

## 55th DIRECTING COUNCIL

### 68th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 26-30 September 2016

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*Provisional Agenda Item 4.3*

CD55/7  
1 July 2016  
Original: English

#### **METHODOLOGY FOR THE PROGRAMMATIC PRIORITIES STRATIFICATION FRAMEWORK OF THE PAHO STRATEGIC PLAN**

##### **Introduction**

1. The Strategic Plan of the Pan American Health Organization (PAHO) 2014-2019 established the framework for the stratification of programmatic priorities (Resolution CD52.R8 [2013]). This framework is intended to serve as a key instrument to guide the allocation of the human and financial resources available to the Pan American Sanitary Bureau (PASB) and to focus efforts to mobilize the resources needed to implement the Strategic Plan and its respective programs and budgets. The framework complements the PAHO Budget Policy (2012) and the Organization's Results-based Management (RBM) Framework (2010).
2. This document responds to Resolution CD53.R3 (2014), which requested the Director to "continue to undertake consultations with Member States to refine the programmatic priority stratification framework and apply it to future programs and budgets." The Strategic Plan Advisory Group (SPAG),<sup>1</sup> is comprised of 12 Member States, was established to take part in the consultations and advise PASB.
3. After reviewing various priority-setting methods, PASB and the SPAG concluded that the improvements introduced in the first iteration of the PAHO-adapted Hanlon method addressed the main concerns. Thus, the refined methodology presented in this document is considered the most suitable and responds to the purpose and objectives of

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<sup>1</sup> At the request of Member States, the Director established the SPAG in October 2014 to provide advice and input on the implementation of the joint monitoring and assessment process and the refinement of the programmatic stratification framework of the PAHO Strategic Plan 2014-2019 (Resolution CD53.R3). It includes 12 members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group is chaired by Mexico and co-chaired by Ecuador and Canada served as the technical lead for the methodology review.

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the PAHO Strategic Plan Programmatic Priorities Stratification Framework. This is the product of the close collaboration between PASB and the SPAG.

4. A progress report on the work undertaken with the SPAG during 2015 was presented in March 2016 to the Subcommittee on Program, Budget, and Administration (SPBA). The SPBA acknowledged the important refinements to the methodology, particularly the inclusion of new components in the formula such as inequity and PAHO's institutional positioning. The Member States highlighted the importance this methodology will have in guiding resource allocation and mobilization in the Organization. They also acknowledged the collaborative work undertaken between PASB and the members of the SPAG. The SPBA noted the robust scientific and innovative approach of the methodology for public health priority setting. The SPBA welcomed the proposal to publish the refined methodology, noting that this would make a major contribution to the regional and global scientific community, highlighting PAHO's role in spearheading innovation in this area.

5. The proposed policy document was presented for review and consideration by the 158th Session of the Executive Committee in June 2016. The proposal incorporated the input and agreements from the third face-to-face meeting of the SPAG members in April 2016. The Committee commended the work of the SPAG and the PASB team for the robust, scientific and innovative methodology. The Member States enthusiastically endorsed the proposed policy paper and its accompanying resolution with minor modifications. The potential impact and benefits that the refined methodology will have on PAHO's work and public health planning in the Region and other regions of WHO was noted.

6. National exercises are planned with the Member States of the 158th Session of the Executive Committee to apply the methodology. Region-wide exercises will be conducted with all Member States as part of the PAHO Program and Budget 2018-2019 development process after the methodology's approval by the Directing Council in September 2016.

## **Background**

7. Recognizing that the PAHO Strategic Plan 2014-2019 would be implemented in a context of limited resources and responding to the recommendations of Member States to focus the Organization's work in areas where PAHO clearly adds value, a programmatic priorities stratification framework was developed to guide the allocation of available resources to PASB and to target resource mobilization efforts. The framework included the adaptation of the Hanlon method to objectively and systematically rank program areas of the PAHO Strategic Plan.

8. The first iteration of the PAHO-adapted Hanlon method was developed and tested by a team of planning and public health experts from PASB and a Countries Consultative Group (CCG) established for the development of the PAHO Strategic Plan 2014-2019.

Programmatic priority stratification exercises were conducted as part of the national consultations for the PAHO Strategic Plan 2014-2019, using the PAHO-adapted Hanlon method. A total of 43 countries and territories, involving more than 1,000 public health officials across the Region of the Americas, participated.

9. Upon approval of the PAHO Strategic Plan 2014-2019 by the 52nd Directing Council and pursuant to Resolution CD52.R8 (2013), the 153rd Session of the Executive Committee established a Countries Working Group (CWG) charged with working with PASB in reviewing and refining the impact and outcome indicators and reviewing the Strategic Plan's Programmatic Priorities Stratification Framework.

