat has sought to minimize reliance on reserves through the prioritization of non-invasive workforce measures, including natural attrition and voluntary early retirement, which together accounted for approximately 51% of total separations and did not require the payment of indemnities. This lower than originally projected utilization reflects a prudent approach to the prioritization and realignment process.

53. These measures were complemented by the implementation of cost-containment efforts across the Organization, including efficiencies in travel and procurement. Moreover, additional voluntary contributions also helped to reduce the initial financing gaps.

54. Collectively, these actions have contributed to partially offsetting the projected salary gap, thereby reducing the overall drawdown on Programme Support Costs fund balances, while maintaining operational continuity during the transition period.

Items	Technical functions (US$ million)	Comment
2025 salary gap coverage	134.9	Actual
2025 indemnities	3.3	Actual
2025 indemnities (provisional)	40.0	Estimate
2026–2027 salary costs of separating staff members	28.0	Estimate
Total	**206.2**	

[11] Decision WHA78(18) (2025).

Action by the Health Assembly

55. The Health Assembly is invited to note the report and provide guidance on the steps to be taken following the prioritization and realignment process.