Charles University

Faculty of Social Sciences

Institute of Political Studies

Countries' Representation in Professional Staff of the World Health Organization

Master's thesis

Author: Eliška Slámková
Study programme: International Relations
Supervisor: Dr. rer. pol. Michal Parízek, M.Sc., Ph.D.
Year of the defence: 2021

Declaration

I hereby declare that I have compiled this thesis using the listed literature and resources only.

I hereby declare that my thesis has not been used to gain any other academic title.

I fully agree to my work being used for study and scientific purposes.

In Prague on 30th April 2021   Eliska Slámková

References

SLÁMKOVÁ, Eliška. Countries' Representation in Professional Staff of the World Health Organization. Praha, 2021. 58 pages. Master's thesis (Mgr.). Charles University, Faculty of Social Sciences, Institute of Political Sciences. Supervisor Dr. rer. pol. Michal Parízek, M.Sc., Ph.D.

Length of the thesis: 97 431 characters

Abstract

My thesis is focused on the composition and countries' representation in the professional staff of the World Health Organization. The thesis will analyse the overrepresentation and underrepresentation of the WHO's member states and explain possible patterns in the staff. The thesis will focus on the relationship between the number of Member State's professional staff in the WHO and the state's GDP growth, expenditure on education and population size. My thesis aims to research the characteristics of staff's composition in the WHO. I will analyse professional staff structure and apply the Principal-Agent theoretical framework. The research will show how the state's representation of member states changed over time and see also the gender composition of the Secretariat. The timeline of this work is from 1999 till 2019. The thesis works with official documents from human resources of the WHO and datasets of the World Bank. Analysis of data is provided by the statistical programme SPSS and Microsoft Excel.

Abstrakt

Má diplomová práce se zaměřuje na složení a zastoupení zemí ve vysokých profesionálních pozicích ve Světové zdravotnické organizaci. V mé diplomové práci budu analyzovat, které členské sáty jsou nad-reprezentovány, a které naopak pod-reprezentovány. Zároveň budu analyzovat personální strukturu této organizace a zaměřím se na podobnosti států, které jsou nejvíce zastoupeny. Cílem mé práce je prozkoumat vlastnosti složení zaměstnanců ve WHO. Budu analyzovat profesionální strukturu zaměstnanců a aplikuji teoretický rámec Principal-Agent. Výzkum ukáže, jak se v průběhu času měnilo zastoupení zaměstnanců členských států ve Světové zdravotnické organizaci. Zároveň se zaměřím na složení mužů a žen v této organizaci. Časová osa této práce je od roku 1999 do roku 2019. Práce pracuje s oficiálními dokumenty z oblasti lidských zdrojů WHO a datovými soubory Světové banky. Analýza dat byla provedena za pomocí statistického programu SPSS a programu Microsoft Excel.

Key words

World Health Organization, representation, professional staff, principal-agent theory, correlation coefficients, regression analysis

Klíčová slova

Světová zdravotnická organizace, reprezentace, profesionální zastoupení, teorie principal-agent, korelační koeficienty, regresní analýza

Název práce

Reprezentace států v sekretariátu Světové zdravotnické organizace

Acknowledgement

Table of Contents

Introduction

The World Health Organization (WHO) is the United Nations (UN) body responsible for directing and coordinating global health. As an actor in international public health and international public health policy, the WHO plays a vital role in the global governance system. In my thesis, I would like to address the workforce composition of the WHO, especially the distribution of nationalities of staff members. My research will study staff's composition and decision-making power in the organisation. I will study the patterns of most represented countries and if the quality of the educational system reflects the number of staff in the WHO.

The thesis will examine the overrepresentation and underrepresentation of the WHO's member states and explain possible patterns in the staff structure. Some authors suggest that the IO's staff distribution does not necessarily imply that the weaker states are underrepresented and vice versa. According to Eckhart and Steinebach (2018), the existing literature refers to three approaches that can explain states representation in the IOs secretariat: power-based, legitimacy-based, or functionality-based rationale. The representativeness also serves as an indicator of the opportunity to enforce the interests of member states in the Secretariat and create the possibility to force or manage essential policies. Also, the organisations represent all states, not only powerful ones.

In my thesis, I will observe the WHO's professional staff representation composition during a timeline from 1999 till 2019. I will work with the official workforce data provided by human recourses of the WHO from an online archive. Documents are updated every year on the official websites of the WHO in the section of Governance, where are available all documentations from Executive Board sessions and Health Assemblies. My focus will be on the staff policy, politicisation, and control of member states through their staff.

I will work with the principal-agent theoretical framework (Hawkins et al. 2006). I chose the PA theory because it understands the patterns of staffing policies of the international organisation. This theory explains why member states (principals) want to control and influence international organisation's bureaucracies (agents). The principal-agent problem is

since the international organisation has vested interests that differ from the voters' preferences. The voters cannot effectively control the international organisation because they are rationally ignorant of most of its activities and or lack the power to impose their will. The global agents are interested in the survival and growth of their organisation: more staff, a larger budget, and increasing competencies (Vaubel 2006).

The PA theory I will combine with representative bureaucracy theory is defined as *"a body of thought and research examining the potential for government agencies to act as representative political institutions if their personnel are drawn from all sectors of society"* (Dolan and Rosenbloom 2003). Mosher (1968) argues that a bureaucracy can be represented in passive and active ways. The passive representation is defined by including a minorities groups, as racial, ethnic or religious, and women. The active representation occurs when the bureaucrats *"press for the interest of those states he is presumed to represent"* (Mosher 1968, p.11). That means that the organisation's policy-making is biased, and some group identities and interests are overlooked. Moreover, another research shows that minority groups are more represented when they constitute a larger share of the population in the area where a public organisation is located.

The basis literature for my theoretical framework is, for example, Michal Parizek *"Control, Soft Information, and the Politics of International Organizations,"* Fanny Badache *"A Representative Bureaucracy Perspective on Workforce Composition in International Organizations: The Case of the United Nations Secretariat,"* Johan Christensen *"Representative Bureaucracy, International Organizations and Public Service Bargains"* or Ronald Vaubel *"Principal-agent problems in international organisations"*.

I will use mainly information from the WHO's archives for data analyses. The Secretariat has prepared the guidelines for implementing WHO's geographical mobility[1] policy and the WHO transformation plan, including the values charter. Based on Resolution WHA56.35 from 2003, where the following formula for the appointment of Secretariat staff was approved, the staff distribution should reflect budget contribution (45%), membership (45%), and population (10%). The WHO is also in favour of creating the WHO Academy and giving

---

[1] See https://www.who.int/docs/default-source/documents/evaluation/summative-evaluation-implementation-mobility-policy-annex.pdf?sfvrsn=c13fcb3c_2

a more significant opportunity to participate even to the people who are not necessarily near the WHO headquarters.

In my thesis, I will analyse the following research questions:

Q1: What are the patterns of countries' representation in the professional staff of the WHO?

Q2: How has the representation in the WHO changed over time?

Q3: How has the female representation in the WHO changed over time?

My thesis aims to research the characteristics of staff's composition in the WHO. I will analyse professional staff structure and apply the Principal-Agent theoretical framework. The research will show how the state's representation of member states changed over time and see also the gender composition of the Secretariat.

The thesis is divided into four parts. In the first chapter, I will write about the theoretical framework. The theoretical framework I will be working with is the Principal-Agent theory. As I mentioned above, this theory explains why states have representatives in the IOs bureaucracy. This theory will be supplemented with Representative Bureaucracy Theory and Shadow Bureaucracies, which is explaining by Eckhart and Dijiskra. In the second chapter, I will focus on the methodology of my work.

The analytical part of my thesis focuses on the analysis of datasets in the Microsoft Excel and statistical programme SPSS to search the relationship between staffing in the WHO and what influence this variable. I use regression analysis and correlation coefficients for my work. In the third chapter, I will write about the structure and functions of the WHO and try to explain future development in staffing policy. In the last fourth chapter, I will analyse my data and try to answer my research questions and hypothesis of this work.

1. Theoretical framework

The thesis attempts to apply the principal-agent (PA) theoretical framework (Hawkins et al. 2006). I chose the PA theory because it understands the patterns of staffing policies of the international organisation. This theory explains why member states (principals) want to have control and influence over international organisation's bureaucracies (agents), as I mentioned in the introduction. The PA framework assumes that more powerful states have more power than the weaker ones because they provide more money to the IOs budget. These wealthy member states can even create their own shadow bureaucracies to duplicate the work of the IOs (Dijkstra 2015).

According to Parizek (2017), the PA model explains why powerful states attempt to increase their power over the IOs and influence the IO's Secretariat with their vision. Parizek also says: *"States provide IOs' bureaucratic bodies with autonomy, but they also want to be able to control what the IOs do. For the powerful states, directing the politics of staffing in the right way may be a cheap means towards this end"*. Nevertheless, the overrepresentation of powerful and wealthy states creates functional and legitimation problems. And also, the relative underrepresentation of the middle-income countries in the Secretariat can be a threat to the IO's long-term stability (Parizek 2017).

Fanny Badache, in her article *A representative bureaucracy perspective on workforce composition in international organisations* mentions that even if bureaucracies can never be fully representative, it is essential to approximate representativeness because it serves as an indicator of the degree of equality of opportunity and access to employment in the public service (Badache 2019). It can also improve citizens' trust in the bureaucracy, thus leading to higher levels of cooperation and coproduction (Riccucci and Van Ryzin 2017) and, under certain conditions, to greater effectiveness (Andrews et al. 2014).

1.1. Principal-Agent Dilemma

The theory of the principal-agent (PA) dilemma is controversial, yet scholars have used scholars in many fields as economics, finance, political science, or sociology. The origins of the theory began during the 1960s and early 1970s in economics. The literature described the risk-sharing problem between cooperating parties with different levels of risk. *"Specifically,*

agency theory is directed at the ubiquitous agency relationship, in which one party (the principal) delegates work to another (the agent), who performs that work." (Eisenhart, 1989).

The dilemma occurs in circumstances where agents are motivated to act in their interests, and also, on the contrary, the principals are motivation on their own. The problem is that both of them have different attitudes toward risk and the principal and the agent prefer other actions. The principal and agent share common assumptions about people, organisations, and information. The problem starts with their behaviour and actions toward governing (Eisenhart, 1989).

I will use the PA framework to analyse the WHO's staff policy and structure of this institution. Generally, the PA model discusses control between member states (principals) and international organisations (agents). Often the critical reason is to create agents able to effectively collect and produce politically relevant credible information that would be difficult to collect for the individual states in the IOs (Parizek 2016). I chose the PA model to apply to the WHO's staffing and understand the patterns of staffing policies of the international organisation.

In delegating, principals prefer to avoid substantial losses in control. To this end, they must screen out unwanted agents, sanction agents that misbehave, and monitor agent behaviour through oversight mechanisms. Agent screening is less valuable when a Director-General does not exercise effective control throughout the organisation. S sanctioning by removing high-level staff faces similar challenges. Oversight is complicated by increased costs of collecting information across multiple offices and the potential for actors with divergent preferences to strategically withhold information (Graham 2014).

1.2. Principal-Agent Theory and Staffing Policy

Roland Vaubel describes the PA dilemma on his figure where he shows monitoring and influencing international organisations. According to Vaubel: *"the executive of the international organisation is farther removed from control by the ultimate principals—the citizens and voters—than any other political actor."* (Vaubel 2005). The problem with the IOs is about control. Member states are trying to create oversight mechanisms to control IO's operations. Of course, more powerful and wealthy states gain more control because they

provide larger shares of the IO's budget. For complete control, states would have to replicate ate work of the IOs. Additionally, states may try to control IOs front side by influencing their personnel policy and ensuring that their people formulate the IOs' positions in the first place (Parizek 2016).

The staff of IOs should be independent of their countries of origin and should fulfil the IO missions regardless of the interests of individual countries. But it is hard to disconnect staff completely from their national identities. We can also assume that the most powerful states, the fundamental principals of the IOs, want to ensure dominant positions in the Secretariat for themselves. The difficult part of the control mechanism in the IOs and staffing policy comes with paid costs and the influence on the functioning and legitimation of IOs. Parizek says: *"the skew in the IOs' staff distribution towards the powerful states necessarily implies that the weaker states are under-represented."* (Parizek 2016).

Parizek and Stephan (2018) argued that highly visible IOs are more likely to favour representative legitimacy relative to control. Because different IOs are likely to strike a different balance. On the other hand, less visible IOs do not face solid external scrutiny, and they prioritise the representation of the powerful states. *They state that "public visibility encourages impartiality and independent behaviour while making the exercise of power and control more difficult."* (Parizek, Stephan 2018).

Many scholars are focused on whether IOs prioritise the interests of their most powerful countries or the most significant contributors through staffing policy. Or, on the contrary, if the IOs are responsible for legitimation demands. In their paper, Parizek and Stephan proposed the argument that the IOs are more likely to favour representative legitimacy relative to control. The less visible ones IOs are more likely to prioritise the representation of powerful states. They also suggest that the IOs be seen as representative of the world population for secure legitimacy as impartial administrators. IO's secretariat composition has affected political conflicts of interest – *"The demand for representative IO secretariats directly challenges the dominance of the powerful states and their ability to exercise control over the IOs"* (Parizek, Stephan 2018).