10. From February to August 2014, the CWG worked with PASB to complete all tasks requested by Member States. The CWG began the review of the PAHO-adapted Hanlon method but was unable to conclude an in-depth analysis and make recommendations for its refinement. The group determined that more time was needed for the analysis so that it could consider all possible options for the development of a robust and comprehensive methodology that would address the concerns expressed by Member States.

11. On 1 October 2014, the 53rd Directing Council approved the amended version of the PAHO Strategic Plan 2014-2019, which included refined outcome and impact indicators. The Council acknowledged the valuable input of the CWG in the refinements to the PAHO Strategic Plan indicators, including the development of a compendium of indicators. It also accepted the recommendation of the CWG to continue collaborating with PASB in an advisory capacity to complete the refinement of the programmatic priorities stratification framework and provide input on the implementation of the joint monitoring and assessment process for the PAHO Strategic Plan (Resolution CD53.R3).

12. In response to Resolution CD53.R3, and given the collaboration with the CWG, the Director invited the members of the CWG to form part of the PAHO Strategic Plan Advisory Group.

### **Situation Analysis**

13. Priority setting is an important component of strategic planning<sup>2</sup> and decision-making given that if everything is a priority, then nothing is a priority. This is especially true when organizations are faced with multiple demands and resources to address them are limited. It is recognized that the process of priority setting involves technical, strategic, and political considerations. Although informed by evidence and analysis, the process cannot be resolved through science, formulas, or decision-making rules alone.

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<sup>2</sup> Neiger BL, Thackeray R, Fagen MC. Basic priority rating model 2.0: current applications for priority setting in health promotion practice. *Health Promotion Practice*. 2011;12:166-171.

14. There are various priority-setting methodologies, from simple and subjective methods to more objective and scientific methods. The challenge, however, is the selection and adaptation of the method that best responds to the scope, purpose, and context of an organization. Identifying a suitable method for the purposes of PAHO, as an international organization, requires the consideration of multiple variables related to its technical cooperation in public health such as social determinants of health and economic, environmental, and political aspects.

15. PAHO has been building on its experience with priority setting as part of its strategic planning and program and budget processes, in line with the implementation of its results-based management framework. In this regard, the PAHO Strategic Plan 2014-2019 included a robust and scientific approach to stratifying the program areas of the Plan using the first iteration of the PAHO-adapted Hanlon method. While Member States acknowledged the benefit of applying an objective and systematic prioritization methodology, they requested that the PAHO-adapted Hanlon method be revised to address potential bias in the formula that might give more weight—and, thus, higher rankings—to disease-oriented program areas. Particular concerns were raised about the limitations and perceived bias of this methodology, which was designed to rank disease problems and did not take into account the changes in the regional and global public health paradigm that have occurred since the methodology was originally developed by Hanlon in 1954 and published in 1984. Further concerns were noted regarding the varying scope of 24 program areas (including diseases, systems and services, public health interventions, and cross-cutting themes) of the PAHO Strategic Plan and the need to improve criteria and definitions for the consistent application of the methodology.

16. In order to address the concerns above, and in response to the mandate of the PAHO Directing Council (Resolution CD53.R3), PASB worked with the SPAG to refine the methodology from early 2015 to April 2016 via virtual sessions and three face-to-face meetings (in Washington, D.C., in May 2015, in Mexico City in August 2015, and again in Washington in April 2016).

17. The SPAG and PASB reviewed and discussed 15 priority-setting methods (see Annex A), including simple and subjective methods such as forced rankings, a nominal group method, and a simple voting procedure as well as more objective measures such as the Delphi method and the Hanlon method. An in-depth critical analysis of the original Hanlon method was conducted, and proposed revisions to the Hanlon equation were also analyzed. After considering the weaknesses and strengths of the various methods, the SPAG concluded that the PAHO-adapted Hanlon method could be refined to make it more adaptable for identifying tiers of public health programs in line with the purpose and objectives of the PAHO Strategic Plan Programmatic Priorities Stratification Framework.

**Proposal**

18. The purpose of the refined PAHO-adapted Hanlon methodology is to serve as the instrument to implement the PAHO Strategic Plan Programmatic Priorities Stratification Framework using a systematic, objective, and robust approach to guide resource allocation and target resource mobilization. It applies the principles and practices of strategic planning and public health and intrinsic values of the Organization with clearly defined components, criteria, and guidelines for its consistent application.

