

Unit 5

Priority Setting at the National Level

Introduction

In assessing worldwide health research for development, the Commission on Health Research for Development identified the need to establish greater coherence of research responses to high-priority problems at the national and international levels as one of the greatest challenges: "...we recommend that each country develop a strong national plan to conduct research on both country-specific and global health problems – a plan that is feasible, economical, and coherent and that involves all relevant groups..." and further "...each developing country will need to set national priorities for research, for using both domestic and external resources..." (CHRD 1990: 85). It is therefore not surprising that the successor of the Commission, the Task Force on Health Research for Development, identified priority setting as one of the seven elements of the Essential National Health Research (ENHR) strategy.

However, was anything really new under the sun? One could indeed argue that, as promoted by organizations like the World Health Organization, a number of countries were already setting health research priorities through medical research councils or analogous bodies, that various ministries of health were adding research chapters to their national health plans, that smart donor agencies managed to get their research priorities sold to national research agendas, that research departments within universities were participating in international health research programs (and working on their priorities), and that in some countries even districts were discussing health research priorities. Was there something wrong with these ongoing exercises? Was there a problem?

With respect to setting priorities for the ENHR action plan, the Task Force formulated the problem as follows:

"Most developing countries have established mechanisms for identifying research priorities at the national level and also within academic and research institutions. Medical research councils and similar bodies usually perform this function for the health sector... The Commission found that, in practice, these mechanisms often fail to focus attention on the key issues affecting the health of the majority of the population, especially the needs of the most vulnerable and the disadvantaged. The priorities enunciated by these bodies tend to be narrowly constructed along disciplinary lines and are predominantly oriented toward medical technology. Often, there is no more than token representation of social and behavioural scientists on these priority-setting bodies; and little attention is given to the potential contributions to health from research in other sectors. Each interested group – researchers, health policy makers, health care providers, and the population at large – has a different perspective on the issues, that need the most urgent attention, but the current mechanisms do not

effectively reconcile these differing views to achieve a consensus on goals and strategies for health research..." (TFHRD 1991: 24).

As a response to this critical analysis of the existing practice in (national) health research priority setting, three important developments should be noted, which shaped in a direct or indirect way the present debate about "priority setting at the national level":

1. The health sector reform movement, which started in the early nineties, affected, in most countries, the role of the Ministry of Health and the structure of the health sector at all levels. One of the Alliance-supported case studies on the enabling environment for research priority setting, production and utilization notes in this respect that "...setting up the new system and putting it into operation would require a great deal of information on morbidity, mortality, service utilization, production and productivity, costs, human resources, etc., most of which was simply not available" (Yepes 2002). The fact that decision makers started to demand this information – to be produced through health policy and systems research – definitely contributed to an increased awareness of the need for national research priority setting (see also Unit 3).
2. Several international health (research) agencies, academic institutions and individual researchers started addressing the issue of health research priority setting by developing tools and methodologies, like burden of disease analysis, the five-step process, the combined approach matrix, cost-effectiveness analysis. Some major approaches have been reviewed in Unit 1. Most of these approaches try, but not always successfully, to be relevant and feasible for national as well as global health research priority setting. In spite of some progress, the methodological debate about priority setting, particularly at the national level, is more open than ever before.
3. Facilitated by the Council on Health Research for Development, which succeeded the Task Force in 1993, an increasing number of developing countries started experimenting with and implementing health research priority setting as a logical component in their essential national health research strategy. The overview, included under Tools and Resources (Item 2.0) of this Unit, gives examples from 27 countries that, over the last decade, developed experience in national health research priority setting, as facilitated by COHRED.

This Unit will summarize some major lessons learned through these country experiences, with a focus on context-specific enabling and hindering factors.

Practical and Learning Objectives

1. To develop a better understanding of enabling as well as hindering factors in the priority setting process through critical review and analysis of priority setting experiences at the national level.

2. To improve knowledge and skills in planning, organizing and implementing a priority setting process at the national level, including the preparatory work and follow-up of the research agenda.
3. To identify when it may be necessary to call upon technical support and expertise for the execution of the above.

Priority Setting as a Process¹

The framework proposed for the analysis of priority setting at the national level has the ENHR strategy as its basis. Priority setting is therefore seen as a component of the ENHR process as a whole. But priority setting itself should also be seen as an iterative and interactive process and not just as a methodology or a set of tools.

Three essential stages can be distinguished in the process of priority setting:

1. Planning the setting of priorities
2. Setting the priorities
3. Implementing the priorities

For each of these three stages a number of relevant issues will be addressed, with a particular attention to lessons learned in dealing with priority setting as a process. For a more detailed discussion about methods, including selection of criteria and research areas, readers/users are referred to Unit 1.

¹ The description and analysis of the priority setting process at the national level, which follows over the next pages, will illustrate the broad variety and diversity between countries in planning, organizing and implementing this process. For this reason, as many country experiences as possible will be referred to, allowing the user to look for more detailed and focused information (See Tools and Resources 2.0 and 3.0) about the country, whose experience seems to have the most relevance for the user.

Planning the Setting of Priorities

Who?

The initiative for planning and organizing a priority setting process at the national level in most cases, but not always, comes from the central government – in particular, the Ministry of Health and/or Ministry of Science and Technology - or from a body, agency or institution which has been officially assigned by the government with the promotion and coordination of health research in the country. Examples of different initiators of a national priority setting process are:

- Ministry of Health: South Africa, Benin, Senegal, Indonesia, Cuba, Nicaragua, Malawi, Sudan.
- Ministry of Health and Ministry of Science & Technology: Ethiopia, Nigeria, Philippines.
- Governmental agency: Kenya (National Center for Health Research Development), Lao PDR (Council of Medical Sciences), Tanzania (National Institute for Medical Research), Nepal (Nepal Health Research Council).
- Non-governmental agency: Bangladesh (BRAC-ENHR B), India (BAIF Development Research Foundation), Thailand (Thai Forum on Health Research and Development).

When?

Most countries have initiated a priority setting process on one of the following two occasions:

- as part of the planning and implementation of ENHR within a country. Most countries under discussion have related – directly or indirectly – priority setting to their ENHR strategy. Explicit examples are: Benin, Kenya, Nicaragua, Philippines, South Africa and Uganda.
- as part of the research agenda setting for the national health plan of the country. For instance, in 1991 the Philippines defined its research priorities in line with five main thrusts of the Department of Health (health sector organization, disease control and public health, personal health care, health care financing and health product development).

Who is involved?

Countries that have used ENHR strategies identified and involved four general categories of participants:

- researchers,
- decision makers at various levels,
- health service providers and
- communities.

Table 1 illustrates the variety of organizations and institutions that might be invited to participate in the ENHR process.

Table 1: List and Number of Organisations and Institutions Identified as Stakeholders in the South African ENHR Process

| Organizations | Number |
|---|---------------------------------|
| Universities | 12 |
| NGOs | 10 |
| Science Councils | 7 |
| Professional Associations | 7 |
| Technikons | 6 |
| Nursing Colleges (excluding universities) | 21 |
| Private Sector | 2 |
| National Civic Organizations | 2 |
| Provincial Health Departments | 9 (only 7 visited; all invited) |
| Other Government Departments | 5 |
| Parliamentary Committees | 1 |
| External Funding Agencies | 13 (not visited but invited) |
| Total Organizations Identified | 95 |

In a typical planning scenario for priority setting, the process starts with a kind of working group, task force or (ENHR) committee, in which government and academia play a major role. This group then consults and involves health service providers and communities in the further planning.

Examples:

- In preparation for its national priority setting workshop, the ENHR secretariat in Tanzania consulted with district medical officers of 113 districts about their top health (systems) problems (1999).
- The ENHR Task Force in Kenya organized consultations with the Ministry of Health, research institutions and districts, for a national priority setting convention (1992).
- A multidisciplinary and inter-sectoral working group organized local, district and regional round tables in Guinea, which included: health service providers, professionals from other sectors, political authorities, traditional healers and community representatives (primarily women's associations) (1992).
- In 1997 and 1998, the Philippine Council for Health Research and Development organized a series of regional and zonal consultative workshops, which formed the groundwork for the national science and technology agenda.

Centralized or decentralized planning?

The most popular type of planning body is a national, centralized committee, operating with and through sub-national consultations. Most countries in one way or the other include a sub-national component in their planning process – local systems of integrated health services (SILAIS) in Nicaragua, regions and zones in the Philippines, municipalities in Cuba, district medical officers in Tanzania, health institutions in Lao PDR. The role and function of these sub-national or decentralized consultations is mostly to collect information to be used and consolidated at the national priority setting event and only marginally to create a forum or platform for feeding back the outcomes of this event to the decentralized levels of the system.