Abbott and Snidal mentioned in their paper that for the efficiency of collective activities and the organisation's ability to affect understanding, environment, and interests of the state, the IOs have to have a stable structure and supportive administrative apparatus. But the problem with this apparatus is in its dependence and the ability to act with a degree of autonomy in different spheres. The administration should operate as a neutral managing body for disputes and conflicts (Abbott, Snidal 1998).

1.3. Shadow Bureaucracies

The preparation of decisions in the IOs is often delegated through international secretariats. Djiskra argues that states have to invest in "shadow" bureaucracies to avoid being dependent on the information and analysis from secretariats. The cost that states can invest into shadow bureaucracies depends on their resources. Member states expect that secretariats provide biased assessments at considerably lower costs than if member states would have to produce such assessments themselves (Djiskra 2014). According to Dijiskra, powerful states maintain "shadow bureaucracies" and seek to position *"like-minded staff within the international bureaucracy who act on behalf of the lobbying state"* (Eckhard and Dijkstra 2017).

Of course, developed countries should be this control mechanism more accessible, and more powerful states want better staff representation in the key IOs. Similarly, the IOs are interested in maintaining the support from their most influential members. These findings can bring us to the assumption that the most powerful and wealthy states have a significant interest in controlling the IOs through staff policies (Djiskra 2014).

1.4. Representative Bureaucracy Theory

"The composition of public administration bodies should correspond to the composition of the underlying population the bodies are supposed to govern" (Meier 1975). Not surprisingly, IOs play an important role in global policy to approach world development and international security. The higher and senior positions in IOs are very desirable and contested by national governments. They seek for these positions to place their employees into IO's office. When they reach to have position in Secretariat, they work in the interest of their national country (Novosad, Werker 2018).

The workforce composition of IOs and the distribution of nationalities of staff members are important, primarily because it reflects the balance of power in the international system. Furthermore, it can constitute a channel of influence for member states in IOs. The representativeness serves as the indicator for equality of opportunity and access to employment in the public space, even if it is impossible that bureaucracies can ever be fully equally representative (Badache 2019).

Selden found out that *"at the socio-demographic level, research shows that minority groups are more represented when they constitute a larger share of the population in the area where a public organisation is located"* (Selden, 1997). Another research shows that the education level of the employees can be an important factor or barrier in the public service. Scholars also found out that another factor on the representation in IO's staff is the democratic system, economic capacities and investments in diplomacy (Badache 2019).

Kenneth Meier, in his article about a critical analysis of the representative theory, mentions that the theory has four serious faults. The first argument is about traditional controls of administrative manipulation, for example, executive hierarchy, legislative budgeting and oversight and the rule of law. This argumentation also mentioned that political controls are used infrequently, and they are ineffective in preventing the determined supervisors from mistreating their position. According to Meir, *the representative bureaucracy is presented as a means of democratic control when other control (external) fails*. The second argument is about representativeness in terms of education, social class, religion, and birthplace. That means that socioeconomic characteristics determine the values of representants. Moreover, the representativeness depends on the values of the staff and the whole bureau (Meier 1975).

Representative bureaucracy is defined as *"a body of thought and research examining the potential for government agencies to act as representative political institutions if their personnel are drawn from all sectors of society"* (Dolan, Rosenbloom 2003). This theory is from the 1950s, and the focus is mainly on the development of bureaucratic systems and increasing their non-elected public servants who shape public policy. Scholars started to apply the theory of representative bureaucracies to justify the argumentation that administrative legitimacy is also required in IOs and that geographical representation plays an important role in staffing policy (Badache 2019).

As I mentioned above, both theories assume that the staff representation in the IOs secretariats should be neutral. Representative bureaucracy also highlights the importance of an educational level and the ability for IOs to recruit staff to the merit principles. The problem is that represented countries do not have equal terms of the educational system and developing countries could cause a barrier to their representation.

1.5. Hypothesis

Theoretical findings lead to the following hypothesises:

(H1): Developed countries are more represented in the professional staff of the WHO than developing ones.

(H2): Quality of the educational system of the member states impacts their staff representation in the WHO.

(H3): Representation of women in the WHO increased over time.

1.6. Definitions

In my thesis, I will analyse if more wealthy countries are more represented in the Secretariat of the WHO. For this analysis, I will use mainly the GDP factor, which shows the economic development of countries. The World Bank classifies countries as "high-income economies", and this term is mainly used in the United Nations. For my thesis, I chose definitions of developed and developing countries.

1.6.1. Developed Countries

A developed country, industrialised country (or post-industrial country), more developed country (MDC), or more economically developed country (MEDC), is a sovereign state that has a developed economy and advanced technological infrastructure relative to other less industrialised nations. Most commonly, the criteria for evaluating the degree of economic development are gross domestic product (GDP), gross national product (GNP), the per capita

income, level of industrialisation, amount of widespread infrastructure, and general standard of living (Developed Economy Definition).

In the thesis, I work with G7 countries as developed countries according to the definition. The G7, originally G8, is a group of states compound of the world's economic leading countries. The list of the countries includes Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States. The G7 group meets at annual summits to discuss ongoing global economic agendas and political issues (European Commission, G7, online).

1.6.2. Developing Countries

A developing country (or a low and middle-income country (LMIC), less developed country, less economically developed country (LEDC), medium-industrialised country or underdeveloped country) is a country with a less developed industrial base (industries) and a low Human Development Index (HDI) relative to other countries (O'Sullivan, Sheffrin 2003).

However, this definition is not agreed upon globally because there is no clear agreement on which countries fit in this category. A nation's GDP per capita, compared with other nations, can also be a reference point. In general, the United Nations accepts any country's claim of itself being "developing". [2]

As a group of developing countries is consider BRICS group. BRICS is a group of five countries defined as an emerging economy. Members are Brazil, Russian Federation, India, China and South Africa. The group was officially formatted in 2009. The BRICS's governments meet annually at formal summits (BRICS, 2019).[3]

---

[2] See https://www.un.org/en/development/desa/policy/wesp/wesp_current/2014wesp_country_classification.pdf
[3] See http://brics2019.itamaraty.gov.br/en/about-brics/what-is-brics

2. Data and Methodology

In my thesis, I work with regression analysis by statistical programme SPSS (Statistical Package for Social Science). Regression analysis is a statistical method that allows us to examine the relationship between independent (x) and dependent (y) variables. This method helps to understand how a dependent variable changes the value of a change in one of the independent variables (while the other independent variables remain constant (Lindley 1987).

The correlation coefficient is a numerical measure for a type of correlation, meaning a statistical relationship between two variables. The correlation coefficient shows the relation between our observed data. Values could range from -1 to +1, where ±1 indicates the strongest possible agreement and 0 the strongest possible disagreement. Properties of the correlation coefficient $r = 0 \Rightarrow$ independence, $r = 1 \Rightarrow$ direct dependence, $r = -1 \Rightarrow$ indirect dependence. Correlation does not imply a causation relationship between the variables (Davda 2020).

The correlation coefficient, mostly used for statistical dependence of linear data, is the Pearson correlation coefficient. The correlation coefficient is greatly affected by outliers, and it is calculated using the standard deviations of both variables and their covariance. Pearson's correlation coefficient is the test statistic that measures the statistical relationship or association between two continuous variables. It is known as the best method of information about the magnitude of the association, or correlation, and the reaction of the relationship. The correlation coefficient allows us to determine whether there is a relationship between the variables and how strong it is (i.e., whether the selected tests correlate, for example, with the evaluation that the employee receives after the probationary period), regression analysis allows us to predict data in the future (Bartholomew, 2010).

In my thesis, I focus on WHO staff composition and its affecting factors. The research finds causality between dependent variable (DV) number of employees of the WHO and independent variables (IV) – GDP (current US$), expenditure on education and size of population during the time from 1999 to 2019.

Collected data of Member States employees' numbers (DV) are from archived documents of the human resources reports presented each year on the World Health Assembly (WHA). I

searched all available professional staff data in the WHO by every country, region, gender and level category. All WHO reports are available online on the official website of the WHO in the section of Documentation of WHO for Executive Board sessions and Health Assemblies[4]. In the first phase of my research, I worked mainly with Microsoft Excel to select relevant numbers for my analysis. For collecting my independent variables, I used data from the World Bank. I was working with three indicators: 1) gross domestic product (GDP current US$), 2) adjusted savings: education expenditure (current US$), 3) total population.

For the regression analysis, I chose SPSS statistical programme. The final datasets are divided into three sections: 1) collected data of 1999, 2) collected data of 2009, 3) collected data of 2019 where is analysed 189 Member States of the WHO. I will compare these findings and analyse how the employee's composition has changed over time and what differences are between these periods.

2.1. Regression analysis

Assumptions of regression analysis are that the dependent variable Y must be a metric variable (measured at the interval level). Independent variables are also measured at the interval level. They can also be non-interval variables but only dichotomous. Since many important independent variables do not have this property, we overcome this problem by creating "dummy variables". Independent variables should not be highly correlated with each other, as this is a violation of the requirement for the absence of multicollinearity. If there is multicollinearity in the data, the regression results are unreliable (de Vaus: 343).

High multicollinearity increases the probability that a good predictor (= independent variable) will be statistically insignificant and excluded from the model. There must be no outliers in the data, as the regression analysis is sensitive. Outliers can seriously interfere with estimates of equation parameters. The variables must be in a linear relationship. Multiple linear regression is based on the Pearson correlation coefficient, so the absence of linearity means that even important relationships between variables, if not linear, remain undetected. Variables are normally distributed; otherwise, there is a risk of inaccurate results. This ensures that breaches of normality in large samples do not have serious consequences (ibid.:344).

---

[4]See https://apps.who.int/gb/index.html

3. The World Health Organization

The World Health Organization (WHO) is one of the specialised agencies of the United Nations, and the WHO is responsible for international public health. The WHO was established on 7 April 1948 by the constitution. This day is also recognised as World Health Day. The initiative proposal came from Brazil and China at the United Nations International Health Conference in New York in 1945 (Andresen 2002).

The WHO has 194 Member States from six regions, and the WHO disposes of more than 150 offices. The WHO staff are united in a shared commitment to achieving better health for everyone and everywhere. The headquarter is located in Geneva, Switzerland, with six semi-autonomous regional offices worldwide. Current Director-General of the WHO is Tedros Adhanom Ghebreyesus from Ethiopia and has served since 2017 (McCarthy 2002).

The responsibilities of the WHO are to assist governments in strengthening health services, establishing administrative and technical services, stimulating and control the spread of diseases, nutrition, sanitation, promoting cooperation among scientific and professional groups, proposing international agreements and conventions on health matters, and developing international standards for food and other products (WHO.int). The main controlling bodies of the WHO are the World Health Assembly, the Executive Board, and the Secretariat. Specialised agencies were put aside with their assemblies mainly because the cooperation between states would be free of the political fights (Charles 1968).

3.1. The Origins of the WHO

The first predecessors of the WHO were *the International Sanitary Conferences* held in 1851. The Conferences lasted from 1851 to 1938 and worked to combat diseases like cholera or yellow fever. Following the success of the Conferences, the *Pan-American Sanitary Bureau* and the *Office International d'Hygiene* was founded. In 1920, when the League of Nations was formed, they established the *Health Organization of the League of Nations*. After World War II, the United Nations absorbed all the other health organisations to form the WHO. The Constitution of the WHO was signed on 22 July 1946 by all 51 Members of the UN and ten other countries, and the constitution came into force in 1948 (McCarthy 2002).

The establishment of the WHO created controversy over the functional structure of already existing regional health organisations. Especially over the status and their autonomy (Jacobsen 1973:177). The compromise was reached after long discussions, and the existing regional organisations were integrated into the WHO system. Within the WHO were created six geographical areas[5] , and the organisational shaping was completed in 1951 (Siddiqi 1995:68). The goal of the WHO founding members was to create universal/global membership. The membership of the WHO had an intense increase over the years from 26 members in 1948 to 191 members in 1991. *"The WHO is one of the most complex UN organisations"* Andresen 2002).

The WHO was established on the functionalist idea – and the organisation should work as an apolitical entity and avoid political disputes. Nevertheless, as with other international organisations, the WHO reflexes the political controversies and global differences – also in questions dealing with membership (ibid. 2002). In 1949 the Soviet Union announced withdrawal from the WHO, and other socialist countries have followed this policy. The claiming reason for withdrawal was an unfair policy of the WHO and discriminative attitude of other member states. While socialistic countries boycotted the WHO, the organisation's membership was dominated by western countries. This changed after Stalin's death in 1951, and socialist countries started to apply for membership again in 1955 (Siddiqi 1995:108).

Another problem with the membership represents the People's Republic of China when in 1952, the WHO decided that the only legitimate representative of China in Taiwan. This situation lasted for 20 years till 1971, when China strengthens its position in the WHO, and the situation reversed (Andresen 2002: 11). The WHO's "politics of exclusion" also happened to South Africa in 1964 when the government declared its official policy of apartheid. The WHO stood up for humanitarian principles and decided to deprive South Africa of voting rights.