19. After careful analysis and pilot tests conducted with members of the SPAG and a national team of senior public health officials from Mexico, it was agreed that the formula below best responds to the purposes of the PAHO Strategic Plan Programmatic Priorities Stratification Framework:

$$\text{Basic Priority Rating (BPR)} = \frac{(A + B + E)C}{5.25} \times F$$

Where:

A = **Size or magnitude of the problem** (range of 0-10 points)—prevalence or incidence of diseases or system or program deficiencies (for non-disease-oriented program areas).

B = **Seriousness of the problem** (range of 0 to 20 points)—includes a combination of four components, each of which can be given a maximum score of 5 points: B<sub>1</sub>) urgency; B<sub>2</sub>) severity of consequences (premature mortality, disability, burden on health services, impact on health and sustainable human development); B<sub>3</sub>) economic loss, and B<sub>4</sub>) negative indirect external effects (negative impact on others or possibility that the problem extends or enhances other events). The importance of the program area in question for the health system and the consequences of not intervening are considered in the scoring of this component.

C = **Effectiveness of interventions** (range of 0-10 points)—availability of effective interventions to address the problems or deficiencies in systems or programs.

E = **Inequity** (range of 0-5 points)—differential occurrence of disease or access to health programs according to gender, ethnicity, income level, geographic location (urban vs. rural), etc.

F = **Positioning factor** (PAHO value-added; range of 0.67-1.5 points)—extent to which PAHO is uniquely positioned to address the program areas based on the

six core functions<sup>3</sup> of the Organization. The positioning factor also allows incorporation of a certain degree of political and strategic considerations in the prioritization process. As F is a multiplier, if the maximum is 1.5, the minimum is the reciprocal of 1.5, which is 0.67.

The **denominator** of the equation is 5.25. Mathematically, this converts the Basic Priority Rating (BPR) in a scale of 0 to 100.

*Note:* A, B, C, and D (feasibility) were the components originally proposed by Hanlon; however, D is no longer used, as suggested by researchers subsequent to Hanlon, particularly in the context of PAHO's Strategic Plan Programmatic Priorities Stratification Framework. Inequity (E) and positioning factor (F) are new components proposed by PAHO.

20. A key improvement to the methodology was the assembly of the PAHO Strategic Plan program areas into two major groups: *i*) disease-oriented programs and *ii*) health systems and public health intervention programs, or non-disease oriented programs (Annex B). This, along with clear definitions of components and criteria (Annex C) for rating diseases and non-disease-oriented program areas, helped to facilitate a consistent approach in the application of the methodology for ranking the 24 technical program areas to which the methodology applies. The absence of this distinction and such definitions was one of the main concerns expressed by Member States about the first iteration of the PAHO-adapted Hanlon method.

21. Along with adding clarity and making the definitions of the original Hanlon method components more adaptable to the wide-ranging PAHO Strategic Plan program areas, the refined methodology incorporates two unique and significant components of PAHO's work: inequity (E) and the positioning factor (F).

22. Inequity is an intrinsic component that is in line with the Organization's values and principles and the vision of the PAHO Strategic Plan 2014-2019. The Plan establishes an explicit commitment to reducing inequities in health throughout the Region and within and among countries, and it recognizes equity as a key strategic approach to improving health outcomes across all program areas. In addition, the inequity component responds to the principles and strategic orientations of the Sustainable Development Goals (SDGs) 2030—"leaving no one behind" and "universality"—and those of the Health Agenda for the Americas 2008-2017.

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<sup>3</sup> The six core functions of the Organization are: *i*) exercising leadership on matters critical to health and engaging in partnerships where joint action is needed; *ii*) determining the research agenda and stimulating the generation, application, and dissemination of valuable knowledge; *iii*) setting norms and standards and promoting and monitoring their implementation in practice; *iv*) formulating policy options that incorporate ethical principles and a scientific basis; *v*) establishing technical cooperation, catalyzing change, and building sustainable institutional capacity; and *vi*) monitoring closely the health situation and assessing health trends.

23. The positioning factor is unique in that it accounts for PAHO's value-added technical cooperation. This factor serves as the dial or fine tuner that allows Member States to identify where PAHO is uniquely positioned to collaborate with countries in addressing problems related to program areas of the PAHO Strategic Plan.

24. Guidelines, tools, and criteria have been developed to ensure the consistent application of the methodology across all Member States and to avoid potential errors. In addition, the tool that was used for the previous stratification exercise was simplified to facilitate its application with the necessary definitions and reference information for participants to complete the exercise in a systematic manner. PASB will also provide training and facilitate the exercise with country offices and Member States. The priority-setting results will be used in the preparation of the PAHO Program and Budget 2018-2019. An overview of the concepts and the criteria for scoring the components is included in Annex C.