Exercise 1: Planning and Organizing a National Health Research Priority Setting Process

1. Assume you are the secretary of a national working group in charge of planning and organizing a process for setting national health research priorities.
2. Review section 2, “Preparatory work by the team convening the priority setting exercise” in the *Manual for Research Priority Setting Using the ENHR Strategy* (see Recommended Readings, Item 3).
3. Prepare a two-page plan to be discussed by your working group, covering all steps involved in the preparatory work.

Which Information?

Since decisions on priorities should be made based on the best available information, one of the major functions of the planning phase is, aside from the involvement and creation of ownership of the process by all stakeholders, the identification and collection of information. As elaborated in Unit 1, basically three broad categories of information are being gathered and, to a certain extent, also analysed during this phase: the health status in a given setting, the health care system, and the health research system.

Unit 1 gives a detailed overview of the information collected and used by the different priority setting methods. In addition, the following observations can be made, based on an in-depth analysis of nine country experiences with priority setting (Nuyens 1997: 22):

- All countries have been using quantitative and qualitative data/information.
- The mixture/balance between quantitative and qualitative data differs between countries.
- Quantitative data are coming from health statistics and review of research.
- Health statistics are mostly restricted to mortality and morbidity, and are for most countries incomplete and of poor quality.
- Qualitative data are mostly related to subjective perceptions of (priority) health needs by various stakeholders.
- Trends in disease profiles, including projection of future trends, are only marginally included.
- Information/data on equity are not included by any country.
- Sub-national data are extrapolated to national level and vice versa.
- Data/information about the health research system (human and organizational capacity) are most of the time not collected.

- Information about which type of research or research disciplines is required is generally not collected.

Setting the Priorities

When, where and how?

The process results in some kind of national event, during which the health research priorities for the country are defined.

Examples include:

- National Convention for Setting Essential National Health Research Priorities (Zimbabwe, 1995)
- First Essential National Health Research Congress on Priority Setting (South Africa, 1996)
- Conference on Prioritization of ENHR Agenda (Nepal, 1998)
- 5th National Health Science and Technology Congress (Philippines, 1999)
- Workshop on Priority Setting for Improving More Health, More Equity and More Human Development in the National Health Research System (Cuba, 2002)

Most of these national events take place in the capital of the country and last between one and three days, with a planning and preparation time between six months (e.g. Cuba) and two years (e.g. Philippines). The agenda of such national events include policy statements, technical presentations (including a summary of planning process), group work and plenary sessions on priorities and recommendations (including a draft list of priorities).

Who is involved?

The national meetings for priority setting have been attended by a minimum of 30 (e.g. Malawi) and maximum 400 people (e.g. Nigeria), with an average of 100 participants.

For example:

- The Tanzania Essential Health Research Priority Setting Workshop (1999) was attended by 40 participants “from a wide range of stakeholders/partners in health research ranging from research institutions, Ministry of Health headquarters, regional and district medical officers, maternal and child health coordinators, representatives of private institutions and non-governmental organizations, traditional healers and representatives of the two main religions namely Christians and Muslims (Tanzania 1999: v)
- The National Health Science and Technology Congress in the Philippines (1999) was attended by 363 representatives from multi-sectoral groups from

all regions. Sectoral representatives included government agencies (Science & Technology, Health, Education, Budget, House of Representatives, etc), academic and research institutions, non-governmental organizations, health care providers, the pharmaceutical industry, international organizations and the media.

In short, the four general categories of participants, who are involved in the planning process – researchers, decision makers, health service providers and communities – are also invited to take part in the priority setting event. The following observations, however, have been made about the participation of each category of stakeholders:

Researchers: There is seldom a balanced representation of between health problem, aetiology, intervention, health services and operational research.²

Decision makers: Mostly come from the health sector, with only a marginal involvement of other (health-related) sectors.

Service providers: Most of them represent managerial positions in the public health sector.

Communities: Most countries have difficulties in organizing solid and representative input from civil society.

The list of most noticeable absentees in national meetings include parliamentarians and representatives from the private sector (i.e. pharmaceutical industry), professional associations, mass media, donor and UN agencies.

Which process and which product?

A number of COHRED publications emphasize that once information is collected about health status, the health system and the health research system, the next step is to transform this mass of information into a manageable list of priority health (system) problems and related research areas/issues, for which criteria for deciding on these priorities have to be selected, plus a way of scoring or weighting them. On paper, this looks simple and logical, but the reality of the priority setting exercise during the national event reveals a different story.

Which entry point?

The way in which information that was collected during the planning phase is organized and used as an input in the priority setting phase is important. Below are examples of several principles for organizing this information:

1. The health problem perspective as organizing principle.

An assessment of health status and trends based on mortality and morbidity data available from vital registration systems or special surveys (e.g. national burden of

² This categorization of different kinds of research was developed by Feacham et al (1989).

disease analysis), combined with subjective perceptions collected during the planning consultations, is introduced to the participants in the national event. Major health problems are then identified by the participants and ranked using some kind of voting. A typical example is South Africa where the national congress on priority setting started with a presentation by the Department of Health and the Medical Research Council on mortality and morbidity data and also health status trends. Using the four criteria developed by the Ad Hoc Committee (see Unit 1), participants then identified and ranked the top ten health problems.

2. The health problem combined with the health system perspective as organizing principle.

Since the health problem perspective ranks diseases and risk factors – and therefore gives itself more over to the identification of biomedical research priorities - countries have been combining this perspective with a health system one as organizing principle for priority setting.

Tanzania offers a good illustration of this approach. Prior to the national priority setting workshop and as a means to collect district based priorities, questionnaires were sent to District Medical Officers, asking them to list the top ten disease problems, the top ten health systems/health services problems and the five major social cultural problems (related to health) in their districts. The results of this survey were used as inputs for the ranking by the participants in the national workshop of the major disease, health service and social cultural problems.

3. Technical/policy areas as organizing principle.

Under the assumption that a prioritized health research agenda should relate to and reflect the information needs of the national health policy (plan), countries have been using technical or policy areas as an organizing principle for their priority setting. Indonesia, for instance, did a situation analysis, including information on health status, the health care system and the health research system. Prior to the national workshop, this situation analysis was submitted to a series of round tables, which were invited to organize their discussions around eight (primary health care-related) areas: health behaviour, the health system, epidemiology and biomedics (communicable diseases), demography, pharmacy and medicine, environmental and occupational health, food and nutrition and non-communicable diseases.

The outcome of these round tables was then used as major input for the national meeting, which organized its discussions and priority setting along the same eight technical/policy areas. A similar approach has been followed in the Philippines.

4. Discipline or type of research as organizing principle

During their national meeting, countries often initiate a discussion about the disciplines or types of research required to address the research priorities (sometimes followed by a ranking of these different types of research). Some countries, however, start their priority setting (at the national meeting) using discipline or different types of research as an organizing principle.

Nepal, for example, at its national conference on prioritization of the ENHR agenda, recommended research needs in four fields (which are basically disciplines or research types): basic health and clinical research, technology and product assessment, health policy and systems research (including research on health economics and resource flows) and behavioural and social research.

Which process?

Whatever entry point and organizing principle is chosen, the process then moves, usually through group discussions, from the prioritized health (system) problems, technical/policy areas or research types toward identification, and possibly ranking, of research areas and/or questions. In most cases, this step comes after a discussion and agreement about criteria or guidelines to be used.

Examples:

- In making the step from “health problems to researchable issues”, participants in Tanzania agreed upon the following criteria: magnitude of the problem, avoidance of duplication, feasibility, focused, applicability of results, adding to new knowledge, political acceptability, ethical acceptability, and urgency.
- Having prioritized some 24 broad health (system) problems, participants at the national meeting in Zimbabwe elaborated more specific research questions, by discussing the research focus, training requirements, legal and policy aspects, socio-cultural issues, broad interventions and evaluation of interventions.
- South Africa used as criteria for the identification of research areas and questions the steps and questions developed by the Ad Hoc Committee (see Unit 1): What are the current interventions available? Are they successful? Why are they not successful? Is a new intervention indicated? What type of research is required?
- Participants in the national meeting in Indonesia used a numerical rating scale to propose research areas within each technical group. The scale took into account relevance, avoidance of duplication, feasibility, political acceptability, applicability, urgency and ethical acceptability.

Which product(s)?