The most controversial and politicization case has been the membership application process of the Palestinian State in 1988. When the PLO applied for membership, 98 countries recognised the self-proclaimed state. The strongest reaction to the application had the United States who threatened to withdraw US funding for the organisation. The WHO refused to be

---

[5] I will talk more about them in chapter 3.6.

in the middle of the political controversy and avoided paralysing situations that affected most UN bodies (ibid.).

3.2. Functions and Structure of the WHO

The main organs of the WHO ate the World Health Assembly (WHA), the Executive Board (EB), and the Director-General (DG) and the Secretariat. The supreme decision-making body of the WHO is the WHA. Member States of the WHO appoint delegations to the WHA. The membership of the WHO is approved by a simple majority vote of the WHA, and all UN member states, or other countries may apply. (Yadav 2017). The WHO's principles are based on the Constitution, where *Article 1* states: *"The objective of the World Health Organization (from now on called the Organization) shall be the attainment by all peoples of the highest possible level of health"* (Constitution of the WHO 1948).

The WHO has 194 Member States, including all UN Member States except Liechtenstein, the Cook Island and Niue. A full member of the WHO, a state becomes when ratifies the Constitution of the WHO. Countries or territories that are not the UN Member States can join the WHO as Associate Members (with limited participation and voting rights) if the WHA approves (Charles 1968). Observed status at the WHA has six entities: The Holy See (Vatican City), the Palestinian Authority, the Sovereign Military Order of Malta, The International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, the South Centre, and the Inter-Parliamentary Union (WHO.int).

The WHO has a decentralised structure unique in the UN, and this structure is important for its leadership and policy formulation of the WHO. The headquarters is formulating policies, budget and future development of the organisation. The regional offices are implementing new policies and directions from headquarters. Moreover, they are essential for developing these policies and effectively working. The Director-General does not appoint the regional directors, but they are elected by the national countries instead. The regional directors are important for managing and controlling the implementation process in their regions, and they report this process to the Executive Board and General-Director (Andresen 2002: 13).

3.3. The World Health Assembly

The World Health Assembly generally meets in May every year at the headquarters in Geneva. The Assembly elects 34 members to the Executive Board for three-year terms, and they also appointing Director-General every five years. The Assembly deals with the financial policies and proposed budget decision. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board (Yadav 2017).

The World Health Assembly's main functions are to determine the Organization supervise financial policies' policies and review and approve the proposed programme budget. The main tasks of the WHA are to decide major policy questions, as well as to approve the WHO work programme and budget and elect its Director-General (every fifth year) and annually to elect ten members to renew part of its executive board. Its main functions are to determine the policies of the Organization, supervise financial policies, and review and approve the proposed programme budget (Basics Documents, who.int).

All WHO members are represented in the World Health Assembly. Each member has one vote but may send three delegates. According to the WHO constitution, the delegates must be chosen for their technical competence and preferably should represent national health administrations. Delegations may include alternates and advisers.

By a two-thirds vote, the assembly may adopt conventions or agreements. While these are not binding on member governments until accepted by them, WHO members have to "take action" leading to their acceptance within 18 months. Thus, each member government, even if its delegation voted against a convention in the assembly, must act. For example, it must submit the pattern to its legislature for ratification. It must then notify WHO of the action taken. If the effort is unsuccessful, it must notify WHO of the reasons for nonacceptance

3.4. The World Health Executive Board

Every year the WHA is electing members of the Executive Board. The Board consists of 34 people and must have an equitable geographic distribution. The Board is elected for three years and may be re-elected. The Board has two meetings per year in the headquarters based in Geneva. Each member state should select a technically qualified person to the Board who

is an expert of health or co-work with another adviser to cover the WHO's agenda (Yadav 2017).

The board's primary function is to advise and help with drafting proposals of the WHA and process the decisions and new policies. Associate Members have equally suitable with Members of the WHO to submit their proposal to the Board and be active. But they are not eligible for membership on the Board (Constitution of the WHO: 212). The Board other function is to oversee and control operations. The Board members are mainly the government officials who reflect their governments' position while the WHA are mostly experts in health problems (Siddiqi 1995:82).

3.5. The Director-General

Director-General is in the structure of the WHO the highest position. The Director-General is WHO's chief technical and administrative officer and oversees WHO's international health work. Member States may propose candidates for the election, and these candidates are considered by the EB. The EB nominates one person by secret ballot. The name of that person is then submitted to the World Health Assembly, making the final appointment. The Director-General is appointed to a five-year term. A Director-General can be re-elected once per Rule 108 of the WHA Rules of Procedure. The current Director-General is Tedros Adhanom Ghebreyesus, who pointed in 2017 (The Election of Director Geneva, who.int).

3.6. The Regional offices

The WHO has six regional offices based on article 44 of the WHO's constitution. The list of regional offices: **AFRO** (Regional Office for Africa) with headquarters in Brazzaville, Republic of Congo. **EURO** (Regional Office for Europe) with headquarters in Copenhagen, Denmark. **SEARO** (Regional Office for South-East Asia) with headquarters in New Delhi, India. **EMRO** (Regional Office for Eastern Mediterranean with headquarters in Cairo, Egypt. **WPRO** (Regional Office for Western Pacific) with headquarters in Manila, Philippines. **AMRO** (Regional Office for the Americas) with headquarters in Washington, DC, USA (Yadav 2017).

Each region has a regional committee and a regional director (RD). The RD manages and supervises staff, and he/she is appointed for a once renewable five-year term. The RD also reports the situation from the Region at the regular meetings of the Board and Assembly. The committee is electing the regional director, and it is also in charge of setting a timeline for the implementation of policies and resolutions adopted by the Assembly.

3.7. Financing Policy and Budget

The budget of the WHO is approved by the WHA every year on a biennial basis. The finances and strategy of the budget are composed of regional preferences, emerging needs and long-term goals of the WHO. The budget has two bases: The Base budget (long-term or established policies) and the Special segment (for special categories or crisis) (Krestova 2020:23).

Funding of the WHO has two main sources. The first one is from the Member States paying their contribution (membership dues), and the second funding source is a voluntary contribution (it could be the Member States or other partners). Membership dues are calculated as a percentage of a countries' GDP and countries' population. The amount is agreed by the Assembly every two years. The Member States contribution covers less than 20 % of the total budget. The biggest amount of the budget is covered by voluntary contributions from the Member States and other UN organisations, philanthropic foundations or the private sector (WHA24.12).[6]

The problem with membership dues and voluntary contribution of the WHO is increasing control and influence of the wealthiest countries or organisations. Another problematic part of the funding is that the voluntary contributions are particular and target a specific agenda preferable by the donor's priority or interest. This leads to overfunding or, in reverse to underfunding of the programmes. Moreover, the problem of voluntary funding lies in its unpredictability of how much the donor decides to contribute and for what (Krestova 2020: 24-25).

The biggest contributor to the WHO's budget in the US. The US has contributed to the last year (2019) more than $400 million, which is more than 15% of the WHO's annual budget. The second-largest funder is the Bill and Melinda Gates Foundation providing more than 9.8% of the WHO's funds. The WHO biggest expenses are to help fight health emergencies and the programme budget. Following the United States is China, with a contribution amounting to $57.4 million, roughly half of that of the US (Moulds, WEF 2020).

---

[6]See https://www.who.int/about/funding

Among the largest contributors are European countries — Germany, the United Kingdom, France, and Italy. These four countries alone contributed an estimated $88 million, which is still below the assessed contribution of the US. Other biggest funders are Germany, Japan, the European Commission, China, Canada, the Republic of Korea or the United Arab Emirates (Moulds, WEF 2020).

WHO's financing is underpinned by four guiding principles adopted during the 2013 Financing Dialogue. The first principle is called alignment and flexibility: funds will be mobilised in alignment with the Member-State approved Programme Budget. Contributor commitments to increase funding flexibility will further facilitate an even distribution of funds across programme areas. Second principle is predictability: Member States and other funders strive to make at least 70% of required funding available at the start of a biennium. In addition, the organisation will promote a longer-term view of organisational financing, including by linking to the six-year general programme of work. Third principle is transparency: WHO makes contributor funding information public through its Programme Budget web portal, facilitating a shared understanding of available and projected income by category, programme, major office and budget centre, providing critical inputs to well-informed decisions about voluntary contributions. And last fourth principle is reducing vulnerability: Member States and other funders expressed their commitment to addressing the organisation's reliance on just contributors for 80% of all voluntary contributions. This will involve broadening and deepening the existing contributor base, with an initial focus on Member States (WHA73.28).

Considering that the World Health Assembly in its resolution WHA8.5 had expressed the opinion that the latest available United Nations scale should be used as a basis of determining the scale of assessment to be used by WHO, taking account of: (a) the difference in membership; and *(b)* the establishment of minima and maxima, including the provision that no country shall be required to pay more per capita than the per capita contribution of the highest contributor (WHA24.12).

3.8.Staffing Policy

The World Health Organization shares common personnel policy with other United Nations agencies. The structure of the WHO is divided into eight divisions addressing: communicable and non-communicable diseases, mental health, family and community health, AIDS, policy development and others.

Professional and higher categories of staff in the WHO require an advanced university degree, appropriate skills, and professional work in a sinuously field. A first-level university degree combined with qualifying experience may be accepted instead of the advanced university degree. The following are the grade levels and generic titles of positions in the Professional and higher categories:P-1 Assistant Officer, P-2 Associate Officer, P-3 Second Officer, P-4 First Officer, P-5 Senior Officer, D-1 Principal Officer, D-2 Director. Professional positions at grades P-3 to P-5 typically require 5-10 years of relevant work experience, while positions at D-1 and higher categories require more extensive experience at higher organisational levels[7].

Human resources annual report states the total number of WHO staff members in 2019 was 8233 when the percentage of staff employed at headquarters was 30.1% (WHA A73/21). Distribution of WHO staff is divided by levels: country offices (general service staff), regional offices (national professional staff) and headquarters (professional and higher category staff). This structure supports the four pillars of WHO: worldwide guidance in health, worldwide development of improved health standards, cooperation with governments in strengthening national health programs, and development of improved health technologies, information, and standards.

The staff of the WHO is divided into two key categories. First are professional (P) or directors (D) who are internationally recruited, and second category is made of general (G) or national professional (NPO) staff who are recruited locally for both fixed and short-term positions. In my thesis I will focus on the professional or higher category of staff. Professional staff and directors are hired internationally and occupy leadership functions or positions that require a significant level of technical expertise. P or D staff are mobile and are expected to work across the globe.

---

[7]See https://www.unsystem.org/content/definition-staff-categories

The organisation focuses on four main areas, led by health intervention efforts, such as controlling and preventing HIV/AIDS, malaria, and tuberculosis. Other WHO priorities include support for government health programs; development of health policies, products, and systems; and efforts related to determinant of health, such as food safety and nutrition (Yadav 2017).

The first paragraph of the Staff Regulation of the WHO states: *"All staff members of the Organization are international civil servants. Their responsibilities are not national but exclusively international. By accepting appointment, they pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view."* (Staff regulations, 2014). The WHO staff should protect global health principles and not prioritise their national policies in the organisation.

The geographical representation of the staff is not equal and regulation for better recruitment was called already in 1996. The resolution WHA 42.12 from 1996 called for better formula for establishing desirable national's recruitment changes from unrepresented and under-represented countries. The Report by the Director-General suggesting progress in improving geographical representation of the WHO staff as follows*:*

1) 40 % of the total staff representation is distributed by the membership factor and equally among all Member States,
2) 55 % of the total number of posts reflects the contribution factor of Members in proportion of the scale of their assessments,
3) 5 % assigned posts are distributed by the population factor (EB99/33, 1996).

3.9. Future Development in Staffing Policy

The WHO provides a global internship programme for all applicants with living allowances and subsistence allowance amounts to US$ 1728 per month in Geneva. Another tool for improving better geographical distribution and developing the WHO is iLearn (implemented in 2018). This programme allows track compliance with mandatory training requirements for future staff applicants (A73/21, 2020).

3.9.1. WHO Academy

The WHO Academy is a project trying to attract young people and focusing on potential future candidates. The Academy is a training institution to bring and reach 10 million students together around the world by 2023. The project was initiated and launched in 2003 to set up an implementation programme in Egypt and Jordan.

The Health Academy team works closely with WHO regional offices and national Ministries of Health and Education to ensure the package complements existing national health promotion and education programmes. There are 15 eLearning courses available, and three more are in development.

To ensure that the Health Academy is implemented effectively for local needs, the WHO collaborates with national Ministries of Health, Telecommunication, and Education and non-governmental agencies. Wherever possible, the local industry is included to encourage capacity building and sustainability. Through its courses, the academy provides health guidance in terms easily understood by a wide range of people and considers cultural sensitivities and traditions. Information is first prepared in English and then translated into other languages.[8]

3.9.2. The WHO strategy

The WHO has many different contracts with its staff, and employees are divided into staff members (continuing, fixed-term and temporary) and non-staff (external advisors). Due to financing, the WHO prefers cooperation with external advisors, and its numbers are increasing. The WHO reform aims to the existing appointments to revise or manage the WHO to work more effectively (WHA66/4.).