25. Based on the tests conducted by PASB and the SPAG members, it has been observed that the refined methodology addresses the main concerns of Member States regarding the inherent bias of the original Hanlon formula with respect to disease-oriented programs. This is illustrated by the results of the latest pilot conducted by the SPAG in April 2016 (Annex D), which show a balanced mix of diseases and health systems and public health intervention programs across all tiers of stratification (high, medium, and low). The results of the national exercises to be conducted with the SPAG members and the 158th Session of the Executive Committee will be taken into consideration in the final proposal to be presented for approval by the Directing Council (September 2016).

26. Caution should be exercised in interpreting the results of the SPAG pilot. First, they do not represent the full regional results. Second, the program areas in the lower tier are not less relevant than those in the first tier, given that all of the Strategic Plan's program areas represent the collective priorities for the Region, as approved by Member States. Lastly, the stratification results facilitate identifying where the Organization should increase or reduce emphasis, taking into consideration the value-added of its technical cooperation and the capacity in countries and the Region as a whole to address problems related to the program areas. However, this may not represent full national health priorities, which require national health authorities and other partner interventions.

27. A scientific journal manuscript on the PAHO-adapted Hanlon method is being prepared for publication. The original Hanlon equation published in 1984, and publication of the PAHO-adapted Hanlon method in a peer-reviewed scientific journal will help validate the method and also will constitute an important contribution to the knowledge, science, and practice of priority setting in strategic planning for public health regionally and globally.

28. In addition to providing an objective guide for the allocation of resources to programmatic priorities, the PAHO-adapted methodology can serve other WHO regions,

government agencies, and other organizations with similar needs in prioritizing their programs and interventions. The methodology can be adapted to the needs of such agencies or organizations through the inclusion of components that are relevant to the context of their mandate and work.

**Action by the Directing Council**

29. The Directing Council is invited to review and approve the Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan.

Annexes



## Annex A

**Priority-setting Methods Reviewed and Discussed by the  
Pan American Health Organization Strategic Plan Advisory Group**

Method	Reference
1. Criteria weighting	Hanlon JJ, Pickett GE. Public health administration and practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984.
2. Decision alternative rational evaluation	Hanlon JJ, Pickett GE. Public health administration and practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984.
3. Delphi method	Gilmore GD, Campbell MD. Needs and capacity assessment strategies for health education and health promotion. Third edition. Sudbury (MA): Jones & Bartlett; 2005.
4. Dotmocracy method	Idea Rating Sheets [Internet]. Diceman J [cited 2016 Jan 21]. Available from: <a href="http://www.idearatingsheets.org/">http://www.idearatingsheets.org/</a>
5. Forced rankings	Gilmore GD, Campbell MD. Needs and capacity assessment strategies for health education and health promotion. Sudbury (MA): Jones & Bartlett; 2005.
6. Hanlon method (Basic priority rating, BPR)	Hanlon JJ, Pickett GE. Public Health Administration and Practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984.
7. Multi-criteria decision analysis (MCDA)	Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. <i>Cost Eff Resour Alloc</i> [Internet]. 2006 Aug 21 [cited 2016 Jan 21]. Available from: <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/</a>
8. Multi-voting method	National Association of County and City Health Officials. First things first: prioritizing health problems [Internet]. Washington (DC): National Association of County and City Health Officials; ND [cited 2016 Jan 21]. Available from: <a href="http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf">http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf</a>
9. Nominal group method	Hanlon JJ, Pickett GE. Public health administration and practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984. Gilmore GD, Campbell MD. Needs and capacity assessment strategies for health education and health promotion. Sudbury (MA): Jones & Bartlett; 2005.
10. Prioritization matrix	National Association of County and City Health Officials. First Things First: Prioritizing Health Problems [Internet]. Washington (DC): National Association of County and City Health Officials; ND [cited 2016 Jan 21]. Available from: <a href="http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf">http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf</a>

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Method	Reference
11. Priority rating method	Hanlon JJ, Pickett GE. Public health administration and practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984.
12. Simple voting procedure	Gilmore GD, Campbell MD. Needs and capacity assessment strategies for health education and health promotion. Sudbury (MA): Jones & Bartlett; 2005.
13. Simplex method	Hanlon JJ, Pickett GE. Public health administration and practice. Eighth edition. St. Louis (MO): Times Mirror/Mosby College Publishing; 1984.
14. Strategy grids	National Association of County and City Health Officials. First things first: prioritizing health problems [Internet]. Washington (DC): National Association of County and City Health Officials; ND [cited 2016 Jan 21]. Available from: <a href="http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf">http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf</a>
15. Two stage method	Choi BCK, Eijkemans GJM, Tennessee LM. Prioritization of occupational sentinel health events for workplace health and hazard surveillance: The Pan American Health Organization experience. <i>Journal of Occupational and Environmental Medicine</i> . [Internet] 2001 Mar [cited 2016 Jan 21];(2)43:147-157. Available from: <a href="http://www.bdsp.ehesp.fr/Base/231916/">http://www.bdsp.ehesp.fr/Base/231916/</a> .