The end product delivered by the national meeting contains:

Minimally: A broad list of priority health (system) problems, for which a specific health research agenda remains to be developed. Nicaragua, for instance, identified the following broad areas for priority research: mother and child health, communicable diseases, drug addiction, health care financing, human resources development and community involvement.

Maximally: A detailed list of priority research questions, for which the research type is defined and/or other relevant information (e.g. who will be the users) has been identified. For example, the South African congress formulated not only specific issues and conditions in relation to the identified top ten health problems, but also listed specific research questions for each research type (clinical, basic, social, health systems and policy).

These products are accompanied by a series of recommendations about “where do we go from here?”.

Implementing the Priorities

In implementing the – minimal or maximal – end product of the priority setting process, countries have been addressing the following issues:

1. Building and facilitating interdisciplinary and multi-sectoral teams to further specify and refine the list of research priorities and to develop them into a research portfolio.

Examples:

- South Africa recommended forwarding the identified priorities to “expert groups for verification and extension”.
 - Nepal proposed the establishment of four special committees, representing the theme of each working group, by involving task force members and other experts in developing research proposals.
2. Research protocol development and establishment of a peer review process. A national list of health research priorities is one thing, but relevant and high quality proposals, reflecting these priorities are yet another and require, particularly in developing countries, specific activities to foster their development.

Examples:

- Once the national health research priorities were identified, Uganda organized a public call for research proposals, addressing those priorities. With the support of three international health research networks/programs active within the country (the International Health Policy Program, the International Clinical Epidemiology Network and COHRED), a forum for peer review was organized to discuss and revise the proposals.
- The National Health Research and Development Centre in Kenya launched a similar initiative by organizing a Concept Paper Meeting for

researchers and experts to present and review research proposals related to the national priorities.

3. Integration of health research priorities within the National Development Plan, the National Health Plan and/or the National Health Research Plan. In order to have the health research priorities accepted and implemented by the research community at large, formal political backing is essential. This can happen by integrating the priorities in an appropriate governmental plan, agenda or policy.

Examples:

- The National Convention on Priority Setting in Zimbabwe recommended the integration of essential national health research, and in particular the identified health research priorities within the National Development Plan.
 - The national health science and technology agenda, as developed at the National Health S&T Congress in the Philippines, was formally accepted by the Department of Science and Technology and the Department of Health as the basis for planning and implementation of S&T related activities in health, particularly in setting directions for health R&D, capability development and information and dissemination activities/strategies in the country.
 - The priority problems, identified during consultations in departments, institutions, schools, hospitals and centres under the direction of the Ministry of Health and consolidated at a national workshop, became the basic draft of the 2nd Five Year Health Research Plan in Lao PDR.
4. Developing a diversified investment portfolio that reflects the research portfolio established through the priority setting process. Considering that research efforts “follow the money”, allocation or re-allocation of resources to fill investment gaps are an essential condition for the implementation of the priorities.

Examples:

- Countries like Kenya, Malaysia, Philippines, South Africa, Thailand and Zimbabwe have initiated plans for realigning their national research programs and resources with identified national health research priorities. The COHRED document, *Health Research in Tanzania: How Should Public Money Be Spent?*, the executive summary of which is included as Case Study 1, gives not only an excellent example of how investments could be aligned with national priorities, but also makes reference to a number of practical ways in which Tanzania can seize the opportunities for realizing higher returns on investments in R&D.
- Given the importance of donor funding of health research, Uganda and Kenya are examples of countries that organized specific round tables to mobilize funding for their research priorities from donor agencies. Ghana offers a case of particular interest since it is one the few countries that has

managed to have its national portfolio accepted as the research component of the health sector reform program.

Despite these examples, the follow-up to the national priority setting exercise – in other words, the implementation of the priorities -- is a poorly documented phase in the research priority setting process. This makes an evidence-based review or assessment of the phase a difficult, if not impossible, undertaking. The absence of reports, documents and analysis of what happens after the national meeting suggests that implementation is never a straightforward exercise and that it may be given insufficient attention during the planning phase.

Exercise 2: Implementing the Research Agenda

1. Still assuming that you are the secretary of the national working party and that you managed to produce a research agenda as output of the priority setting process, review section 6, “Implementation” of the *Manual for Research Priority Setting Using the ENHR Strategy* (see Recommended Readings, Item 3).
2. Write a two-page plan, to be discussed by your working group, addressing the major issues in implementing the research agenda.

Lessons Learned

In February 1990, at the 15th Nobel Conference in Stockholm the Commission on Health Research for Development recommended that “...each developing country will need to set national priorities for research, for using both domestic and external resources...”. A decade later, in May 2000, at a (donor) meeting in Oslo on Development Research Funding, participants agreed that “...national institutions in the South should have much greater opportunity to participate actively in setting priorities and in defining the international research agenda...”. What happened between 1990 and 2000 in the national arena of health research priority setting and what lessons can be learned?

It goes without saying that a lot has been achieved over the last decade and that significant progress has been made in health research priority setting at the national level. What follows is an effort to identify the most remarkable ACHIEVEMENTS or “enabling factors” in national priority setting. Each of these achievements, however, does raise new questions or critical issues which CHALLENGE the scientific and political community at large. Most, if not all, of these achievements and related challenges have implications for the potential user of this unit and are included in this overview as ISSUES FOR CONSIDERATION. It is hoped that by looking at these three items together the user will be supported in making the bridge between analysis and action.

1. **ACHIEVEMENT:** The promotion and advocacy work of the Commission, Task Force, COHRED and other organizations in relation to national priority setting

has clearly made an impact. An increased number of developing countries have indeed initiated national priority setting exercises over the last decade, thus making available a wealth of information and experiences, from which other countries can learn.

CHALLENGE: The systematic formulation, articulation and dissemination of national research agendas in an increasing number of countries could be important inputs to the global research agenda (Working Group 2000: 135). To balance an often perceived “one-sidedness” in global agenda setting, an upward synthesis of national priorities at the regional and global levels was advised ten years ago by the Commission, but remains an unfinished agenda item. Efforts to synthesize country processes in priority setting as well as to integrate different methodologies have to be complemented with a systematic upward synthesis of national priorities.

ISSUE FOR CONSIDERATION: If you are involved in a priority setting exercise at a sub-national or institutional level, think about the way such an exercise could be linked to the national context or a national process.

2. **ACHIEVEMENT:** National experiences in priority setting show a gradual shift away from an incremental approach whereby existing priorities and practices are extrapolated into the future, toward a more rational approach in which collection and use of information on what is needed and what is possible becomes crucial.
CHALLENGE: Although countries are basing their priority setting on some kind of situation analysis and are, in this way, providing a more rational basis for the process, lack of data and the poor quality of available information represent serious obstacles to evidence-based priority setting and further development and refinement of appropriate methodologies.
ISSUE FOR CONSIDERATION: Think about how you could increase the collection and use of information in your priority setting exercise.

3. **ACHIEVEMENT:** Given the traditional importance of donor funding in health research and the related, and much criticized, donor-driven character of health research in developing countries, the formulation and articulation of a national research agenda by the countries themselves has definitely contributed to a more balanced and coordinated dialogue between national stakeholders in health research and the donor community.
CHALLENGE: A donor transition can be observed in the late 1990s with the expanding role of advanced country foundations, pharmaceutical companies and research institutions. A recent Global Forum publication states that “... the implications of this transition to improve the health of the majority of the world’s population, a global public good, are not clear and have to be documented in future...” (GFHR 2001: 43). A similar remark could be made about the effects of this transition on national health research priorities.
ISSUE FOR CONSIDERATION: Develop some strategies to get donor agencies involved in your priority setting process.

4. **ACHIEVEMENT:** National priority setting initiatives have predominantly taken place within the context of implementing an ENHR process. This context has given more substance, content and relevance to ENHR in countries, and at the

same time it has offered countries the potential to link priority setting to other issues in the construction of a national health research system, like capacity development, coordination and monitoring mechanisms and resource flows.

CHALLENGE: Where priority setting within the context of implementing ENHR could be, at least in principle, an enabling factor to make priority setting an iterative, ongoing process with spin-offs for the overall national health research system, the country reality shows a different picture. With the caveat that a more in-depth analysis is necessary, one can not avoid the impression that in most – but not all – cases the priority setting exercise remains an isolated, one-time event with little or no impact on the evolving construction of a national health research system.

ISSUE FOR CONSIDERATION: Make a list of additional issues you might wish to address through your priority setting exercise.