In 2018 the Director-General Tedros Adhanom reported reform called "Better value, better health" to the WHA meeting (EB142/7 Rev.1). This reform followed the previous Human Resources Strategy from 2013. In the report, Dr Tedros stated that the WHO has to stay on its values and be attractable for the right people to continue to protect these values and standards to implement them as global manners. He also addresses the WHO staff when he says that

---

[8] See https://www.who.int/about/who-academy

employees by themselves have to carry their work attitude and be able to manage their careers (ibid.)

As I mentioned above, in 2013 the WHO published the Revised Human Resources Strategy with three pillars to change recruiting and staffing policy in the organisation. The first pillar is called *Attracting talent*; the strategy of this pillar is to focus on the right candidates who would share common values. The WHO, in general, would like to improve its recruiting strategy and increased diversity between staff. The second pillar is *Retaining talent: career management* and the third is *Enabling working environment*. The goal of this strategy has four principles:1) *Gender balance*, 2) *Diversity*, 3) *Collaboration,* and 4) *Accountability* (A/66/4, 2013).

The WHO is focusing very intensively on gender parity in staff and the WHO have taken many action steps to improve this agenda. For example, existing measures are resolution A/67/3474 with UN-SWAP performance standards on accountability. The numbers of women in the WHO are increasing, and more importantly, this trend shows in higher categories of staff. The WHO approaches the UN Sustainable Development Goals – specifically goal number 5: *Achieve gender equality and empower all women and girls,* and the WHO targets to promote strong female leadership and empower women staff applying gender equal opportunity within the organisation (Gender Parity in Staffing, 2015). I will discuss women and their staff development in the WHO in the next chapter.

Another key element of the strategy is mobility, which provides opportunities for new career experience and learning from regional practice. The main goal is to focus on staff diversity to enrich staff members and a whole organisation. It is also challenging task but necessary to secure understanding of international professional staff inside the WHO. This element is also important for addressing global health agendas, cooperation and crisis solution.

4. Data Analysis

In the analytical part of my thesis, I will describe how the structure of the staff has changed over time and how are women represented in this organisation. I worked with data from the World Bank and official archives document presented human resources of the WHO. The results from my research shows some patterns of the most represented member states in the WHO.

In my thesis, I analyse the structure of the professional staff of the WHO. I work with the SPSS programme to analyse the data by linear regression. Pearson's correlation was carried out to look for relationships between the variables: 1) GDP (current US$), 2) education expenditure (current US$) and 3) population size. The number of cases in my dataset is 189 (Member States of the WHO). This thesis aims to find out if GDP, education expenditure, and population size influence number of professional employees in the WHO. I suggest that countries with good economic conditions and higher GDP will have more employees in the WHO. Furthermore, I suggest that bigger population size and higher spending on education will affect the number of employees in the WHO. As a further research question, I also expect that number of female employees has increased over time, and the female staff is mainly from the western regions.

I collected available data from three periods: 1999, 2009 and 2019. I want to compare these periods to see if increasing GDP affects professional staff numbers in the WHO.

1. *(H1): Developed countries are more represented in the professional staff of the WHO than developing ones.*
2. *(H2): Quality of the educational system of the member states impacts their staff representation in the WHO.*
3. *(H3): Representation of women in the WHO increased over time.[9]*

My analysis focuses on whether developed and more wealthy countries have more extensive representation in the professional staff of the WHO. For answering this question, I worked with correlation coefficients and regression analysis in SPSS to see dependence of GDP, size population and expenditure on education on the staffing policy of the WHO. Hence, I can see

---

[9]This hypothesis is searched and commented in chapter 4.4. Women and the WHO.

if powerful states attempt to influence the Secretariat over their increasing power and control them.

4.1. Results of regression analysis

As I mention in the beginning, data analysis of my thesis was made by the statistical programme SPSS and Microsoft Excel. For my work I use regression analysis to examine the relationship between state's staff representation in the WHO and its economic power, level of education and size of the population. My goal is to find out which factor has the most significant influence on staffing policy in the WHO. The analysis is divided into three decades, starting with the year 1999, following 2009 and then 2019. I would like to compare these three periods and analyse how the countries' representation changed over decades and confirm my hypothesis mentioning in the above section.

The dependent variable of regression analysis is the number of professional staff for each Member State in the WHO. I work with available data of human resources 'reports from 1999 to 2019. I have 189 cases (some crucial data were not available). The independent variables are GDP, size of population and expenditure on education.[10]

4.2. Results 1999

The first results from regression analyse is from the year 1999. According to the first hypothesis (H1), state's representation will be influence by the economic power of the country, and I suggest that Member States having bigger GDP similarly have an increasing number of professional staff in the WHO. The second hypothesis (H2) indicates that the quality of education, influenced by how much money the state is willing to spend on education, affects countries' staff representation in the WHO.

The findings shows that the most substantial effect on staffing policy in 1999 had GDP. The analyse showed a positive and strong correlation (r=0. 571, p<0.02). A significant relationship has also been found between expenditure on education and staff numbers (r=0.517, p<0.2). The relationship between population size and the number of staff is positive but does not significantly affect (r=0.470, p<0.01). The GDP and spending on education have a positive relationship; nevertheless, the values are still moderate. A very strong relationship is seen between GDP and expenditure on education. The correlation value is r=0.825. That

---

[10] Data are from the World Bank (2021).

means: the richer the state is, and the more invests into education. The relationship between GDP and population size also has a strong correlation r=0.603. On the contrary, the relationship between population size and expenditure on education is weak. The correlation value is r=0.463. The outcome is that the country's population size does not affect education spending.

In summary, the GDP and spending on education affect staffing policy in the WHO, but the correlation is not very strong. GDP and education have a positive relationship with staffing policy, but it is not the only cause effect.

Model 1 shows the scatterplot of the regression analyses with residual statistics. The model display underrepresentation and overrepresentation of the WHO's Member States based on examined data. For example, China, India, South Africa, Italy and even the United States are underrepresented in 1999. On the other hand, countries like Chad, Togo or Niger were overrepresented.

Model 1. Scatterplot of countries' representation in the WHO from 1999
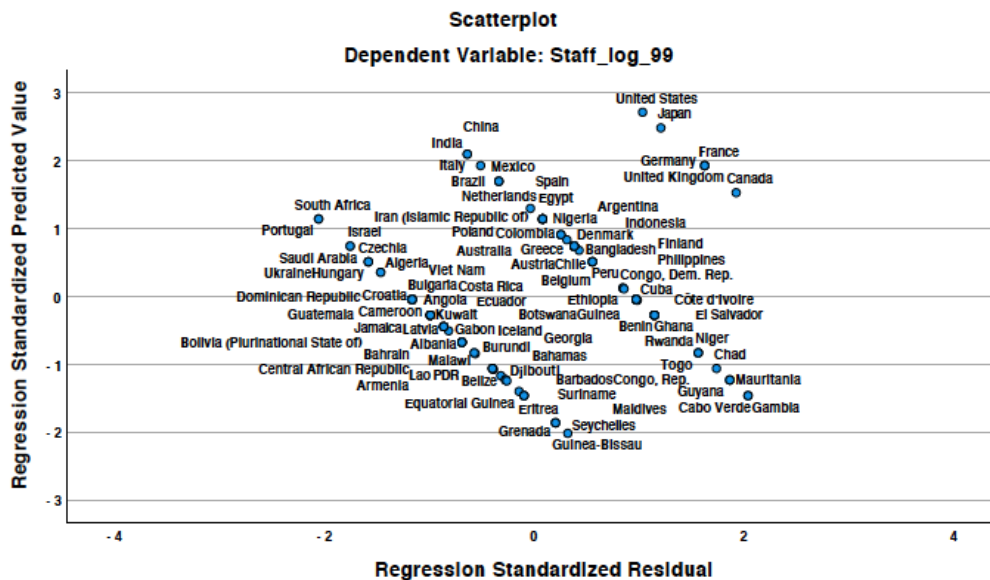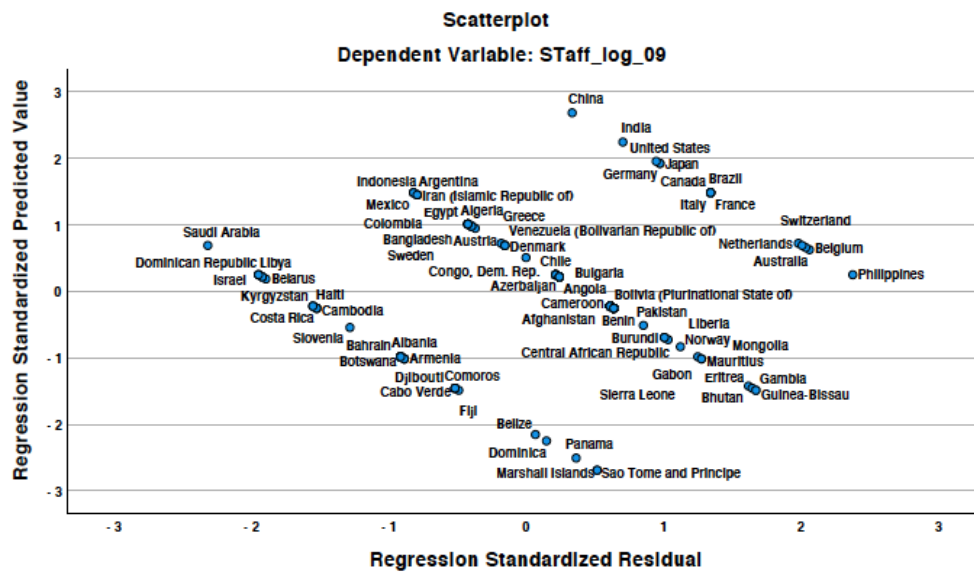
4.3. Results 2009

Findings from 2009 show different results than in 1999. A significant relationship has been found not between GDP and the number of staff but instead between the size of population and staffing. The correlation between staff and population size is stronger than in previous decade ($r=0.602$, $p<0.00$). The biggest influence on WHO's staffing in 2009 had population size of its Member States. The positive association on staffing policy had also GDP but the correlation value was weaker than in 1999 ($r=0.571$). The weakest relationship has been found between expenditure on education and the number of staff ($r=0.477$).

Surprisingly, according to the findings, the biggest correlation value of these factors has population size. Moreover, there was a significant evidence in relationship between GDP and expenditure on education in 2009 ($r = 0.825$, $p < 0.00$). The correlation value is the same as in 1999. The relationship between GDP and size of population is also strong ($r = 0.654$, $p < 0.00$). The relationship between education and population size is the weakest but still significant ($r=0.537$).

In summary, according to the findings from 2009, the strongest effect on WHO's staffing policy had the population size factor. A positive correlation has been found also between GDP and the number of staff. The education factor does not seem to affect the number of professional staff in the WHO in 2009.

Model 2 shows scatterplot of countries' representation in 2009. According to the findings, underrepresented countries are still China, India, the United States and Japan. Even though, these countries have increasing GDP, expenditure on education and even size of the population. The biggest deviation pursuant staff representation in Saudi Arabia. Overrepresented countries in 2009 were the Philippines, Belgium, Australia, Switzerland, Netherlands, Bhutan or Gambia.

**Model 2. Scatterplot of countries' representation in the WHO from 2009**

4.4. Results 2019

Findings from 2019 shows positive correlation between countries' representation in the WHO and their GDP (r=0.554, p<0.02). Positive relationship was found also between number of staff and population size of Member States (r=0.542, p<0.01). Weak relationship was found between expenditure on education and staff members (r=0.408, p<0.76). Interestingly the strong relationship was found between GDP and the size of population (r=0.731, p<0.00), but the value has decreased compared to previous period in 2009. The analysis has shown a positive correlation between countries' representation and GDP and between countries' representation and population size. The expenditure on education has also positive effect on staffing policy but not very strong.

The model 3 shows countries' representation in the WHO in 2019. The model displays deviations of exanimated data where it is seen which countries are underrepresented or overrepresented according to dataset. For example, the United States are underrepresented even though the US has the biggest number of professional staff in the WHO, the biggest GDP and education expenditure. China is likewise underrepresented even though China has the most significant population, and the GDP is growing every year. On the contrary, countries: Bhutan, Kenya, Armenia, Gambia or Uganda are overrepresented in the WHO although their GDP or expenditure on education are not significant.