## Annex B

**List of Program Areas by Groups: Disease-oriented Programs and Health Systems and Public Health Intervention Programs**

Group	Program Area
<b>Disease-oriented Programs</b>	<ul style="list-style-type: none"> <li>1.1 HIV/AIDS and STIs</li> <li>1.2 Tuberculosis</li> <li>1.3 Malaria and other vector-borne diseases (including dengue and Chagas)</li> <li>1.4 Neglected, tropical, and zoonotic diseases</li> <li>1.5 Vaccine-preventable diseases (including maintenance of polio eradication)</li> <li>2.1 Noncommunicable diseases and risk factors</li> <li>2.2 Mental health and psychoactive substance use disorders</li> <li>2.3 Violence and injuries</li> <li>2.4 Disabilities and rehabilitation</li> <li>2.5 Nutrition</li> </ul>
<b>Health Systems and Public Health Intervention Programs</b>	<ul style="list-style-type: none"> <li>3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health</li> <li>3.2 Aging and health</li> <li>3.3 Gender, equity, human rights, and ethnicity</li> <li>3.4 Social determinants of health</li> <li>3.5 Health and the environment</li> <li>4.1 Health governance and financing; national health policies, strategies and plans</li> <li>4.2 People-centered, integrated, quality health services</li> <li>4.3 Access to medical products and strengthening of regulatory capacity</li> <li>4.4 Health systems information and evidence</li> <li>4.5 Human resources for health</li> <li>5.1 Alert and response capacities (for IHR)</li> <li>5.2 Epidemic- and pandemic- prone diseases</li> <li>5.3 Emergency risk and crisis management</li> <li>5.4 Food safety</li> </ul>

## Annex C

## Components and Definitions of the PAHO-adapted Hanlon Methodology

Criteria <sup>a</sup>		Definitions	Low Score	Medium Score	High Score
<b>A = Size or magnitude of the problem (0-10 points)</b>		For disease-oriented programs, the size or magnitude of the problem is the extent of the disease in the population. It is measured by rates such as incidence, prevalence, age-adjusted cause-specific mortality rates, and proportional mortality ratios, among others.	<b>(Score: 0-3)</b> Prevalence <50/100,000	<b>(Score: 4-6)</b> Prevalence 50/100,000- 5,000/100,000	<b>(Score: 7-10)</b> Prevalence >5,000/100,000
		For health systems and public health intervention programs, the size or magnitude of the problem is the extent of the deficiency of the system or program. It can be measured by the percentage of the population exposed to the problem (e.g., without access to a health program) or the degree of lack of response capacity.	<b>(Score: 0-3)</b> High access to health programs or response capacity 67%-100%	<b>(Score: 4-6)</b> Medium access to health programs or response capacity 34%-66%	<b>(Score: 7-10)</b> Low access to health programs or response capacity 0%-33%
<b>B = Seriousness (0-20 points)</b>	<b>B<sub>1</sub> = Urgency (0-5 points)</b>	Urgency is the emerging nature of a program area, that is, the degree to which a problem is worsening, stabilizing, or improving based on 5-year trend data. Alternatively, it can be measured by the degree of progress towards achieving the target.	<b>(Score: 0-1)</b> Problem has been improving during the last 5 years	<b>(Score: 2-3)</b> Problem has been stabilizing (remains the same) during the last 5 years	<b>(Score: 4-5)</b> Problem has been worsening during the last 5 years
	<b>B<sub>2</sub> = Severity of consequences (0-5 points)</b>	Severity of consequences measures the extent of premature mortality and disability. Other considerations include loss of quality of life caused by the problem, burden to health services, and impact on health and sustainable development. Consequences	<b>(Score: 0-1)</b> Problem/ response capacity causing low level of mortality or disability	<b>(Score: 2-3)</b> Problem/ response capacity causing medium level of mortality or disability	<b>(Score: 4-5)</b> Problem/ response capacity causing high level of mortality or disability

<sup>a</sup> Definitions of size or magnitude and effectiveness are distinguished for program areas based on disease-oriented programs, and health systems and public health intervention programs.