5. **ACHIEVEMENT:** The Commission’s message that “...any process designed to set priorities, therefore, should not lose sight of the fundamental questions: whose voices are heard, whose views prevail and, thus, whose health interests are advanced...” (CHRD 1990: 44) has been heard by countries. National initiatives report conscientious efforts to make priority setting a participatory and transparent process with the involvement of all stakeholders.
CHALLENGE: Despite consensus about the need for a participatory approach in priority setting and related efforts of countries to involve various stakeholders, involvement of the community in most countries remains a critical and unresolved issue. Questions like: who represents the community (or civil society) and how to involve the community in an effective way, at which stages in the process, and with which role, function or responsibility, need to be addressed.
ISSUE FOR CONSIDERATION: Identify the relevant stakeholders for your priority setting exercise and formulate strategies to involve them.

6. **ACHIEVEMENT:** Priority setting planning tends to be organized around geographical levels, from the sub-national (district, province, region) towards the national level. This bottom-up approach increases the chances for a more context- and culturally-sensitive priority setting process, than does reliance on a national burden of disease analysis. It also strengthens the potential for implementation of priorities at sub-national levels.
CHALLENGE: In most countries, national priority setting follows a bottom-up approach, whereby an upward synthesis takes place of priorities identified at sub-national levels (district, province, region). It is, however, unclear if and how the outcomes of the national event – in other words, the list of national health research priorities – are fed back to the sub-national levels of the health (research) system and how these levels adapt the national priorities to their specific and priority needs.
ISSUE FOR CONSIDERATION: Explain if and how your priority setting exercise is context- and culturally-sensitive.

7. **ACHIEVEMENT:** Although the information used for national priority setting is predominantly based on some kind of quantification of the health problem approach (i.e., what are the top ten health problems in the country), efforts are

made by most countries to supplement this information with data about the health system (and to a lesser extent also the health research system) as well as with subjective perceptions of priority needs by stakeholders. This results in a better balance between professional expertise and lay experience in the setting of priorities.

CHALLENGE: Regarding the information base for priority setting, a review of methodological developments makes it clear that most progress has been made in the quantification of the health problem approach, with similar developments in the area of measuring the performance of the health system. Less development, innovation and progress can be noted in the analyses of user demands, felt needs and values and how to use more qualitative information/data in the priority setting process. This could be a hindering factor in developing a balance between professional expertise and lay experience.

ISSUE FOR CONSIDERATION: Describe the approach you will follow to bring the subjective perceptions of priority needs by stakeholders into your exercise.

8. **ACHIEVEMENT:** The formulation of criteria for priority setting is becoming a common practice, and has been facilitated by related methodological discussions and developments. This results in a more systematic and transparent process of priority setting, in which it becomes easier to identify the values underlying the choices made.

CHALLENGE: The ultimate goal of any health research priority setting process is to define an investment portfolio of health R&D, with the greatest possible impact on the health of the majority of the population, in particular its poorer segments. It is, therefore, surprising that, while equity is included in most lists of possible criteria for priority setting, only in exceptional cases it is effectively used as one. Questions like how to operationalize equity as a criterion for priority setting, what information needs to be collected and how to establish the political will to actually use it, deserve urgent attention and action.

ISSUE FOR CONSIDERATION: Give a justification for the criteria that you selected for your priority setting exercise.

9. **ACHIEVEMENT:** National priority setting processes are resulting more frequently in some kind of a product: a list, an agenda or a program of health research priorities. Countries have been building up experiences, however limited, in managing this product -- from disseminating it to stakeholders to advocating for an investment portfolio in support of the research one.

CHALLENGE: The outcome and impact of national priority setting processes have not been very well documented and certainly not evaluated in a proper way. The absence of documentation and evaluation could mean, of course, that up until now implementation has been weak, but sufficient evidence is lacking to either confirm or contradict this. In any case, countries should give more consideration and attention to the implementation aspect of national priority setting at an early stage in its planning.

ISSUE FOR CONSIDERATION: Develop a workplan for managing the outcome product of your priority setting exercise.

Exercise 3: Critical Analysis of Priority Setting Experiences at the National Level

1. From the COHRED website, select two country reports on priority setting.
2. Read the reports and identify for both countries enabling as well as hindering factors in the priority setting process.
3. Synthesize and integrate your observations of enabling and hindering factors in a comparative table.

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- Feachem, R.G., Graham, W.J., Timaeus, I.M. 1989. Identifying health problems and health research priorities in developing countries. *Journal of Tropical Medicine and Hygiene* 92:133-191.
- Global Forum for Health Research. 2001. *Monitoring Financial Flows for Health Research*. Geneva: Global Forum for Health Research
- Nuyens, Y. 1997. *Workshop on Priority Setting for Essential National Health Research (PSENHR), Review of Processes, Mechanisms and Outcomes of PSENHR*. Geneva: Council on Health Research for Development.
- Tanzania (ENHR Secretariat, National Institute for Medical Research, Dar es Salaam) 1999. *Tanzania Essential National Health Research Priority Setting Workshop, Arusha International Conference Centre, 15-21 February 1999. Final Report*.
- TFHRD (Task Force on Health Research for Development) 1991. *Essential National Health Research. A Strategy for Action in Health and Human Development*. Geneva: Task Force on Health Research for Development.
- Working Group on Priority Setting (COHRED). 2000. Priority setting for health research: Lessons from developing countries. *Health Policy and Planning* 15(2):130-136.
- Yepes, F.J., Sanchez, L.H., Ramirez, M.L. 2001 *Funding Research for Policy in Colombia's Reformed Health Sector*. Alliance for Health Policy and Systems Research Working Paper 11.

Recommended Readings

1. Nuyens, Y. 1997. *Workshop on Priority Setting for Essential National Health Research (PSENHR), Review of Processes, Mechanisms and Outcomes of PSENHR*. Geneva: Council on Health Research for Development, 23 pages.

This working paper, prepared as input into the COHRED Workshop on Priority Setting for Essential National Health Research, reviews the experiences of nine countries with health research priority setting. It analyses the experiences according to the following questions: who participated in the exercise, how have the participants been involved, what information was collected to set priorities, which criteria have been used, what was the outcome of the priority setting process?

2. COHRED (Council on Health Research for Development) 1997. *Essential National Health Research and Priority Setting: Lessons Learned*. Geneva: Council on Health Research for Development, COHRED Document No. 97.3, 66 pages.

Experiences in priority setting continue to accumulate worldwide. While the conceptual framework, perspectives and practices of priority setting may differ from country to country, its impact is common to all – it is guiding them in planning their health research programs, in mobilizing and allocating their research resources and in strengthening local research capacity. This monograph is the outcome of the COHRED Working Group on Priority Setting. It can be used by different stakeholders at district, national and global levels, to guide them in a process, which has as its ultimate goal the achievement of equity in health and development.

3. COHRED (Council on Health Research for Development) 2000. *A Manual for Research Priority Setting Using the ENHR Strategy*. Geneva: Council on Health Research for Development, COHRED Document No. 2000.3, 47 pages.

This manual provides facilitators of a health research priority setting workshop with a step-by-step guide for successfully leading the process. Starting with the preparatory work needed for a priority setting exercise, the manual continues by discussing elements for priority setting, the follow-up activities after the priority setting exercise and the implementation of the research agenda. The annex of the publication includes modules on how to use criteria for research priority setting.

4. Schneider, M. 2001. *The Setting of Health Research Priorities in South Africa*. Tygerberg, South Africa: Medical Research Council, 137 pages.

The study examines the approaches used for prioritization and consolidates them into a framework for analysing and classifying health research. In addition, the document examines how the measurement of the burden of disease can inform such a process. Particular attention is given to issues related to equity and the debates around composite measures of health such as the Disability Adjusted Life Years (DALY). Progress has been made in terms of prioritization but needs to be followed by detailed analysis to develop a more usable list of priorities.

5. Philippine Council for Health Research and Development . 1999. *Proceedings of the 5th National Health S&T Congress*. Philippines: Philippine Council for Health Research and Development, Department of Science and Technology, 126 pages.

A National Health Science and Technology Congress was organized by the Philippine Council for Health Research and Development (Manila, 1999) to present the health S&T priorities of the various regions of the country, to create national and inter-regional awareness on the health situation of the various regions and their R&D priorities, and to provide funding agencies directions as to where to support health R&D. The report gives a detailed description of the bottom-up approach adopted for the formulation of the national health S&T agenda and summarizes the methodologies used by each region to identify priorities.

Tools and Resources

1.0 Framework for Priority Setting Using the ENHR Strategy

(Source: COHRED. 1997. *Essential National Health Research and Priority Setting: Lessons Learned*. Geneva: Council on Health Research for Development, COHRED Document No. 97.3, Page 5.)