Model 3. Scatterplot of countries' representation in the WHO from 2019
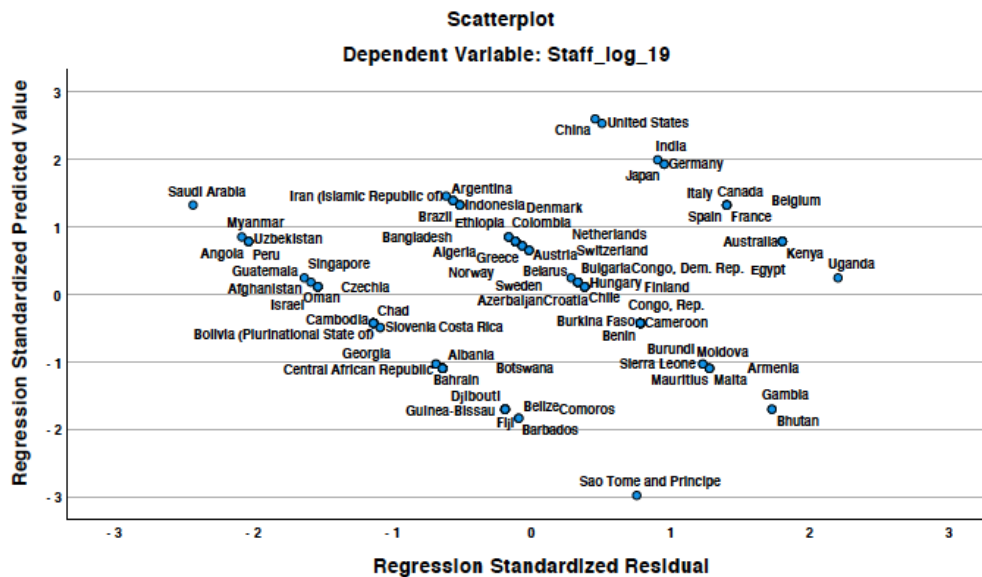
Scatterplot
Dependent Variable: Staff_log_19

As a result, the H1(state's representation is affected by the country's economic power) and H2 (state's expenditure on education influence countries' representation in the WHO) can be confirmed. In all three periods, there has been a positive relationship between GDP and the number of professional staff in the WHO. The economic power of the Member States affects staffing policy in the WHO. The weakest effect on staffing policy has had the expenditure on education. The relationship is positive but not significant. Surprisingly, in 2009 the strongest effect on staffing has had population size of Member State country.

According to findings, the significant relationship between GDP and expenditure on education has been found in every period. That means that the richer the state is, the more significant investment is in providing education. Scatterplots show, that even though the state has big GDP, population or expenditure on education it can be still underrepresented and vice versa.

# 5. BRICS and G7 Countries' Representation in the WHO

This section will analyse in more detail influencing factors on staff's development in the WHO. I will compare two developing (BRICS) and developed (G7) countries[11]. The graphs show countries' development in three periods: 1999, 2009 and 2019. Total number of professional staff in the WHO is increasing every year. In 1999 it was 1259 employees while in 2019 it is 2175, about almost once so much. The positive side is that women's representation went from 377 to 973 employees. But there is still difference between men and women representation. Male employees in 2019 make up 1202 professional member staff, that's still 225 more than women. In 1999 it was 882 men vs 377 women.

The Graph 1 displays representation of BRICS and G7 countries in the WHO. The United States dominates in the WHO and 1999 had 145 employees and this number went up to 170 in 2019. However, the US's representation is relatively constant. The most considerable increase we notice in India. India's staff went up from 22 to 111 in 20 years. This is increase of 404 %. We can see the second most significant increase in South Africa from 3 to 15 member staff. Another considerable increase we see in France. The French staff went from 49 to 118 employees. The simulates case is also United Kingdom where the numbers of employees increased from 55 to 118.

Almost all above selected countries have been increasing their staff: Canada, China, Germany, Italy, France, India, United Kingdom, United States and South Africa. Only countries with decreasing tendency are Brazil, Japan and Russian Federation. In 1999, Brazil had 26 employees in the WHO while in 2019 number dropped to only 12. Japan went down from 41 to 32 employees and Russian Federation from 31 to 22 professional staff. Interesting is that these countries have increasing GDP and even expenditure on education and still decreasing numbers in professional staff.

---

[11]Note: I added Czechia just for interest since I live and study in the Czech Republic.

**Graph 1. Professional staff in the WHO 1999-2019**
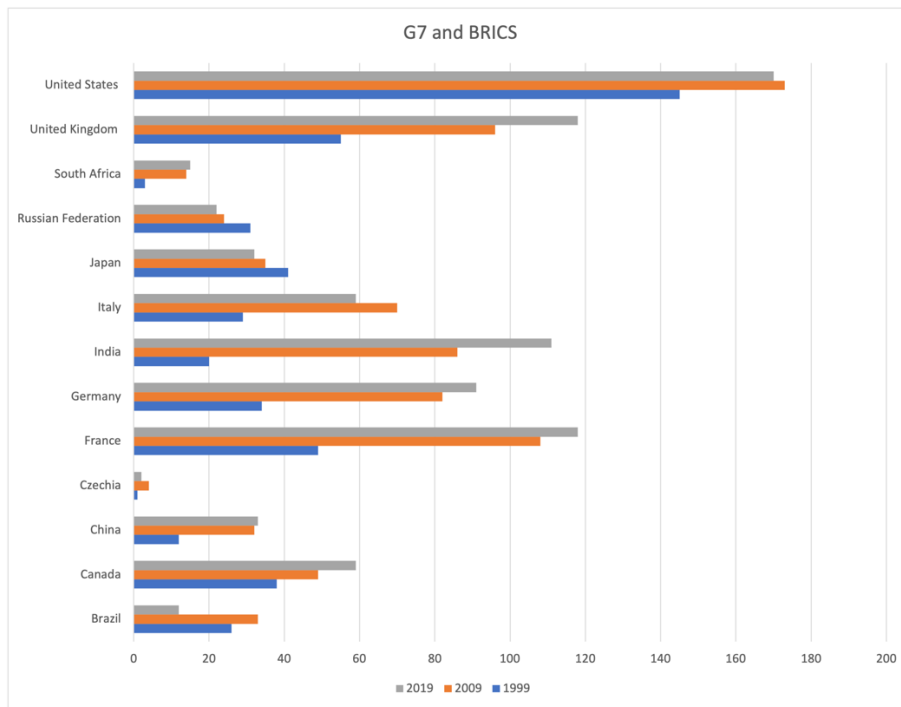
Graph 2 shows growth of population size. Population of all countries have been increasing except Russian Federation and Japan. In Russia population went down from 147 million in 1999 to 144 million in 2019. In Japan the population number is still 126 million. The professional staff of these two countries are declining. The biggest increase of population is seen in India and China. India's population has grown form 1 billion in 1999 to 1,36 billion in 2019. In China it was from 1,25 billion in 1999 to 1, 39 billion in 2019.

Graph 2. Population growth 1999-2019 (in million)
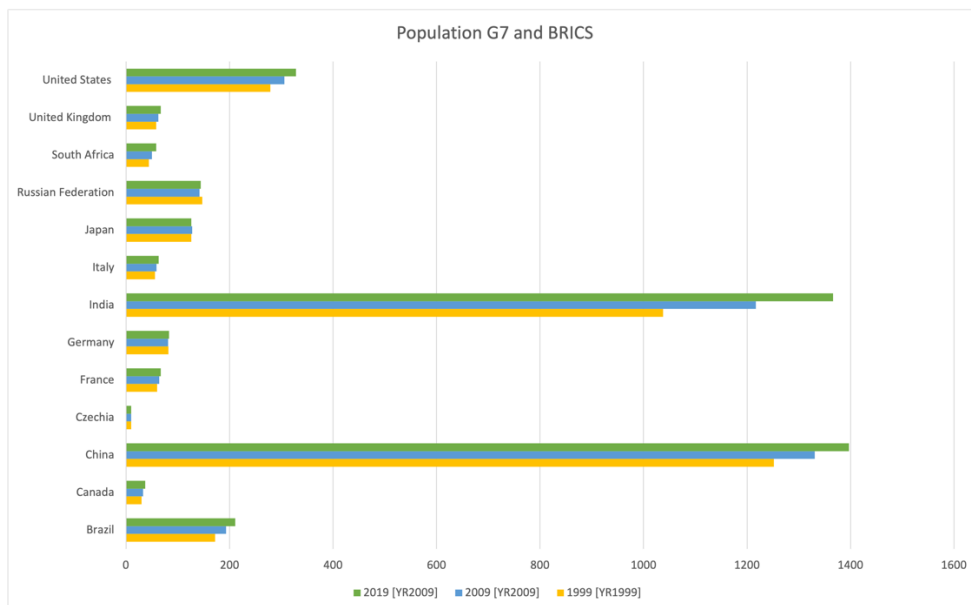
Graph 3 shows GDP growth of selected countries. The biggest change in GDP has been seen in China. GDP of China went up almost 14x from 1,1 billion US$ to 14,4 billion US$. Another huge increase has been seen in Russia when in 1999 GDP was 0,2 billion US$ in 2019 the amount went up to 1,7 billion US$. In India GDP multiplied 6x from 0,4 billion US$ in 1999 to 2,8 billion US$ in 2019. The United States dominates the group and in 2019 already tripled its GDP to 21,4 billion US$. Italy and Japan are only countries in this group to have smaller GDP than in previous decade. Thus, the biggest GDP increase have China, India and their staff went significantly up in case of Russia it is otherwise and professional staff of Russia decreasing each year.

Graph 3. GDP growth 1999-2019 (in billion)
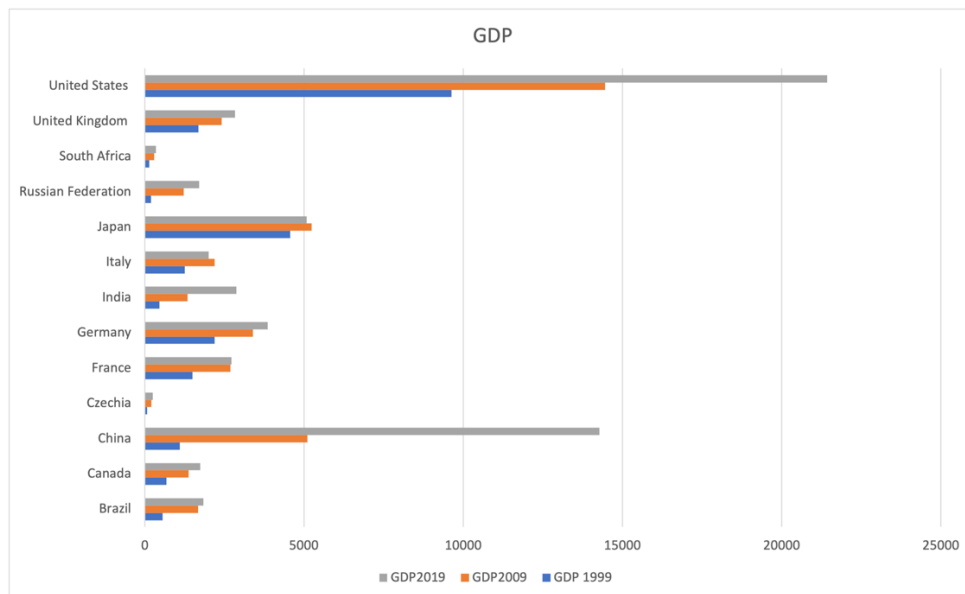
The graph 4 shows expenditure on education from 1999 to 2019. The biggest amount of expenses on education it has been noticed in the United States with 916 billion US$ in 2019. It is more than twice more than in 1999. China is second country with the biggest spending on education and the biggest change from 1999. In 2019 China has spent 248 billion US$ while in 1999 it was only 19 billion US$. But China's spending on education is still 3,7x less than the US. Another significant increase is seen in Brazil when in 1999 amount of the expenditure on education was only 22 billion US$ while in 2019 it was 112 billion US$. India went up from 19 billion US$ to 83 billion US$ in 2019. Russian Federation's expenditure on education increased from 7 billion US$ in 1999 to 59 billion US$ in 2019. However, in India also increased number of professional staff in the WHO while Russian's number of employees decreased.