Criteria <sup>a</sup>		Definitions	Low Score	Medium Score	High Score
		of non-action should also be considered.			
	<b>B<sub>3</sub> = Economic loss (0-5 points)</b>	Economic loss is the cost, both direct and indirect, borne by society that is associated with the health problem.	<b>(Score: 0-1)</b> Problem causing low level of economic loss	<b>(Score: 2-3)</b> Problem causing medium level of economic loss	<b>(Score: 4-5)</b> Problem causing high level of economic loss
	<b>B<sub>4</sub> = Negative impact on others (0-5 points)</b>	Negative impact on other people and/or countries is measured by <i>i</i> ) the communicable nature of the health problem (e.g., communicable diseases), <i>ii</i> ) behavioral effects related to the health problem on others (e.g., second-hand smoke, drinking and driving), and <i>iii</i> ) the ability of the problem to spread and cause other problems.	<b>(Score: 0-1)</b> Problem has low level of communicability through disease or risk factors to other people or countries/lack of access has low level of negative impact	<b>(Score: 2-3)</b> Problem has medium level of communicability through disease or risk factors to other people or countries/lack of access has medium level of negative impact	<b>(Score: 4-5)</b> Problem has high level of communicability through disease or risk factors to other people or countries/lack of access has high level of negative impact
<b>C = Effectiveness of interventions (0-10 points)</b>		For disease-oriented programs, effectiveness is the degree to which an intervention is successful in producing a desired result under ordinary circumstances. (This is not to be confused with efficacy, which is the degree of success under ideal conditions, such as controlled environments or in a laboratory.) The effectiveness of the interventions considers: <i>i</i> ) effectiveness (%), or the overall success of the method to be employed, and <i>ii</i> ) reach or target potential (%), the degree to which the target population will respond.	<b>(Score: 0-3)</b> Low level of effectiveness and reach 0%-33%	<b>(Score: 4-6)</b> Medium level of effectiveness and reach 34%-66%	<b>(Score: 7-10)</b> High level of effectiveness and reach 67%-100%
		For health systems and public health intervention programs, it is a qualitative assessment of the effectiveness of interventions (to correct deficiencies).	<b>(Score: 0-3)</b> No effective intervention to correct problem	<b>(Score: 4-6)</b> Somewhat effective intervention to correct problem	<b>(Score: 7-10)</b> Very effective intervention to correct problem

Criteria <sup>a</sup>	Definitions	Low Score	Medium Score	High Score
<b>E = Inequity (0-5 points)</b>	According to PAHO/WHO, health inequities are <i>unfair</i> and <i>unjust</i> inequalities that are <i>unnecessary</i> and <i>avoidable</i> between groups of people within and between countries. <sup>b, c</sup> Inequity can be measured by differential occurrence of disease and access to services or programs according to gender, ethnicity, income level, geographic location (urban vs. rural), and so forth within and among countries.	<b>(Score: 0-1)</b> No differential occurrence	<b>(Score: 2-3)</b> Moderate differential occurrence	<b>(Score: 4-5)</b> Large differential occurrence
<b>F = Positioning factor (0.67-1.5 points)</b>	Positioning is an institution's added value in each of the program areas being prioritized. For PAHO, this means the extent to which the Organization is uniquely positioned to collaborate with Member States to address program areas based on <i>i</i> ) political, strategic, or technical issues and <i>ii</i> ) country-, subregional-, or regional-level technical cooperation and other similar aspects, taking into consideration PAHO's six core functions. The institutional positioning factor also allows incorporation of political and strategic considerations into the prioritization process.	<b>(Score: 0.67-0.99)</b> The country has the capacity to respond to the scope of the program area and/or has another strategic partner/ organization that is providing the necessary technical collaboration. PAHO could decrease its collaborative technical cooperation.	<b>(Score: 1)</b> The country has some capacity to respond to the scope of the program area. PAHO should maintain its current level of technical cooperation.	<b>(Score: 1.01-1.5)</b> The country has limited capacity to respond to the scope of the program area. PAHO should increase its current level of technical cooperation.

Source: PASB technical teams and the Strategic Plan Advisory Group.

<sup>b</sup> PAHO Strategic Plan 2014-2019 (Resolution CD53.R3 [2014]).

<sup>c</sup> See [http://www.who.int/social\\_determinants/thecommission/finalreport/key\\_concepts/en/](http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/).

