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REFINEMENT OF THE PROGRAMMATIC PRIORITY STRATIFICATION FRAMEWORK OF THE PAHO STRATEGIC PLAN

Introduction

1. This report is presented pursuant 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." It provides an update on the progress made by the Pan American Sanitary Bureau (PASB) in collaboration with the PAHO Strategic Plan Advisory Group (SPAG)[1] in the revision of the purpose, criteria, and methodology of the PAHO Strategic Plan Programmatic Priority Stratification Framework during 2015.

2. After reviewing various priority-setting methods, including in-depth consideration of the Delphi and Hanlon methods, the SPAG and PASB concluded that, with some improvements, the originally PAHO-adapted Hanlon Method was a suitable instrument for the PAHO Strategic Plan Programmatic Stratification Framework. The group has produced a refined formula for the PAHO-Hanlon-adapted method, which includes new and expanded definitions, concepts, and components.

3. A complete report that includes results of the work with the SPAG and recommendations for the application of the refined programmatic prioritization methodology, will be presented to the Executive Committee in June 2016. A face-to-face meeting with the SPAG is scheduled for April 2016 to conduct a final review of guidelines, definitions, and recommendations for the application of the refined methodology.

[1] At the request of Member States, the SPAG was established in October 2014 to provide advice and input to the implementation of the joint monitoring and assessment process, and to 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 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.

Background

4. 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 priority stratification framework was developed to guide the allocation of available resources to the Pan American Sanitary Bureau 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.

5. 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.

6. 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 in the Strategic Plan's Programmatic Priority Stratification Framework. 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 give more weight—and, thus, higher rankings—to disease-oriented program areas. It was noted that the methodology needed to compare the wide range of program areas (24) in the PAHO Strategic Plan, which include diseases, systems and services, public health programs, and cross-cutting themes.

7. From February to August 2014, the CWG worked with PASB to complete all tasks requested by Member States, except for the refinement of the Programmatic Priority Stratification Framework. And while it began the review of the PAHO-adapted Hanlon method, it 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 to be able to consider all possible options for the development of a robust and comprehensive methodology that would address the concerns expressed by Member States.

8. 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

priority stratification framework and provide input in the implementation of the joint monitoring and assessment process for the PAHO Strategic Plan (Resolution CD53.R3).

9. 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 (SPAG).

Progress Report

10. The SPAG worked with PASB during 2015 in virtual sessions and face-to-face meetings (a two-day meeting in Washington, D.C., in May, and a three-day meeting in Mexico City in August). A summary of the work completed by the group to date is presented below. A complete report, including results, conclusions, and recommendations, will be presented to the Executive Committee in June 2016.

11. **Review of priority-setting methods** – the SPAG and PASB reviewed and discussed 15 methods published in the literature (see the Annex), including simple and subjective methods such as forced rankings, a nominal group method, and simple voting procedure; and more objective measures such as the Delphi method and the Hanlon method. An in-depth review and a critical analysis of the original Hanlon method and subsequent revisions to the Hanlon equation were also conducted. After considering the weaknesses and strengths of the various methods compared to the PAHO-adapted Hanlon method, the SPAG concluded it could be refined to make it more adaptable for identifying strata of public health programs in line with the purpose and objectives of the PAHO Strategic Plan Programmatic Prioritization Framework.

12. **Refined PAHO-adapted Hanlon method** – after its review and analysis of the original PAHO-adapted Hanlon method, including comments from Member States, the SPAG agreed with the refined formula described below. Important improvements include the definition of components in order to apply consistent criteria to rate diseases and non-disease-oriented program areas of the PAHO Strategic Plan. The absence of such definitions was one of the main concerns expressed by Member States about the first iteration of the PAHO-adapted Hanlon method.