Graph 4. Expenditure on education 1999-2019 (in billion)
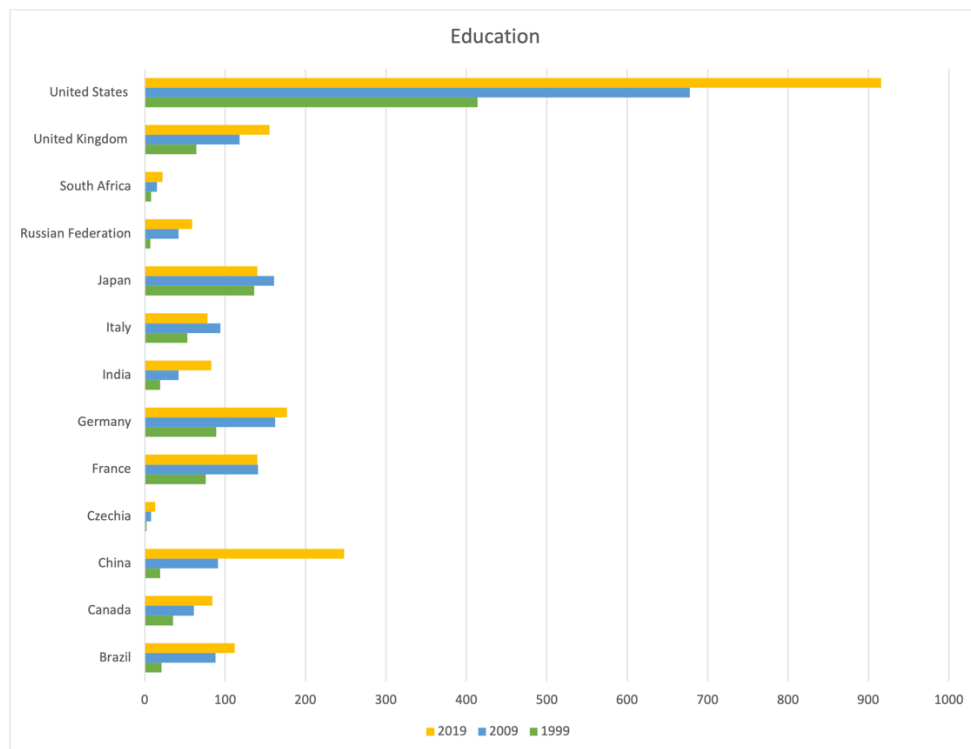
Education

This chapter displayed detailed analysis about all examined variables/factors which affect staffing in the WHO. This section dealt with the development of the number of employees in the WHO, GDP, education expenditure and population growth in the G7 and BRICS countries. The biggest increase of staff in the WHO was India, South Africa, the United Kingdom, and France. Countries having decreasing number of their professional staff are Brazil, Japan and Russian Federation. The biggest GDP growth expenditure on education have the United States, China and Japan. Only countries having decreasing GDP from previous decade are Japan and Italy. The biggest expenditure on education have been found in the United States, China, Brazil and India. The biggest population growth has India and China.
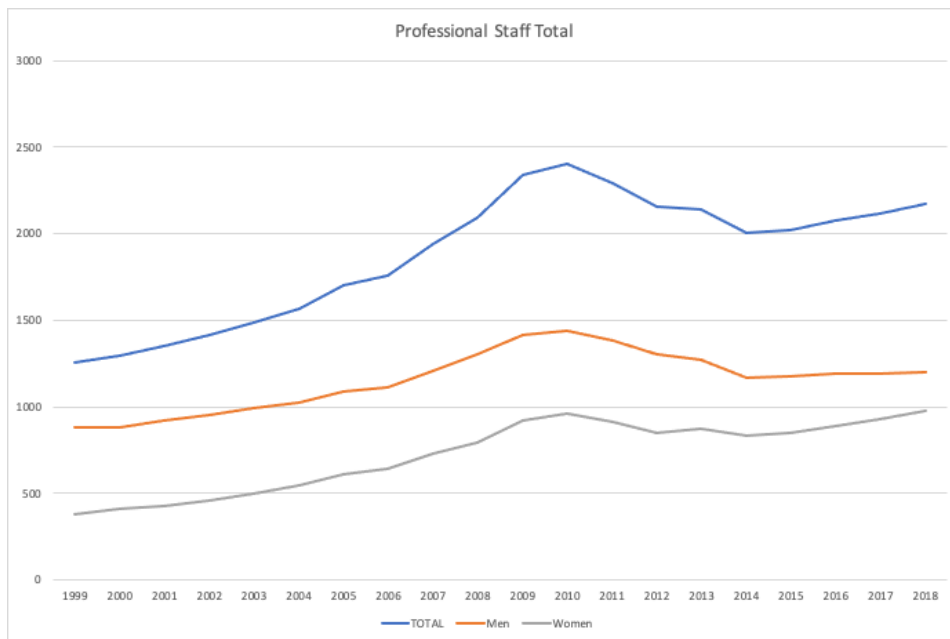
6. Composition of Professional Staff

Representation and composition of IOs secretariats are important for maintaining important information and creating international reforms and policies. The PA framework assumes that more powerful and wealthy countries have more control over international bureaucracies because they can provide more money to the IOs budget. In this section I will analyse professional staff categories and determine which regions are the most represented in each of them. Total number of WHO's employees is in long term period around 8000 thereof 2500 professional staff.

The Figure 3. shows increasing tendency of numbers in the professional staff. Numbers in last decades were between 2000 and 2500 people. After 2008 we can see decreasing numbers caused by financial crisis and European debt crisis when the financial contribution to the WHO have been reduced. Another important factor was the outbreak of Ebola virus disease in 2014 which dramatically impacted WHO. The outbreak was one of the public health emergencies and WHO spent US$ 71 million on activities related to this outbreak. Many resources were re-prioritised and WHO staff were redistributed. Nevertheless, staff and other personnel costs were still the largest category of expenses and represented 41% (43% in 2013) of the total expenses in the programme budget (Financial Report A68/38).

Increasing number of the professional staff depends on member states' financial contribution and other voluntary contributors. In time of the Ebola crisis, we can see staff reduced by almost 500 people and lightly decreased after the financial crisis in 2008. Moreover, we can see gradually rising numbers of women representants in the professional staff approaching staff numbers of men. In the 1999, the number of women's staff was only 377 and men by 882. In comparison, in 2018 the number of women was 973 and men 1202.t is almost threefold increase of women in the professional and higher category of staff.

Figure 3. Total number of professional staff 1999-2019

Category P1

The Figure 4 shows P1 category of professional staff in the WHO. P1 category is very rare position. For this "entry level", the candidate is not required to have work experience, or the candidate should have at least one year of relevant professional work experience. In this entry level category work around 10 – 25 people and mostly young absolvents of universities. This category is classified as "junior professionals". The Figure 4 shows that this position is mostly occupied by women staff and dominant region in this category is Europe.
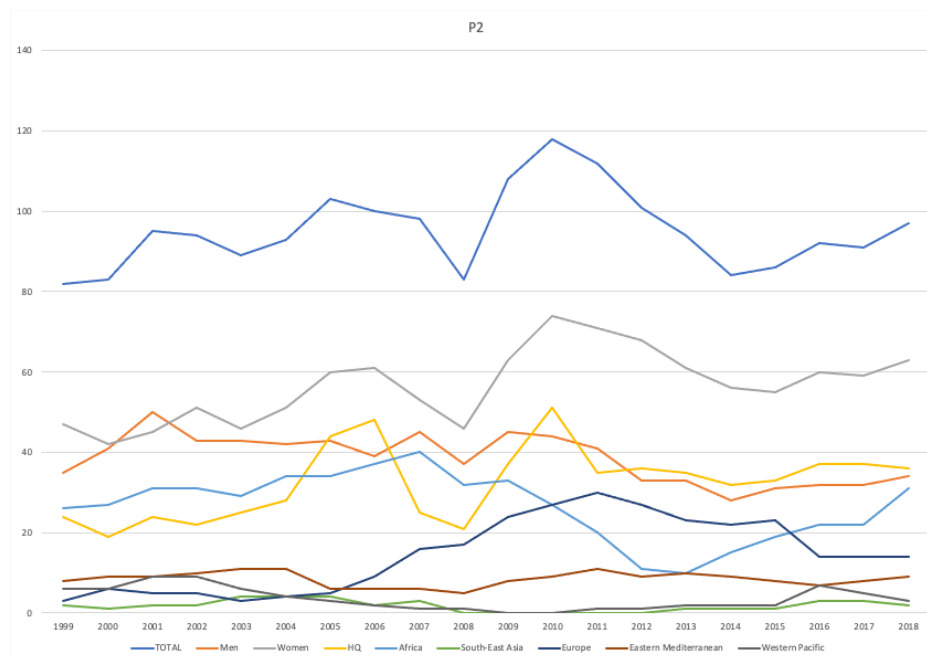
Figure 4. P1 category of professional staff
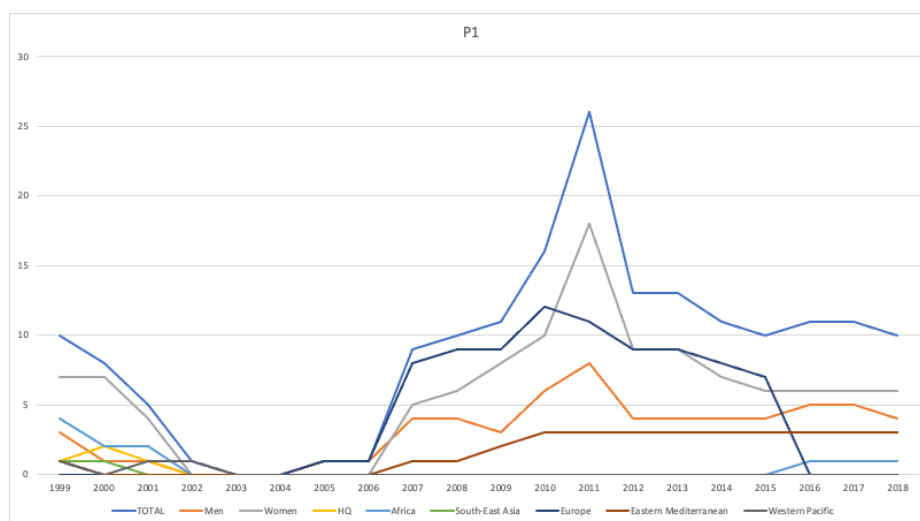
Category P2

FoThe2 category of professional staff is requires least two years of work experience. Of course, for ag analytical and communication skills, substantial experience and solid leadership ability. These are required for all P and D positions are various jobs within these categories, ranging from programme specialists and operations experts to communications specialists, information systems professionals, and many others. These positions are normally internationally recruited (UNFPA, 2018).

Also, in this category we can see that is represented mostly by women. Representation of women is twice as large as staff representation of men. We can see increasing tendency of Africa region in this category followed by Europe. The most positions in this category are available in the Geneva headquarter.

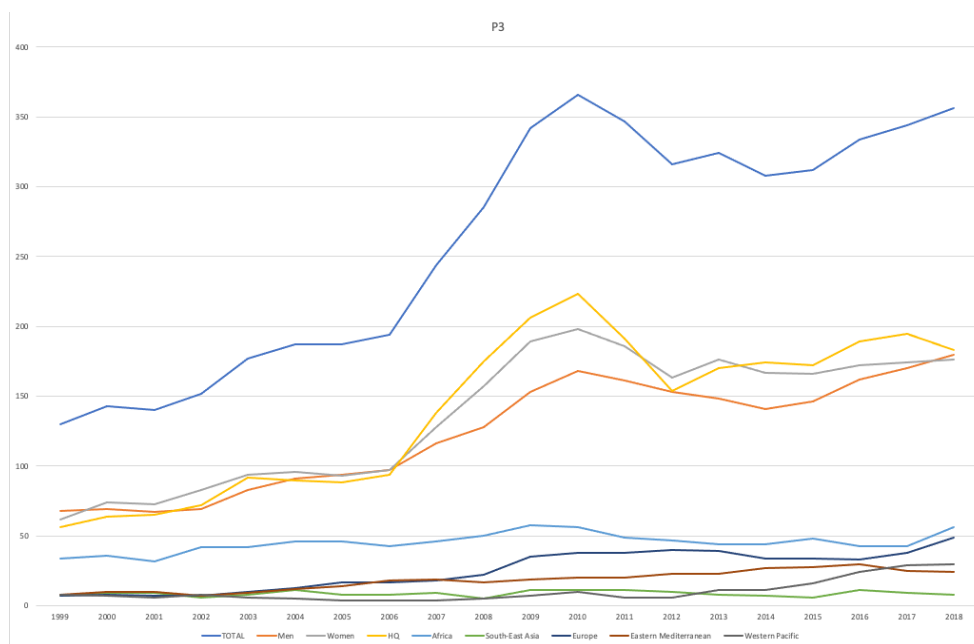**Figure 5.** P2 category of professional staff

Category P3

For P3 category of professional staff is required minimum of 5 years of work experience. This category still belongs to entry level of work. The base salary, which is determined by the grade of the post specified in the job opening and by the existence of any dependants, is the

same throughout the United Nations system. Annual net base salary ranges, for entry level professionals (P1 - P3) 67,000 - 106,000 US$ (Staff Regulations and Staff Rules, WHO). [12]

The Figure 6 shows how the numbers of staff have changed over time. In 1999, only 130 people were working in this category, in comparison in 2018 there were 356 workers. Women represented most of the staff until the 2017 where the situation changed and for the first time, men's representation were dominant.

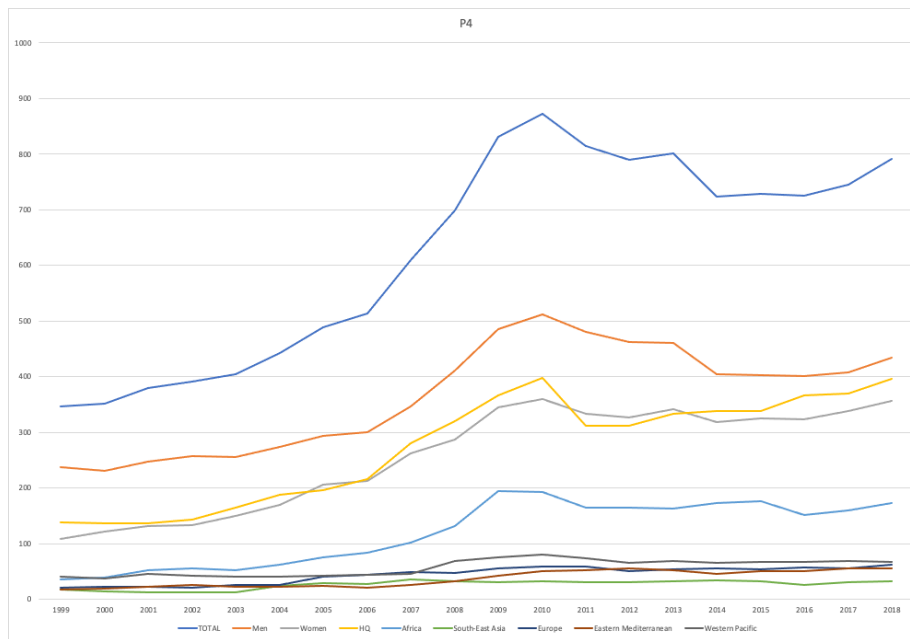**Figure 6**. P3 category of professional staff

Category P4

P4 level is categorised as "mid-level professional" and for this position is required minimum of 7 years of work experience. The Figure 7 shows that in this higher category dominate men over women. The biggest gap between them was in 2010 when the representation of male staff was 512 and female only 360. The most people in this category work for the headquarters and are from African region.