The framework gives a comprehensive overview of the various actors, data, activities and levels included in a priority setting process using the ENHR strategy.

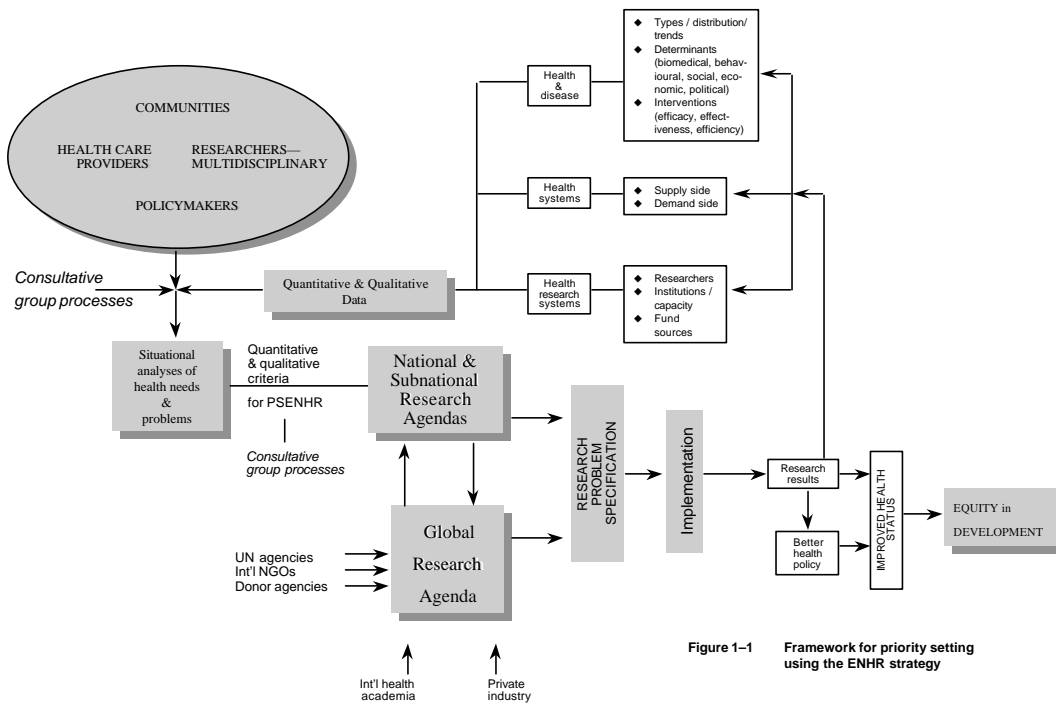


Figure 1-1 Framework for priority setting using the ENHR strategy

2.0 Overview of Countries with Experience in Health Research Priority Setting, as Facilitated by COHRED

For each country the following information (if available) is included:

- year(s) of the priority setting process
- reference document
- contact person and e-mail address

To obtain a reference document, readers are invited to contact the country contact person or cohred@cohred.ch.

BENIN

- 1991 & 2000
- Cellule Beninoise Decentralisee de la RNES, Plan Quinquenal 1993-1997, Mars 1993
- Cesar Akpo (bfayomi@internet.bj)

BURKINA FASO

- 1997
- Actes du premier Symposium sur la Recherche Nationale Essentielle en Sante au Burkina Faso, 1997
- Alain Zoubga (alain.zoubga@sante.gov.bf)

CAMEROUN

- 2001-2002
- Martyn Sama (msama@camnet.cm)

CUBA

- 2002
- Final Report. Workshop on Priority Setting for Improving More Health, More Equity and More Human Development in the National Health Research System, 2002
- Eric Martinez (adolfo@infomed.sld.cu)

CURACAO

- 1996
- The Curacao Health Study: A First Step Towards ENHR in the Netherlands Antilles, 1996
- Izzy Gerstenbluth (izzyger@attglobal.net)

ETHIOPIA

- 1997
- Proceedings of the Workshop on ENHR, 1998
- Yemane Teklai (yemaneteklai@hotmail.com)

GUINEE

- 1992 & 2000
- Recherche Nationale Essentielle en Sante en Guinee, RNES: Politique et Strategies, 1992
- N'nah Djenab Sylla (drsyllam@sotelgui.net.gn)

INDIA

- 1992
- ENHR: Priorities and Capacity Building Needs, Proceedings of the National Workshop held at Pune (BAIF Foundation), 1992
- (cohred@cohred.ch)

INDONESIA

- 1999
- The Development of National Health Research Priority and National Health Research Agenda for Indonesia(2000/1 – 2004/5)
- Agus Suwandono (dragus@indosat.net.id)

IVORY COAST

- 2000
- Rapport d'avancement. Enquetes pour l'identification des besoins prioritaires de la sante des populations, 2000
- Louise Haly Djoussou (djoussou@globeaccess.net)

JAMAICA

- 1996
- A Profile of Health Research in Jamaica 1991-1995, 1998
- Peter Figueroa (figueroap@moh.gov.jm)

KENYA

- 1992 & 1997
- ENHR in Kenya - Executive Summary: Concept Papers Meeting for ENHR in Kenya, 1997
- Mohammed Abdullah (Abdullah@iconnect.co.ke)

LAO PDR

- 1997
- Priority Setting in Lao PDR, 1997
- Boungnong Boupha (boungnong@moh.gov.la)

MALAWI

- 2001
- Report on Essential National Health Research Priority Setting Exercise, 2001
- Allan Macheso (malaria@malawi.net)

MALI

- 2001
- Premier symposium national sur la recherche en sante-definition des priorites nationales de recherche en sante au Mali, 2001
- Absatou N'Diaye (absatoundiaye@hotmail.com)

NEPAL

- 1998
- Conference on prioritisation of ENHR Agenda (Journal of ENHR), 1998
- Gopal Prasad Acharya (nhrc@healthnet.org.np)

NICARAGUA

- 1992
- Prioridades de Investigaciones Essenciales en Salud y Potencial de Recursos Humanos, 1992
- Ernesto Medina (emedina@unanleon.edu.ni) and (cohred@cohred.ch)

NIGERIA

- 1991
- International Conference on Health Research Priorities for Nigeria in the 1990s and Strategies for their Achievements, 1992
- Oni Idigbe (nimr@home.metrong.com)

PAKISTAN

- 2001
- Report of the Seminar on Health Research Priorities for Pakistan
- Tasleem Akhtar (pmrc@isb.comsats.net.pk)

PHILIPPINES

- 1992 & 1999
- Health Science and Technology Priorities, 1999-2004, 1999
- Mario Villaverde (marcvill@central.doh.gov.ph)

SENEGAL

- 2000
- Programme National de Recherche en Sante (PNRS), 2001
- Babacar Drame (bdrame@sentoo.sn)

SOUTH AFRICA

- 1996
- Proceedings of the First ENHR Congress on Priority Setting, 1996
- Lindiwe Makubalo (makubl@health.gov.za)

SUDAN

- 1999
- Priority Setting and Advocacy Workshops in Sudan, 2000
- Samia Habbani (samia_habbani@hotmail.com)

TANZANIA

- 1999
- Tanzania Essential National Health Research Priority Setting Workshop, 1999
- Andrew Kitua (akitua@twiga.com)

THAILAND

- 1997
- National Workshop on Prioritisation of Health Research and Development, 1997
- Chitr Sitthi-amorn (schitr@chula.ac.th)

UGANDA

- 1992
- Report of the Ad Hoc Committee on ENHR in Uganda, 1992
- Raphael Owor (unhro@infocom.co.ug)

ZIMBABWE

- 1995
- The Essential National Health Research Process, 1995
- Stephen Chandiwana (chandiwana@blair.co.zw)

3.0 Country experiences in priority setting

- 3.1 Sanchez, D.M., Bazzani, R., Gomez, S. 1998. *Priorities in Collective Health Research in Latin America*. Montevideo: Geops, ISBN 9974-32-187-5, Pages: 210.

This book represents an effort to determine an agenda in collective health research for the Latin American region. It is intended to be useful for decision making in the area of health research policies, both for national and international agencies.

- 3.2 National Institute of Health Research and Development (MOH, Indonesia) 1999. *The Development of National Health Research Priority and National Health Research Agenda for Indonesia (2000/1-2004/5); By Application of ENHR Approaches*. National Institute of Health Research and Development, Ministry of Health, Indonesia, Pages: 87.