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

Where:

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

B = Seriousness of the problem (range 0-20) includes a combination of urgency, severity, economic cost, and negative externality (negative impact on others or ability of the problem to spread and cause other problems). For non-disease program areas, how essential the system or program is, and what the consequence of inaction is, are taken into consideration;

C = Effectiveness of interventions (range 0-10)—availability of cost-effective interventions to address the problem or deficiencies in programs;

E = Inequity factor (range 0-5)—differential occurrence of disease, access to services or programs;

F = Positioning factor – PAHO's value-added (range 0.67-1.5)—extent to which PAHO is positioned to address the program areas based on the six core functions of the Organization. As F is a multiplier, if the maximum is 1.5 the minimum is the reciprocal of 1.5 or 0.67.

A division by 5.25 gives the BPR a range of 0-100.

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

13. In addition to adding clarity and making the definitions of the original Hanlon method components more adaptable to the wide range of the PAHO Strategic Plan program areas, the SPAG conducted a thorough review of the inequity factor (E) and the positioning factor (F), to ensure that they were consistent with the purpose and context of PAHO's Strategic Plan and with the Organization's technical cooperation. These two factors represent unique and significant features of the PAHO-adapted Hanlon method. After much deliberation among the SPAG and PASB, it was agreed that applying the inequity factor as a separate component was essential, given the importance that inequity has across program areas and the emphasis given in the PAHO Strategic Plan 2014-2019 to reduce inequities in health throughout the Region, and within and among countries. The inequity factor was part of the seriousness component (B) in the original PAHO-adapted Hanlon method. The positioning/PAHO value-added factor was also revised from its original conception to strengthen the objectivity and balance of the influence of this factor on the eventual result of the modified equation.

14. The formula was piloted by the SPAG members and a team of Mexican public health experts in August 2015. The availability and robustness of data for each component, and the need for clear and consistent definitions for each component criteria were noted as key issues to address in both pilot exercises to reduce subjectivity.

15. The SPAG also reviewed the purpose, scope, and procedures for the application of the PAHO Programmatic Priority Stratification Framework. The group concurred with the original purpose of the framework, but recommended further clarifications on the application of the scope and application methodology from a country perspective versus a regional one, as well as the use of the results to guide resource allocation. It also asked PASB to prepare comprehensive guidelines, provide training, and facilitate piloting of the methodology with Member States. This is being considered as part of the process for the preparation of the PAHO Program and Budget 2018-2019.

16. PASB is preparing a comprehensive document to clarify concepts and the rationale of weighting and balance for each of the components, while further defining the components. In addition, PASB will compile evidence for greater objectivity of the ratings for each component of the 24 program areas of the PAHO Strategic Plan 2014-2019 to which the methodology will be applied. These will be reviewed and finalized with the SPAG during a face-to-face meeting scheduled for April 2016.

17. A manuscript of the PAHO-adapted Hanlon method is being prepared for publication under the leadership of the Canadian delegate in the SPAG, in collaboration with technical experts from PASB. The original Hanlon equation was 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 and practice of priority-setting in public health.

18. In addition to the refinement of the PAHO-adapted Hanlon method, the SPAG also provided input and guidance for the completion of the joint monitoring and assessment process for the PAHO Strategic Plan. Details on this point are provided under Document SPBA10/2 of the SPBA agenda.

Action by the Subcommittee on Program, Budget, and Administration

19. The Subcommittee is invited to take note of the progress report on the Refinement of the Programmatic Priority Stratification Framework of the PAHO Strategic Plan and provide any comments or recommendations it might consider important.

Annex

Annex

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: http://www.idearatingsheets.org/
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. *Cost Eff Resour Alloc* [Internet]. 2006 Aug 21 [cited 2016 Jan 21]. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/
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: http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf
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: http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf

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: http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf
15. Two stage method	Choi BCK, Eijkemans GJM, Tennassee LM. Prioritization of occupational sentinel health events for workplace health and hazard surveillance: The Pan American Health Organization experience. *Journal of Occupational and Environmental Medicine*. [Internet] 2001 Mar [cited 2016 Jan 21];(2)43:147-157. Available from: http://www.bdsp.ehesp.fr/Base/231916/.

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