Figure 7. P4 category of professional staff

Category P5

The Figure 8 is last category of professional staff categorised as mid-level professionals. For this position is required minimum of 10 years of experience. Total number of employees is around 700 and almost 400 of them are male staff. The region which dominates P5 category is Africa followed by Eastern Mediterranean region.

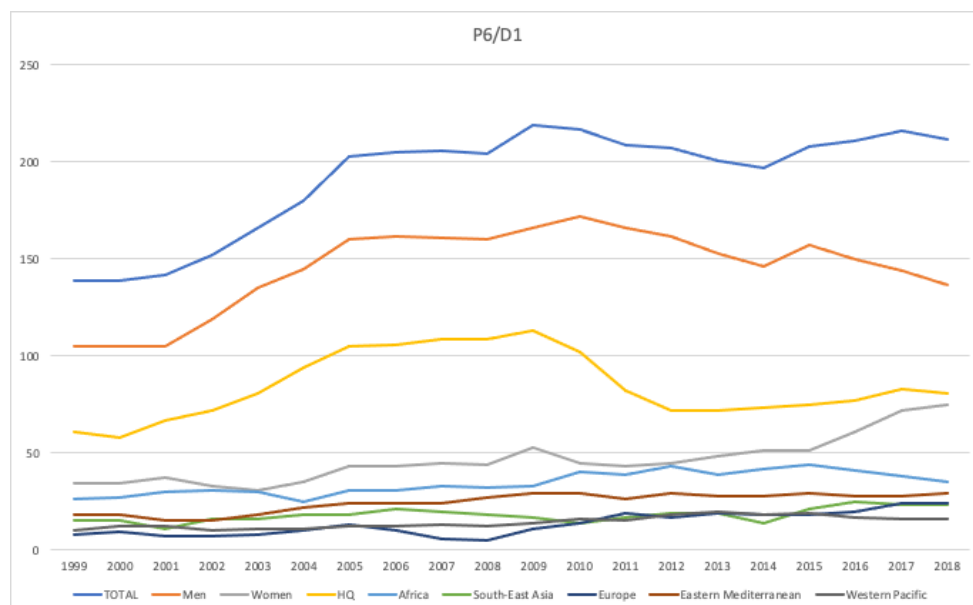**Figure 8**. P5 category of professional staff
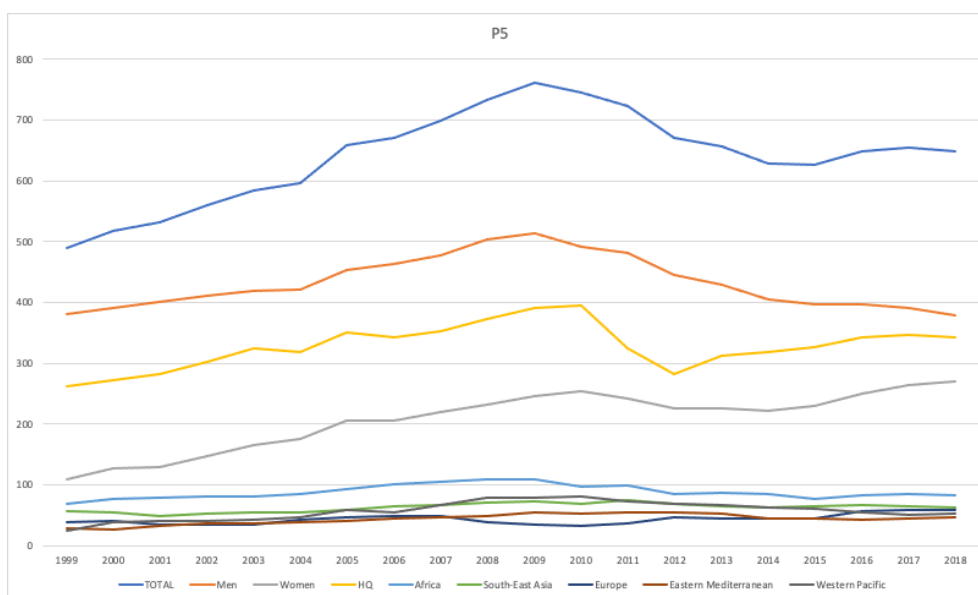
Category P6/D1

Category P6/D1 is first of the senior level professional level. For this position level is required at least15 years of work experience. In this category we can see difference from previous graphs where the representation of female staff exceeded male staff. In this category called as "directors", are more dominant male staff representation. The WHO is trying to change this trend in long-term period; however, the gender gap is still too high.

The gender difference shows the Figure 9. The biggest gap in representation of male and female staff in this category was in 2012. O 45 women worked on directors' positions while in the same category worked 162 men. These numbers are changing over the years and the gap between them is decdecreases2018, total the number of staff in D1 category was 212 and 75 of the men.

Big change in this context was the Revised Human Resources Strategy from 2014 focused on new rules in recruiting policy and selection process for the higher positions. Gender equality and work diversity should be provided in the context of a transparent selecting procedure that endorse equal and parity opportunity for all candidates. The HR Strategy stated: *"Staff can encourage, mainly by example and their support of sound policies, gender balance and diversity. They can also participate in selection panels, thereby assisting in the hiring of candidates with the highest standards of professionalism, competence and integrity."* (WHA 66/44).

**Figure 9**. P6/D1 category of professional staff

Category D2

The Figure 10 shows D2 category of staff – senior level professionals with more than 15 years of experience. Directors (D-1 and D-2 levels) represent the highest level on the career staffing structure of the Organization. Directors manage a programme of the Organization. They also provide leadership in formulating and implementing the substantive work programme of an office, determine priorities, and allocate resources for the completion of outputs and their timely delivery. Senior professionals hired for positions at the D1 and D2 level typically work as senior advisers or experts, bringing several years of analytical and research experience to the WHO (UN Careers, online).

Number of professional staff in D2 category is around 40-50 employees. Most of them, almost 50 %, are based in HQ in Geneva. Dominant position has male representatives in this category. The difference between gender representation in this category is marginal. Female staff represents only 10 % as directors. The WHO declared that the gender should be equal in all categories of staff by 2030. What is also surprising is the Eastern Mediterranean region which is most represented in this category.

Figure 10. D2 category of professional staff
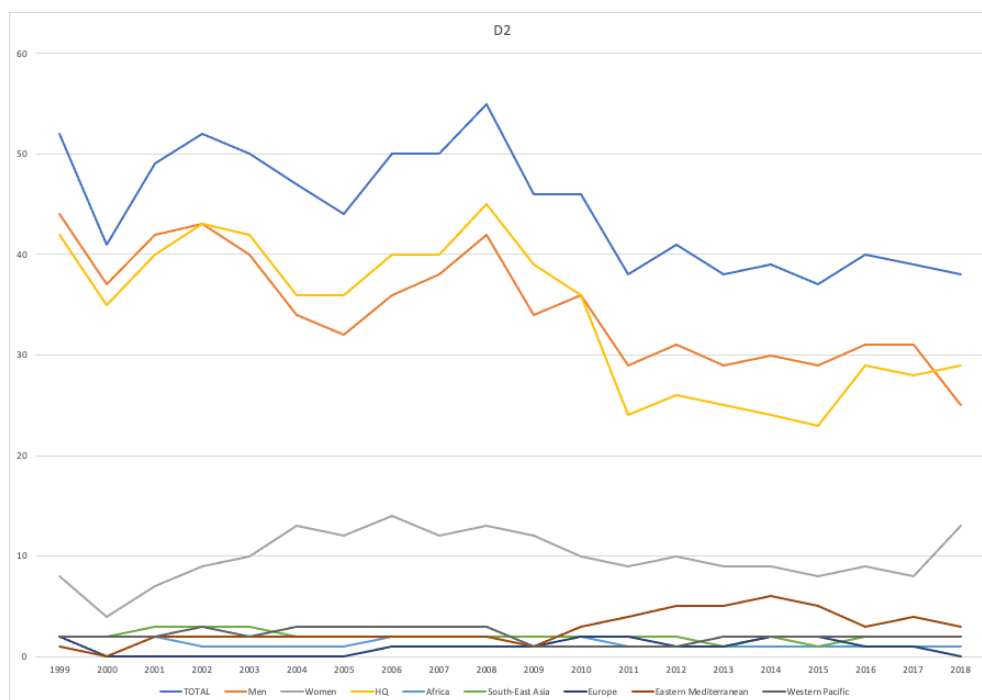
7. Women and WHO

The WHO has been criticized many times for the underrepresentation of women in higher professional positions. For example, in 2017 only 31% of the 191 heads of Member State delegations were women. The new mandate of Director-General Tedros Adhanon started in 2017 and he appointed a senior leadership team which was made up of 67% women. In this time there were only 30% of Directors women and only 42% of WHO staff in professional categories were women. The shift in gender imbalances made by Dr Tedros was a promising step in WHO's staffing policy with a possible global impact. WHO acknowledged this in its 13th General Programme of Work: *"WHO cannot work effectively on gender equality and health equity without turning the mirror upon itself." (Bohren et al. 2019).*

The Secretariat of the WHO tries to develop better environment for recruiting women into higher positions. In 2014 the Secretariat introduced the revised human resources strategy containing three pillars: attracting talent, career management and enabling work environment. The strategy represents principles of gender balance, diversity, collaboration and accountability (Executive Board: EB134/INF./2).

When I compare reports from online archive of the WHA from 1999 and 2019 we can see the difference in the professional and higher categories staff. For example, in 1999 total representation of women in the professional staff were only 29.9% and the most women worked in the headquarter in Geneva by 32.9%. The professional staff of the WHO is composed by six professional categories of staff and two director levels. In the first director level P6/D1 are 24.5% of women and in the second level D2 there are only 15.4% of women. Another interesting factor is that African region was represented by 21.4% of women and European region by 32.5% (HR annual report: A53/23).

By comparison, in 2019 the female representation of professional staff has increased to 45.4%. Working women in the headquarter raised from 32.9% to 51.5%. Even more women are representing European region by 52.7%. On the other hand, African region is represented by only 31.8% of women in professional staff. What I see as a big change is representation in director level of staff where in P6/D1 level are 35.4% of women and in D2 level category there are 35% of women directors. These changes have been caused by many factors one of

them could be educational system of member states and a new reformed strategy of recruiting higher staff in the WHO (HR Workforce data 2018).

The HR strategy from 2014 states that the WHO will commit the four cross-cutting principles. Gender balance and diversity will be one of the priorities of the WHO and the Secretariat will promote equal opportunity for all. The HR strategy is important also in the establishing a workspace where managers and directors will be able to select their staff in achieving gender balance in their department: *„The HR department and the hiring managers will assess their performance in recruitment and selection against a set of performance indicators, thereby increasing their accountability."* (HR revised strategy 2014).

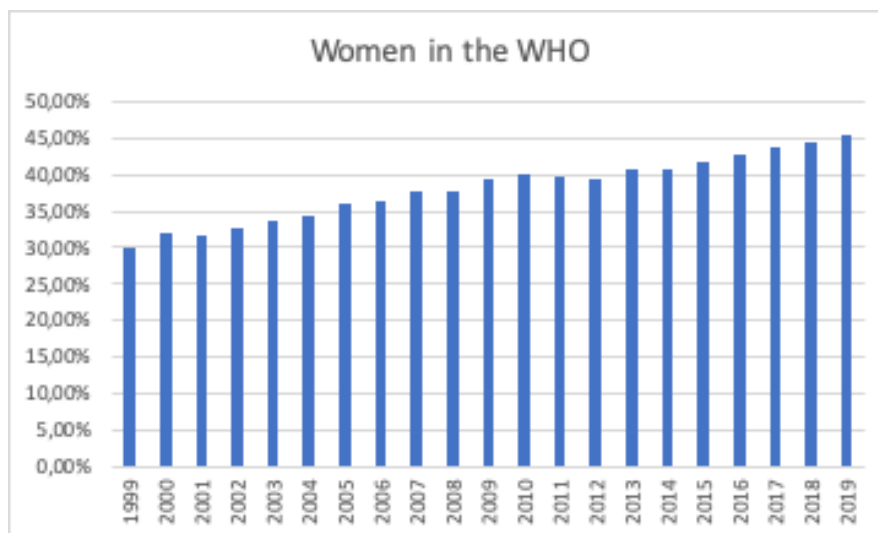**Figure 1.** Percentage of women in professional staff of the WHO from 1999 – 2019

Figure 1. shows increasing numbers of female representation over the years in the WHO by over 15%. The Secretariat and human resources of the WHO have long-term strategy for equal representation in professional staff and increase the percentage to 50%. Of course, this change has many other push factors e.g. changing society, better access to higher position for women or other activities.