The National Institute of Health Research and Development (NIHRD) of the Ministry of Health took the lead in setting a health research agenda for Indonesia. The following process was followed to set the research agenda:

- *Situation analysis of health needs, status, problems and potentials by reviewing relevant secondary resources.*
- *Round table discussions between all stakeholders, organized around eight primary health related areas. Based on discussion of the situation analysis and their own experiences and research needs, participants in each round table discussion group developed a list of proposed essential research.*
- *National workshop to develop a national health research priority list.*
- *Establishment of a national health research agenda, following the national workshop.*

- *Establishment of a mechanism to channel and utilize the research results. To ensure the effective management and implementation of the research agenda a Network on National Health Research and Development has been formed by Ministerial Decree (September 1999).*

The report provides, beyond a description of the process, a list of priority research areas, including the sub-areas of research, the expected output and the expected users of this research.

3.3 COHRED. 2000. *Priority Setting for ENHR - The Indonesian Experience*, COHRED Learning Brief No. 2000.4, Geneva: Council on Health Research for Development.

This learning brief presents the Indonesian experiences with priority setting for health research.

3.4 Ministère de la Santé. 1999. *Sénégal Programme de Promotion - Plaidoyer et de définition des priorités pour la Recherche Nationale Essentielle en Santé*. Dakar: Ministère de la Santé, Sénégal, Pages: 5.

In 1998, the Research Bureau conducted a study on health research at the district level. The main objective of this study was to evaluate research capacities within the health system, identify priority research areas and training needs, and advocate for health research at all levels. As a result of this study, a plan of action was elaborated.

3.5 Blair Research Laboratories, Ministry of Health and Child Welfare (Zimbabwe). 1995. *The Essential National Health Research Priority Setting Process. Proceedings of the National Convention on ENHR Priority Setting Process*. Harare, Zimbabwe: Blair Research Laboratories, Ministry of Health and Child Welfare, Pages: 68.

In 1995, a National Convention for ENHR Priority Setting was held. Prior to this, data was collected over a two-year period, beginning at the grassroots level and progressing to the higher levels in the districts and provinces. At the district and provincial levels, structured questionnaires were used and a review of disease statistics was carried out. At the community level, key stakeholders, including women's groups, were consulted using focus groups. A total of 112 focus group discussions were conducted in all the 56 districts of the country. The data generated provided background information for district level meetings. Recommendations arising from these meetings were discussed and refined during eight provincial level workshops. A list of health and health research priorities was compiled and formed the background document for the national convention, at which 20 priority areas were identified, 18 of which are disease oriented, two are related to health services.

3.6 Abdullah, M.S., Mugambi, M., Owor, R. 1995. *National Convention for Setting ENHR Priorities in Zimbabwe; 22-25 August 1995, Report*. Pages: 27.

Report on the ENHR Priority Setting workshop by the regional facilitators. The report

touches on relevant aspects of the meeting.

- 3.7 ENHR Secretariat, National Institute for Medical Research, Dar es Salaam. 1999. *Tanzania Essential National Health Research, Priority Setting Workshop Arusha International Conference Centre, 15-21 February 1999. Final Report.* Pages: 50.

The priority setting process was the beginning of a dynamic process of identifying where Tanzania's meager research funds should be focused. The process was demand driven. The exercise involved modifying the "standard" methodology to suit the local needs. The result is a list of priorities that have been reached by involving most stakeholders in health research.

- 3.8 Kitua, A., Mashalla, Y.J.S., Shija, J. 2000. *Coordinating health research to promote action: The Tanzanian experience.* British Medical Journal, 321: 821-823.

The failure of the malaria eradication program in some developing countries illustrates the failure of those countries to coordinate their health research activities. Coordination is needed to use scarce resources effectively but also to identify priorities and communicate these to policy makers and the public. After years of Tanzanian health research institutions failing to collaborate, they have now joined in a national health forum. The forum has already identified research priorities and is setting out an ethical framework for research.

- 3.9 1998. *Sachetana, Journal of Essential National Health Research Nepal.* Kathmandu: Nepal Health Research Council, Pages: 54.

This first issue of Sachetana provides the proceedings from the conference on prioritization of the ENHR agenda, held in Nagarkot, Nepal, August 12-14, 1998. It includes the methodology used for health research priority setting, the experiences of the participants using this methodology and the research priorities identified.

- 3.10 COHRED. 2000. *ENHR Priority Setting - Lessons from Nepal.* Learning Brief No. 2000.3, Geneva: Council on Health Research for Development.

The conference on priority setting for health research, which took place in 1998, provides some lessons learned for other countries about to embark on similar activities.

- 3.11 Directorate Research Coordination and Management, Department of Health, Pretoria, South Africa. 1996. *Proceedings of the first ENHR Congress on Priority Setting Edelweiss Functions Centre, November 14-15 1996, Pretoria, South Africa.* Pretoria: Directorate Research Coordination and Management, Department of Health, Pages: 34.

The first National ENHR Congress on Priority Setting in South Africa was hosted by the DOH in 1996 and was attended by 77 organizations. The aims of the workshop were

three-fold: to identify health research areas that address priority health problems, to develop a process for consensus building and to facilitate the establishment of an ENHR committee. The congress achieved its aim of establishing a preliminary list of priority health problems and urgent research questions. This was achieved through consensus and participation of basic scientists, clinical researchers, administrators, health service providers, funders and representatives of professional associations. The Congress also provided insight into the prioritization process.

- 3.12 Schneider, M., Bradshaw, D. 1998. *Setting Priorities for Health Research, Experiences from South Africa*. Tygerberg: Medical Research Council, Pages: 27.

The authors attempt to understand the process of health research prioritization and reflect on South African experiences. The report examines in depth two priority setting perspectives – that is, the health systems perspective and health problem perspective. The authors recommend that both approaches be used in South Africa, but with special attention to equity.

- 3.13 Schneider, M. 2001. *The Setting of Health Research Priorities in South Africa*. Medical Research Council, Burden of Disease Research Unit, South Africa, ISBN 1-919809-15-5. Pages: 137.

The study examines the approaches used for prioritization and consolidates them into a framework for analyzing and classifying health research. In addition, it examines how the measurement of the burden of disease can inform such a process. Particular attention is given to issues relating to equity and the debates around composite measures of health such as the Disability Adjusted Life Years (DALY).

The study observes that Essential National Health Research has been adopted as a policy but efforts to implement it need to be more vigorous. Progress has been made in terms of prioritization but this needs to be followed by more detailed analysis to develop a more usable list of priorities. Efforts to audit the expenditure on health problems need to be strengthened.

- 3.14 CCMRC. 1995. *Regional Workshop on Essential National Health Research and Priority Setting in Health Research*. Ocho Rios, Jamaica, November 6-8, 1995, CCMRC, Pages: 30.

During the workshop participants identified and examined issues and problems in implementing health research in their countries. They critically reviewed mechanisms for priority setting for health research in the Caribbean, and discussed how these could be improved. Finally, each country team prepared a draft plan of action for ENHR and regional proposals for collaboration in ENHR activities in the Caribbean. It was anticipated that country teams would continue to promote and develop ENHR activities on their return to their home countries.

- 3.15 ENHR, B Secretariat. 1997. *Priority Setting for Research in Health and Population: Bangladesh Experience*. ENHR, B Secretariat, Bangladesh, Pages: 13.

This paper, presented at the Asian ENHR Regional Meeting (1997), gives an overview of the Bangladesh approach to priority setting for health research from 1990 till 1997.

- 3.16 *Atelier de réactualisation des priorités nationales en matière de recherche en santé en République de Guinée, Conakry, 26-29 Avril 2000*. Pages: 7.

This report gives a summary of the research priority setting workshop that took place in Guinea in April 2000. It includes a detailed list of the research priorities and research topics identified.

- 3.17 Philippine Council for Health Research and Development, Department of Science and Technology, Philippines, 1999. *Proceedings of the 5th National Health S&T Congress*. Pages: 126.

A national Health Science & Technology (S&T) Congress, organized by the Philippine Council for Health Research and Development (PCHRD), was held in Manila in March 1999. Region-based and nationwide consultations (coordinated by the PCHRD, in partnership with the ENHR Unit in the Department of Health) were undertaken in 1997 and 1998 in preparation for this conference. The methodologies used by each region to identify Health S&T priorities, included a consultative workshop, review of statistics, in-depth interviews and survey questionnaires. The output from the regions formed the groundwork for the national S&T agenda. The identified priorities focused on the traditional concerns of improving health and health care: diagnosis, treatment, management, prevention and control. The importance of socio-cultural and behavioural dimensions in priority health issues was also highlighted. The need to understand the social factors associated with specific health problems indicated people's growing awareness for the adoption of a more holistic approach in addressing the country's health concerns.