## Annex D

**Programmatic Priorities Stratification Results of the Pilot Exercise Conducted with the SPAG Using the Proposed Methodology**

Program Area	Priority	
	Tier	Rank
3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health	1	1
2.1 Noncommunicable diseases and risk factors	1	2
4.1 Health governance and financing, national health policies, strategies and plans	1	3
3.4 Social determinants of health	1	4
5.2 Epidemic- and pandemic- prone diseases	1	5
1.3 Malaria and other vector-borne diseases (including dengue and Chagas)	1	6
2.3 Violence and injuries	1	7
4.3 Access to medical products and strengthening of regulatory capacity	1	8
5.3 Emergency risk and crisis management	2	9
4.5 Human resources for health	2	10
2.2 Mental health and substance use disorders	2	11
2.5 Nutrition	2	12
4.2 People-centered, integrated, quality health services	2	13
5.1 Alert and response capacities (for IHR)	2	14
1.5 Vaccine-preventable diseases (including maintenance of polio eradication)	2	15
4.4 Health systems information and evidence	2	16
2.4 Disabilities and rehabilitation	3	17
3.2 Aging and health	3	18
3.3 Gender, equity, human rights, and ethnicity	3	19
5.4 Food safety	3	20
1.1 HIV/AIDS and STIs	3	21
3.5 Health and the environment	3	22
1.2 Tuberculosis	3	23
1.4 Neglected, tropical, and zoonotic diseases	3	24

	Disease-oriented Programs
	Health Systems and Public Health Intervention Programs

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CD55/7  
Annex E  
Original: English

### *PROPOSED RESOLUTION*

#### **METHODOLOGY FOR THE PROGRAMMATIC PRIORITIES STRATIFICATION FRAMEWORK OF THE PAHO STRATEGIC PLAN**

##### ***THE 55th DIRECTING COUNCIL,***

(PP1) Having reviewed the *Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan* (Document CD55/7);

(PP2) Considering the importance of having a robust, objective, and systematic methodology to implement the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan;

(PP3) Recalling the request from the 53rd Directing Council in 2014 (Resolution CD53.R3) for the Director “to continue to undertake consultations with Member States to refine the programmatic priority stratification framework and apply it to future programs and budgets” in order to address weaknesses, including potential bias in the original methodology that might have resulted in giving more weight—and, thus, higher rankings—to disease-oriented programs and the fact that the methodology did not take into account changes in the regional and global public health paradigm;

(PP4) Acknowledging the valuable input, collaboration, and commitment of the Strategic Plan Advisory Group<sup>1</sup> in advising PASB on conducting extensive analyses of

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<sup>1</sup> At the request of Member States, the Director established the SPAG in October 2014 to provide advice and input on the implementation of the joint monitoring and assessment process and the refinement of the programmatic stratification framework of the PAHO Strategic Plan 2014-2019 (Resolution CD53.R3). It includes 12 members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group is chaired by Mexico and co-chaired by Ecuador, and Canada served as the technical lead for the methodology review.

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various priority-setting methodologies in order to refine the PAHO-adapted Hanlon methodology;

(PP5) Recognizing the role that objective and systematic priority setting can have in the process of strategic planning and decision making, especially in the context of multiple demands and resource limitations;

(PP6) Recognizing the importance of having a scientific methodology consistent with the Organization's context, values, and strategic vision, including the incorporation of new components such as equity and PAHO's institutional positioning factor (the Organization's added value) that are unique to the refined PAHO-adapted Hanlon methodology,

***RESOLVES:***

(OP)1. To approve the *Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan*.

(OP)2. To promote awareness of the PAHO-adapted Hanlon methodology as a useful tool in priority setting in public health in the Region and globally.

(OP)3. To urge Member States, as appropriate and taking into account their national context, to:

- a) participate actively in national consultations and apply the methodology in an objective and systematic manner as part of the process for development of the Program and Budget 2018-2019;
- b) consider the adoption, adaptation, and utilization of this methodology at the national level, to the extent that it is appropriate and relevant, in order to better inform priority setting, thereby guiding the allocation of limited resources to where they can have the greatest public health impact.

(OP)4. To request the Director to:

- a) apply the methodology for the development and implementation of the Program and Budget 2018-2019 in close collaboration with Member States and partners;
- b) support national consultations in all countries and territories in the Region, while promoting the consistent application of the methodology in line with the components, criteria, and guidelines, in an effort to obtain the clearest and most accurate picture of the public health priorities of the Region;
- c) report on the application of the programmatic stratification for resource mobilization and resource allocation in the final assessment of the PAHO Strategic Plan 2014-2019 to be presented in 2020;

- d) support the publication of the PAHO-adapted Hanlon methodology in order to contribute to regional and global scientific knowledge for priority setting in public health and to promote this innovation and its results as a best practice and example of the collaborative work of PASB and Member States;
- e) consult with Member States on necessary updates and refinements to the methodology for future Strategic Plans and Program and Budgets taking into consideration the lessons learned and experiences from previous biennia.

## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

**1. Agenda item:** 4.3 - Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan

**2. Linkage to PAHO Program and Budget 2016-2017:**

**a) Categories:**

While the item falls under Category 6 (Corporate Services/Enabling Functions) and the specific program area/outcome below, it impacts all other categories and program areas of the Strategic Plan.