Women are more represented in lower categories (P1-P4) of professional staff rather than in director's positions. But this trend is changing over time and in the last years we can see increasing numbers even in the D1 and D2 categories. My data analysis shows that percentage of women in higher staff category of professional staff has been increased over time.

In summary the biggest progress to reach gender equality has been made in the European Region. The percentage of female staff went up from 25 % in 1999 to 52 % in 2019. The second biggest increase happened in Western Pacific Region where female staff went up from 28 % in 1999 to 53 % in 2019. In African region the progress has been made up only by 10 % from 21 % in 1999 to 31 % in 2019. Interestingly, the most common age of professional staff in the WHO is still between 50-60 years old. In 1999, staff working in age category 50-60 was 51 % and the number went down only by 5 % in 2019 to 46 %. The analysis confirms the third hypothesis H3, that the representation of women in the WHO increased in the WHO over time.

Conclusion

In the thesis, it was analysed countries' representation in the professional staff of the WHO. My work aims to study how the representation of staff in the WHO changed over period from 1999 to 2019. I focused my findings on assumptions whether developed countries are more represented than the developing ones and how has changed the female representation in the Secretariat of WHO. I tried to analyse which member states are overrepresented and underrepresented and explain possible patterns of the staff structure.

I worked with correlation coefficients and regression analysis in SPSS and Microsoft Excel. The numbers and data about staff representation in the WHO were collected from the WHO archives online. The data are reported annually by human resources on the WHA and EB meetings. Member states' GDP development, population size, and expenditure on education are from the World Bank databank available online.

The research shows the increasing tendency of the number of professional staff. The total number of employees in WHO is around 8 000 thereof 2000-2500 are professional staff in the Secretariat. After 2008 we can see decreasing numbers caused by the financial crisis and European debt crisis when the financial contribution to the WHO has been reduced. Another change in staffing caused the outbreak of the Ebola virus disease in 2014, which dramatically impacted WHO. Many resources were re-prioritised, and the WHO staff were redistributed. Nevertheless, staff and other personnel costs were still the most significant expenses. The WHO's annual budget is about $ 2 billion, and the funds come from contributions from 194 member countries, most of which are the United States.

According to document WHA56.3 from 2003, the representation and staff distribution is reflected by budget contribution, membership and population. The WHO is trying to formulate programmes to interact with more people and provide a bigger opportunity to participate in the WHO's secretariat structure (e.g., WHO Academy).

The findings show that GDP growth affects countries' representation and staffing in the WHO. As a result, the H1(state's representation is affected by the country's economic power) and H2 (state's expenditure on education influence countries' representation in the WHO) can be confirmed. There has been a positive relationship between GDP and the number of

professional staff in the WHO in all three periods. The economic power of the Member States affects staffing policy in the WHO. On the other hand, the weakest effect on staffing policy has impacted education in all three researched periods. The size population had a significant effect on staffing in 2009.

The wealthy countries are the most represented in the WHO, meaning the total number of employees. The largest total number of employees in the WHO employees are the United States, the United Kingdom, France, Canada, Germany, Italy, Australia, India, Belgium, Philippines, Spain, Nigeria and Congo. Reports from the WHO show raising numbers of staff in France, Germany, India and the UK. However, according to WHO's statistics, the most overrepresented countries are from the African region.

Surprisingly, even with the most significant number of employees, the US belongs to an underrepresented country in the WHO. The US also has a weak correlation, and GDP has no significant influence on the number of the US in the WHO. The case of the US is particular, and in the relationship within the WHO are essential other factors. In this case, we have to look for another causal effect.

The most significant increase of staff in the WHO was India, South Africa, the United Kingdom and France. Countries having a decreasing number of their professional staff are Brazil, Japan and Russian Federation. The biggest GDP growth expenditure on education has the United States, China and Japan. Japan and Italy are the only countries having decreasing GDP from the previous decade. The most significant expenditure on education has been found in the United States, China, Brazil and India. The most extensive population growth has India and China.

Representation of women increased over time from 29% to almost 45%. Still, women are more represented in lower categories of professional staff rather than in higher ones (D1-D2). Gender balance and diversity are among the main priorities of the WHO's human resources and even Director-General Dr Tedros. The Secretariat tries to develop a long-term policy for a better environment for women in higher positions, and 2014 presented a revised human resources strategy containing three pillars to attract new talents. The data analysis shows that percentage of women in the higher staff category of professional staff has been increased over time in all categories. The biggest progress to reach gender equality has been made in

the European Region. The percentage of female staff went up from 25 % in 1999 to 52 % in 2019. The number of women in the Secretariat has increased over 30 years by about 16 %. In conclusion, the research also confirmed the H3 (the representation of women in the WHO increased over time).

According to the research, findings show that the wealthier countries have more representatives in the professional staff of the WHO. Developed countries provide a bigger contribution to the WHO's budget, but that does not necessarily mean that they have more extensive control over the Secretariat or impact on policymaking since new resolutions and policies are presented and discussed at the Executive Board meeting.

The thesis has many deficiencies which could be better proceeded. In the future development, I would also work with numbers of applicants to the WHO and better analyse rejected applications to see which countries are more successful in the recruitment process. I would also proceed with more financial contribution data to the WHO's budget to see the relationship between staff representation and the biggest funding countries.

References

Abbott, K. W., Snidal, D. 1998. Why States Act through Formal International Organizations. *Journal of Conflict Resolution*, 41 (1), 3–32. https://doi.org/10.1177/0022002798042001001

Andresen, S. 2002. Leadership Change in the World Health Organization: Potential for Increased Effectiveness? *The Fridtjof Nansen Institute*. p. 1-33. Available online at: https://www.files.ethz.ch/isn/100212/FNI-R0802.pdf

Badache, F. 2019. A representative bureaucracy perspective on workforce composition in international organisations: The case of the United Nations Secretariat. *Public administration* 29 (4): 1–36.

Barnett, M., Finnemore, M. 1999. The politics, power, and pathologies of international organisations. *International organisation*, 53: 699-732. DOI 10.1162/002081899551048

Bartholomew, D. J. 2010. *Analysis and Interpretation of Multivariate Data*. International Encyclopedia of Education (Third Edition) p. 12–17. Available at: https://www.sciencedirect.com/science/article/pii/B9780080448947013038. DOI 10.1016/B978-0-08-044894-7.01303-8

Bohren, M. A., Javadi D., Vogel J. P. 2019. Gender balance in WHO panels for guidelines published from 2008 to 2018. *Bulletin of the World Health Organization* 97:477–485. DOI: http://dx.doi.org/10.2471/BLT.18.226894

Christensen, J. 2019. Representative bureaucracy, international organisations and public service bargains. *Public Administration, 1–16.* https://doi.org/10.1111/padm.12625

Charles, J. 1968. Origins, history, and achievements of the World Health Organization. *BMJ.* 2 (5600): 293–296. DOI: 10.1136/bmj.2.5600.293.

Davda, J. 2020. Python Correlation – A Practical Guide. AlgoTrading 101. Available online: https://algotrading101.com/learn/python-correlation-guide/

Dolan, J., Rosenbloom, D. H. 2003. *Representative bureaucracy: Classic readings and continuing controversies*. Armonk, NY: M. E. Sharpe.

Dijkrstra, H. 2015. Shadow bureaucracies and the unilateral control of international secretariats: Insights from UN peacekeeping. *The Review of International Organizations,* 10: 23–41. DOI 10.1007/s11558-014-9203-7

Eckhard S., Steinebach Y. 2018. *Experience, education and skills: A supply-side explanation of geographical representation in 38 international organisations*. ISA Annual Convention, 1– 30.

Eisenhardt, K.M. 1989. Agency Theory: An Assessment and Review. *The Academy of Management Review*, 14 (1): 57–74, doi:10.5465/amr.1989.4279003. Available in: https://www.jstor.org/stable/pdf/258191.pdf?ab_segments=0%252Fbasic_SYC-5187_SYC-5188%252F5188&refreqid=excelsior%3Afcaae5384355bb5069efe1ec83011046

Godlee, F. 1994. The regions-too much power, too little effect. *British Medical Journal*, 309(December), 1566–1570.

de Vauss, David. 2002. *Analysing Social Scinece Data*. SAGE, London.

Graham, E. R. 2014. International organisations as collective agents: Fragmentation and the limits of principal control at the World Health Organization. *European Journal of International Relations*, 20(2), 366–390. https://doi.org/10.1177/1354066113476116

Hawkins, D. G., Lake, D. A., Nielson, D. L., Tierney, M. J. (Eds.). 2006.. *Delegation and Agency in International Organizations*. Cambridge: Cambridge University Press.

Jacobsen, H. 1973. WHO: Medicine, Regionalism and Managed Politics, in Cox, R. and H. Jacobsen, *The Anatomy of Influence Decision Making in International Organizations*, New Haven: Yale University Press.

Krestová, K. 2020. *WHO: an independent guardian of global healh?* Praha. Master's thesis (Mgr.). Charles University, Faculty of Social Sciences, Institute of Political Sciences.

Lindley, D.V. 1987. Regression and correlation analysis. New Palgrave: A Dictionary of Economics, 4, pp. 120–23.

Meier, K. J. 1975. Representative Bureaucracy: An Empirical Analysis. *The American Political Science Review*, 69 (2): 526–542. Available in: https://www.jstor.org/stable/1959084

Mitnick, B. M. 1982. Regulation and the Theory of Agency. *Review of Policy Research*, 1(3), 442–453. https://doi.org/10.1111/j.1541-1338.1982.tb00448.x

McCarthy, M. 2002. A brief history of the World Health Organization. *The Lancet* 360 (9340): 1111–1112. doi:10.1016/s0140-6736(02)11244.

Novosad P., Werker E. 2018. Who runs the international system? Nationality and leadership in the United Nations Secretariat. *The Review of International Organizations*, 14 (1): 1–33. DOI 10.1007/s11558-017-9294-z

Parizek, M. 2017. Control, soft information, and the politics of international organisations staffing. *The Review of International Organizations*, 12: 559 – 583. DOI 10.1007/s11558-016-9252-1.

Siddiqui, J. 1995. *World Health and World Politics: The World Health Organisation and the UN System.* London: C. Hurst & Co. Ltd.

Vaubel, R., Dreher, A., & Soylu, U. 2007. Staff growth in international organisations: A principal-agent problem? An empirical analysis. *Public Choice*, *133*(3–4), 275–295. https://doi.org/10.1007/s11127-007-9188-3

Vaubel, R. 2006. Principal-agent problems in international organisations. Review of International Organizations, 1(2), 125–138. https://doi.org/10.1007/s11558-006-8340-z

Yadav, M. K. 2017. Structure and Functions of the World Health Organization. *IOSR Journal of Humanities and Social Science*, 22 (9): 15–41. Available online at

http://www.iosrjournals.org/iosr-jhss/papers/Vol.%2022%20Issue9/Version-1/C2209011541.pdf.

Online documentation

Archived Documentation of WHO for Executive Board sessions and Health. Available at: https://apps.who.int/gb/index.html

The WHO. *Basic Documents: forthy-ninth edition 20202.* World Health Organization. Available at: https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf#page=213

The WHO. *Draft thirteenth general programme of work 2019−2023.* Advance edited version. Geneva: World Health Organization; 2018. Available from: https://www.who.int/about/what-we-do/gpw13-expert-group/Draft-GPW13-Advance-Edited-5Jan2018.pdf

The WHO. *Human resources: update. Workforce data. 2018.* Available at: https://www.who.int/about/finances-accountability/budget/HR-workforce_data-20181231.pdf?ua=1

The WHO. *The Constitution of the World Health Organization (1948).* Available at: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

The WHO. *Staff regulations and staff rules of the World Health Organization* (2014). Available   at: https://www.who.int/employment/what_we_offer/EN_Staff_Regulations_and_Staff_Rules-2014.PDF?ua=1

The WHO. *A73/21. Human resources: annual report. Report by the Director-General (2020). Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_21-en.pdf*

The WHO. *EB99/33. Report by the Director-General. Recruitment of international staff in WHO: geographical   representation   (1996).* Available   at: https://apps.who.int/iris/bitstream/handle/10665/173174/EB99_33_eng.pdf?sequence=1&isAllowed=y

The WHO. WHA24.12. *Review of method of establishment of scale of assessment* (1971). Available at: http://apps.who.int/iris/bitstream/handle/10665/91849/WHA24.12_eng.pdf;jsessionid=42169 AEFBEB1A0183CEAD17D7563DBE0?sequence=1

The WHO. *Gender Parity in Staffing 2016-2017*. Developed by Think Tank on Gender Equity in 2015. Available at: https://www.who.int/docs/default-source/documents/gender/gender-parity-in-staffing.pdf? sfvrsn=b2f5a0df_4&download=true