- 3.18 Philippine Council for Health Research and Development, Department of Science and Technology, Philippines, 1999. *Draft National Health S&T Priorities 1999-2004*. Pages: 49.

This document presents the results of the region-based nationwide consultation process which the Philippine Council for Health Research and Development (PCHRD) convened from September 1997 to mid-1998. The report highlights the rationale for these consultations and the uniqueness of each region or zone. It presents a summary of research and development (R&D) priorities, capacity development concerns, identified information needs and recommended utilization and communication strategies. The document concludes with proposals as to how the results of these consultations can have an impact on national research planning and implementation.

The following zonal reports about health research priority setting 1999-2004 have been published:

- National Capital Region
- Region 1 (Ilocos region)
- Region 2
- Region 3 (Central Luzon)
- Region 4 (Southern Tagalog)
- Region 5 (Bicol)
- Region 6 (Western Visayas)
- Region 7 (Central Visayas)
- Region 8 (Eastern Visayas)
- Region 9 (Western Mindanao)
- Region 10 (Northern Mindanao)
- Region 11 (Southern Mindanao)
- Region 12 (Central Mindanao)
- Cordillera Autonomous Region (CAR)
- Caraga
- Autonomous Region of Muslim Mindanao (ARMM)

- 3.19 Boupah, B. 1997. *Priority Setting in LAO PDR Country Report*. Vientiane: Ministry of Health, Council of Medical Sciences, Pages: 4.

This paper, presented at the ENHR Asian Meeting in Hanoi (1997), focuses on priority setting and its use for the development of the second five-year Health Research Master Plan.

- 3.20 Essien, E.M., Idigbe, E.O., Olukoya, D.K. 1991. *International Conference on Health Research Priorities for Nigeria in the 1990s and Strategies for their Achievement, February 19-22, 1991. Proceedings and Recommendations*. Lagos: National Institute for Medical Research, Pages: 486.

The National Institute for Medical Research in conjunction with the Federal Ministry of Health organized a priority setting conference in February 1991. The content of this report consists of communications and recommendations of the conference, including presentations at the preparatory meetings.

- 3.21 Mugambi, M. 1995. *Country Experiences with Priority Setting for ENHR. A Working Document*. Geneva: Council on Health Research for Development, Pages 22.

This document reviews country experiences in implementing the ENHR strategy, with a particular emphasis on priority setting for research. It looks at processes, mechanisms and outcomes as outlined in plans and is based on experiences from seven countries (or groups of countries).

4.0 Other

- 4.1 IDRC (International Development Research Centre) *Designing and Conducting Health Systems Research Projects, Part I : Proposal Development and Fieldwork*, HSR Training Series. Ottawa, Canada: IDRC, 1991, 376 pages

This volume, which is part of a five volume HSR Training Series, contains twenty modules, which will lead the reader/participant/trainee through all steps required in the development of a (health systems) research project. Each module contains instructions for group work and also Trainers Notes for facilitators. Module 3 focuses on “Identifying and prioritising problems for research”.

- 4.2 COHRED Website (<http://www.cohred.ch>)

The COHRED website has extensive information on ENHR activities, publications and contact people.

Case Studies

Case Study 1: Tanzania

(Excerpted from: Harrison, D. 2000. Health Research in Tanzania. How Should Public Money be Spent? Geneva: Council on Health Research for Development. COHRED Document 2000.9 Pages: 2-4.)

Tanzania cannot afford to waste its scarce resources and must ensure that public funds spent on health research lead to better health for its people. In 1999, the National Forum on Health Research conducted a process of priority setting for health research, which established a ranked list of topics regarded as most important for Tanzania. The challenge now is to translate that list into a research agenda expected to realise the greatest social benefit. Essentially, this involves two iterative steps. The first is to define a public investment portfolio of R&D expected to maximise improvements in health. The second is to ensure efficient implementation of the portfolio, so that expected benefits actually materialise.

Analysis of the results of priority setting showed strong consensus on the main diseases causing morbidity and mortality in Tanzania. Malaria is the clear priority, and infectious diseases still dominate the health profile. The priority setting process clearly defined the *scope* of a public investment portfolio with respect to health problems to be addressed, although the validity of precise rankings is arguable: - results from household-based surveillance suggest that upper respiratory tract infection is over-represented as a determinant of total burden of disease, and HIV/AIDS and associated tuberculosis under-represented. Provided the list of priorities is not regarded as immutable, it is still a good standard against which to assess current investment patterns.

Participants did not reach the same level of agreement on service delivery priorities and socio-cultural determinants of health. This probably reflects wider variation of conditions across the country, and suggests that a local, context-specific approach may be more effective in setting a corresponding research agenda.

Aligning R&D with national priorities sets research efforts on the right track towards maximal social benefit. However, expected returns will only be realised if investments are made in forms of R&D most appropriate for Tanzania. The strategic emphasis identified through priority setting is to improve the use of existing health interventions and allocate resources more equitably. New product development and finding cost-effective applications for interventions known to be efficacious are important, but secondary objectives.

While the final investment portfolio will be shaped by practical considerations, it should bear a close resemblance – both in scope and strategic direction – to the research agenda agreed to by the national meeting. In the short- to medium-term, the national portfolio will continue to be shaped largely by donor funding. However, it can serve as a clear expression of Tanzanian intent and could significantly mold the health sector reform program if it were accepted as its research arm.

Having defined the R&D portfolio expected to maximise social benefit, the National Forum on Health Research should ensure its efficient implementation. Tanzania can

boost returns on its current investments both by enhancing outputs and reducing costs. Enhanced outputs can be achieved by stimulating demand for research and increasing its supply. To date, strategies to stimulate a demand for research have not received as much attention as efforts to increase supply, yet hold the key to substantial efficiency gains. Supply-side strategies have tended to focus on building up new resources, but more could be done to allocate existing resources better.

Cost reduction could lead to substantial efficiency gains, and the major transaction costs associated with research in Tanzania are incurred in communicating information.

Striking opportunities exist to realise greater returns from current levels of investment in health research.

First, there are clear gaps in the present national investment portfolio, both in terms of the scope of funding and the type of R&D instruments employed in addressing priorities. Filling these gaps will improve efficiency allocation of research funds. In terms of diseases, more should be invested in addressing the priorities of acute respiratory infection, diarrhoeal disease and anaemia. With respect to R&D instruments, there is an obvious need for more operational research aimed at improving technical efficiency and achieving greater equity in resource allocation.

Analysis of R&D trends over time suggests that prevailing incentives will not fill the gaps identified, and the National Forum on Health Research will need to provide added motivation for researchers. Team-based incentives should be designed to encourage researchers to respond to deficiencies in the current R&D portfolio. Given resource constraints, incentives will need to be a mix of financial benefit and psychic reward, but will only provide the right motivation if the individual's share of collective benefits exceeds the personal gains of working alone. This may be achieved by preserving the typical rewards of science such as peer-recognition, supplemented with other incentives such as better access to new information through collaboration.

Second, despite pockets of R&D efforts, there is no sustained national program to improve equity of resource allocation and efficient use of existing tools at the local level. A program of district-based problem-solving, sharing knowledge and learning from each other would not only fill in some of the gaps in the spatial distribution of research, but may also increase returns to R&D by stimulating demand across the country. Research should be locally initiated as part of each district's development plans, and should form part of a multi-pronged process of support to improve service delivery. Lessons learnt should be actively shared across the country, and proactive national leadership is required to make this happen.

Third, communication is constrained by tangible deficiencies in infrastructure, as well as by invisible barriers between research organisations. Dismantling these barriers could boost R&D outputs and reduce transaction costs. A practical place to start is for the National Forum on Health Research to agree on a few common outputs, including a series of learning briefs distributed regularly to every district in the country and an annual review of progress in addressing disease priorities. A deliberate process of technical and user support is required to make the most of electronic networks and information resources, but this does not replace the value of

face-to-face interaction. Taken together, these communication strategies can help promote a stronger "culture of learning" in the Tanzanian health sector.

The cost of access to global knowledge is high, and the National Forum should work steadily to keep costs down. This includes negotiating favourable terms for software licenses and attempting to moderate the isolating effects of the international agreement on Trade-Related Aspects of Intellectual Property Rights.

