Statement by Medicus Mundi International
to the 130th Session of the Executive Board
on Agenda Item 5 WHO Reform: Programme and Priority Setting

Thank you, Chair.

I am speaking on behalf of Medicus Mundi International, among other organisations and coalitions represented by the People's Health Movement.

We are of the view that programme and priority-setting are fundamental areas to the reform process and also recall Dr. Chan calling it in November the «hardest part of the reform».

We have 3 points to raise about document EB130/5Add.1:

1. **Priority-setting should not be driven by the availability of resources, but rather by the mandate of the WHO.** The document portrays demand-led approach for priority-setting as a challenge, while presenting development agencies as the solution, particularly in low-income countries. This allows donor countries to interfere in the sovereign domain of health policy making in developing countries. There is currently a disconnect between priority-setting and the allocation of resources. Country-driven priority setting is often neutralised by the multitude of vertical disease-focused programmes, driven by Global Public-Private Partnerships (GPPPs) which influence resource allocation within WHO country offices. The success of any new mechanisms for prioritisation will depend upon addressing the distortions of resource allocation arising from tied donor funding.

2. **Programme and priority-setting requires a participatory process, rather than immediate identification of fixed core priority areas to be applied to all countries.** The seven core areas of work may not reflect the actual priorities of many countries, particularly when the methodology behind their selection is not clear.

Member states should focus, at this point in time, on the process and mechanism of priority-setting rather than agreeing on specific priorities.

3. **The document introduces the concept of country groupings or "typologies"**. While we welcome this approach, we find that the five categories proposed are simplistic, and almost entirely based on economic variables.

The concept of country groupings could better be applied both **across** and **within** regions using more representative criteria. Sub-regional groups can be identified, based on common health situation and priorities, within every single region. Empowerment of regional offices, and decreasing the level of centralisation in the WHO are prerequisites for the success of such regional and sub-regional groupings, and for the entire exercise of priority-setting.

Thank you.