**b) Program areas and outcomes:**

Program Area: 6.3 Strategic Planning, Resource Coordination, and Reporting

Outcome: 6.3 Financing and resource allocation aligned with priorities and health needs of Member States in a results-based management framework

Outcome indicators: 6.3.1 (Percentage of Program and Budget funded) and 6.3.2 (Percentage of outcome indicator achievement)

**3. Financial implications:**

**a) Total estimated cost for implementation over the life cycle of the resolution (including staff and activities):**

Based on past experiences, the estimated cost for the implementation of this item is US\$ 240,000, which includes main direct costs related to travel, editing, and coordination, including support to countries from the PAHO Headquarters and PAHO/WHO Representative Offices:

- Training, orientation, and support to countries: US\$ 120,000
- Editing, translation, publication, and promotional material: US\$ 45,000
- Coordination and briefing meetings and report writing: US\$ 75,000

**b) Estimated cost for the 2016-2017 biennium (including staff and activities):**

Same as above - all costs to be incurred during the 2016-2017 biennium.

**c) Of the estimated cost noted in b), what can be subsumed under existing programmed activities?**

The costs outlines above will be incorporated into the respective work plans of the Department of Planning and Budget, relevant technical departments/units, and PAHO/WHO Representations.

**4. Administrative implications:**

**a) Indicate the levels of the Organization at which the work will be undertaken:**

The process will be led by the Department of Planning and Budget (PBU), with the support of other technical departments at Headquarters and all PAHO/WHO Representative Offices. Advisory input will be obtained from the members of the PAHO Strategic Plan Advisory Group (SPAG), a group of 12 Member States. All countries and territories in the Region will participate in the programmatic prioritization stratification exercise, which will be conducted as part of the consultation process for the development of the PAHO Program and Budget 2018-2019.

**b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

N/A. The work will be conducted with current staff and in collaboration with relevant PASB entities and Member States.

**c) Time frames (indicate broad time frames for the implementation and evaluation):**

The time frame for implementation of the consultations is from September 2016 to November 2016. Once the PAHO Directing Council approves the methodology in September 2016, it will be applied for the development of the PAHO Program and Budget 2018-2019. The development of the Program and Budget will continue through 2017, with the presentation of the first draft proposal to the Subcommittee on Program, Budget, and Administration in March 2017. Thereon the process will follow the 2017 PAHO Governing Bodies cycle.

A manuscript on the PAHO-adapted Hanlon method is currently being prepared in collaboration with the SPAG members for publication in a peer-reviewed scientific journal.

The results from the national consultations will be applied during 2018-2019 to guide the mobilization and allocation of resources. The impact of the application of the methodology will be included in the final evaluation on the PAHO Program and Budget 2018-2019 that will be presented to PAHO's Governing Bodies in 2020.

## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.3 - Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan
2. **Responsible unit:** Planning and Budget (PBU)
3. **Preparing officers:** Rony Maza and Andrea Morales
4. **Link between Agenda item and [Health Agenda for the Americas 2008-2017](#):**  
 Although the methodology is linked and contributes to all eight areas of action of the Health Agenda for the Americas, the three that have the most direct links are:
  - a) Strengthening the National Health Authority;
  - d) Diminishing health inequalities among countries and inequities within them; and
  - g) Harnessing knowledge, science, and technology.
 These areas are in line with the principles, purpose, and objectives of the programmatic priorities stratification framework and the refined PAHO-adapted Hanlon methodology.
5. **Link between Agenda item and the [PAHO Strategic Plan 2014-2019](#):**  
 While the item falls under Category 6 (Corporate Services/Enabling Functions), and specifically Program Area 6.3 (Strategic Planning, Resource Coordination, and Reporting), it impacts all other categories and program areas of the Strategic Plan.
6. **List of collaborating centers and national institutions linked to this Agenda item:**  
 12 Strategic Plan Advisory Group (SPAG) members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group is chaired by Mexico and co-chaired by Ecuador, and Canada has served as the technical lead for the methodology review.
7. **Best practices in this area and examples from countries within the Region of the Americas:**  
 The PAHO-adapted Hanlon methodology is the result of close collaboration and commitment between the Member States, through the SPAG, and PASB, which has contributed to strengthening the work of the Organization. Such collaborations demonstrate how the combination of talent and resources of Member States and PASB can lead to innovation and the development of leading scientific work that will promote the efforts of the Organization and thereby contribute to its strategic positioning. The documentation and publication of lessons learned and innovations will contribute to regional and global scientific knowledge regarding priority setting in public health.
8. **Financial implications of this Agenda item:**  
 US\$ 240,000, based on past experiences, to cover expenses related to coordination, training, editing, and publication.