Tanzania faces daunting pressures to overcome poverty and improve health. In this context, health research can only be justified if it leads to better health. For the majority of people, the research that could make the biggest difference is practical problem-solving – helping districts to get more out of their budget allocations by improving efficiency and targeting resources to those most in need. Contributing to new product development and finding cost-effective applications for efficacious interventions are important objectives, sustainable through prevailing incentives. Designing additional incentives to fill obvious gaps will not jeopardise existing research disciplines, and should in time stimulate the overall demand for research.

At present though, the strategic emphasis of health research in Tanzania is inefficient in improving health. Significant opportunities exist for the newly established National Forum on Health Research to implement an investment portfolio for R&D expected to maximise social benefit.

Case Study 2: South Africa

Tables 5-8 from the *Proceedings of the First ENHR Congress on Priority Setting*, (Pretoria, South Africa: Directorate for Research Coordination and Management, 1996, pages 18 – 21.) illustrate how the approach specified priorities for types of research with respect to the identified priority health concerns.

Table 5: Broad Research Questions by Discipline for STDs/HIV/AIDS, TB and Malaria

| DISEASE CONDITION | HIV/AIDS | TB | MALARIA |
|---|---|---|--|
| RESEARCH TYPE | | | |
| BASIC RESEARCH | <ol style="list-style-type: none"> 1. Rapid test 2. Congenital STD detection 3. Syndromic treatment 4. Asymptomatic detection | <ol style="list-style-type: none"> 1. Rapid disease diagnosis 2. Detection of MDR 3. Detection in children 4. Detection of re-infection vs reactivation 5. Determination of specimen quality 6. Identification of BCG strains for vaccine development 7. Identification of individual susceptibility | <ol style="list-style-type: none"> 1. Development of appropriate diagnostic guidelines 2. Identification, behaviour and susceptibility of vectors 3. Outbreak predictions 4. Improved diagnostics for malaria |
| CLINICAL RESEARCH | <ol style="list-style-type: none"> 1. Congenital STD Detection 2. Syndromic Treatment 3. HIV Treatment 4. Vaccine Development 5. Vertical transmission drug development | <ol style="list-style-type: none"> 1. Alternative drug delivery systems 2. BCG vaccine efficacy | <ol style="list-style-type: none"> 1. Efficacy, acceptability and type of therapy and prophylaxis |
| SOCIAL SCIENCES | <ol style="list-style-type: none"> 1. Condom usage 2. Asymptomatic detection 3. patient behaviour 4. health worker issues 5. Vertical Transmission 6. Socio-economic impact assessment | <ol style="list-style-type: none"> 1. Identification of environmental and social determinants of disease | <ol style="list-style-type: none"> 1. Increase in community co-operation with malaria control programmes |
| HEALTH SYSTEMS, PUBLIC HEALTH AND POLICY RESEARCH | <ol style="list-style-type: none"> 1. Policy development and evaluation 2. Socio-economic impact assessment 3. Models of care 4. Asymptomatic detection 5. Health worker issues 6. Post exposure prophylaxis 7. Ethical legal issues | <ol style="list-style-type: none"> 1. Identification of Environmental risk factors 2. Feasibility of on site treatment 3. Improved information systems 4. Systematic review of efficacy 5. Case holding patterns 6. Identification of service organisations | <ol style="list-style-type: none"> 1. Efficacy, appropriateness and quality of surveillance systems 2. Appropriate diagnostic guidelines 3. Health care workers attitudes to identification and treatment 4. Outbreak prediction 5. Cross border control of malaria |

Table 6: Broad Research Questions by Discipline for Diarrhoea and Respiratory Infections

| DISEASE CONDITION RESEARCH TYPE | DIARRHOEA AND RESPIRATORY INFECTIONS | ACUTE RESPIRATORY INFECTION | INFECTIOUS DIARRHOEA |
|---|---|---|---|
| BASIC RESEARCH | <ol style="list-style-type: none"> 1. Vaccine Development for HiB, Measles and pneumonia 2. Identification of antibiotic resistance | <ol style="list-style-type: none"> 1. Identification of resistance factors in ARI | <ol style="list-style-type: none"> 1. Aetiology and strain identification 2. Methods for the detection of Rotavirus and routes of transmission 3. Diagnostic indicators to distinguish between osmotic and secretory diarrhoea 4. New test kits |
| CLINICAL RESEARCH | <ol style="list-style-type: none"> 1. Interaction of infectious agents with predisposing illness 2. Improved compliance 3. Vaccine effectiveness | <ol style="list-style-type: none"> 1. Effectiveness of chemotherapy 2. Clinical trials on pneumococcal vaccines | <ol style="list-style-type: none"> 1. Rotavirus vaccine testing 2. Cost effectiveness of Rotavirus vaccine 3. Monitoring vaccine efficacy and standards |
| SOCIAL SCIENCES RESEARCH | <ol style="list-style-type: none"> 1. Identification of lifestyle risk factors 2. Identification of factors for compliance with therapy | <ol style="list-style-type: none"> 1. Identification of ARI risk factors: housing, overcrowding, pollution | <ol style="list-style-type: none"> 1. Identification of lifestyle risk factors: housing and sanitation |
| HEALTH SYSTEMS, PUBLIC HEALTH AND POLICY RESEARCH | <ol style="list-style-type: none"> 1. Pollution avoidance 2. Risk factor identification 3. Assessment of vaccine cost, accessibility, availability and effectiveness | <ol style="list-style-type: none"> 1. Identification of ARI risk factors 2. Cost effectiveness of chemotherapy | <ol style="list-style-type: none"> 1. Cost effectiveness of Rotavirus vaccine 2. Evaluation of Oral Rehydration therapy 3. Effective systematic reviews 4. Monitoring of vaccine efficacy and Standards |

Table 7: Broad Research Questions by Discipline for Nutrition and Cancers

| DISEASE CONDITION RESEARCH TYPE | NUTRITION | CANCERS |
|---|---|---|
| BASIC RESEARCH | <ol style="list-style-type: none"> 1. Food Safety 2. Bioavailibilty of nutrients 3. Malabsorption 4. Competing nutrient demands | <ol style="list-style-type: none"> 1. Improved detection of aetiology |
| CLINICAL RESEARCH | <ol style="list-style-type: none"> 1. Interaction between substance abuse and nutritional status 2. Development of nutritional status assessment methods | <ol style="list-style-type: none"> 1. Risk factor identification for oesophageal cancers 2. Effectiveness of cervical cancer treatment |
| SOCIAL SCIENCES RESEARCH | <ol style="list-style-type: none"> 1. Food security KAP study 2. Food accessibility 3. Food security education and capacity development | <ol style="list-style-type: none"> 1. Development of cancer prevention strategies |
| HEALTH SYSTEMS, PUBLIC HEALTH AND POLICY RESEARCH | <ol style="list-style-type: none"> 1. Prevalence rates of nutritional disease 2. Development of nutritional status assessment methods 3. Impact of programme implementation 4. Development of monitoring tools 5. Interaction between substance abuse and nutritional status | <ol style="list-style-type: none"> 1. Improved surveillance system for identification of incidence and prevalence 2. Effectiveness of cervical cancer screening programmes 3. Cost utility studies of interventions based on length of life, QOL and financial meta-analyses |

Table 8: Broad Research Questions by Discipline for Mental Health and Violence/Injuries

| DISEASE CONDITION RESEARCH TYPE | MENTAL HEALTH | VIOLENCE |
|---|---|--|
| BASIC RESEARCH | | |
| CLINICAL RESEARCH | 1. Identification and management of mental health problems among health care workers | 1. Cost effectiveness of clinical management of injury from violence |
| SOCIAL SCIENCES RESEARCH | 1. Development of interventions for the integration of the disabled 2. Development of culturally appropriate intervention 3. Counselling skills for Health Care workers 4. Development of community based interventions | 1. Resource needs of the criminal justice system to decrease injury rates 2. Training and sensitising police in dealing with injury |
| HEALTH SYSTEMS, PUBLIC HEALTH AND POLICY RESEARCH | 1. Development of community based interventions 2. Incidence of teenage suicide 3. Integration of mental health into PHC 4. Integration of traditional healers into the Mental Health Services 5. Economic impact of Mental Health on the society | 1. Integrated intersectoral pilot programmes - Use of trauma centres as a site for police presence - Impact of education and recreational facilities on sexual abuse and violence among youth 2. Training of HCW to deal with injuries 3. Effectiveness of compensation system for all injuries 4. Economic and social impact of injuries 5. Development of cost effective management interventions for dealing with injuries and violence 6. Legislation effectiveness 7. Development of a surveillance system and strategies for injury and violence prevention and legislation implementation |