

Unit 2

The Priority Setting Process: Practical Steps

Introduction

In this unit, the process of health research priority setting is examined in more detail. Included is a discussion on the questions: who should set health research priorities and how can various “stakeholders” engage in this process in a mutually satisfying manner? The importance of preparing a detailed “health situation analysis” is presented. The unit also includes a section on how criteria for priority setting can be identified and used.

This unit should be studied and used together with other units in the module, particularly Unit 1 (Approaches to Priority Setting) and Unit 5 (Priority Setting at the National Level). For an overall priority setting framework developed by a COHRED working group, please see Tool 1.0 in Unit 5.

This particular unit presents a 7-step process for priority setting. While the ideas in this module are adapted primarily from priority setting at a national level, the steps can be applied at various levels: institutional (see Unit 4 for more details), national (Unit 5) and global (Unit 6). With each step there will be some reference to tools and resources, many of which can be found in other units in this module.

It should also be noted that there already are available useful resources concerning priority setting methods, such as the "combine approach matrix". Readers are referred in particular to the COHRED manual, described in some detail in the Tools and Resources section.

Practical and Learning Objectives

1. To become familiar with the steps involved in setting health research priorities.
2. To apply these steps to particular situations, using the readings, tools and resources that are provided.

A Proposed 7-Step Process

Step 1: Planning & Getting Started

As stated in the overview of this module, priority setting is simply one component in the larger process of creating and maintaining effective health research systems, at any level – institutional, national and global. At the outset, it is important for all concerned to realize that priority setting should not be seen as a "one time only" event; rather it is a dynamic and iterative process, where each step is influenced by the results of the work and thinking in preceding steps.

The preparatory work in getting started includes elements such as the following:

- **Identifying suitable leadership:** Those who take on the responsibility of convening a priority setting process must see the "larger picture" (as noted above), be acceptable to the stakeholders involved, and be knowledgeable about how and where to obtain the necessary information. In particular, the leadership group must recognize that the process takes time, and therefore persistence and determination are key requirements.
- **Raising awareness with stakeholders:** This can be done by holding open meetings that permit discussion and debate, supported by distribution of appropriate summary materials (including the use of examples from other jurisdictions).
- **Agreeing on a work plan:** In the discussions with different stakeholder groups, it is important to determine in what areas and how each group will cooperate. The plan should include the identification of a "core" working group, the members of which are acceptable to key stakeholders. This group then has the responsibility of working out the details – times, places, expected outcomes, and so on. An important component is ensuring that resources (funding, facilitators, etc.) are available to see the process through to completion.

Box 1 displays a checklist covering preparations for convening the priority setting process.

Box 1: Preparatory Work by the Team Convening the Priority Setting Process

(Adapted from: COHRED (Okello, P. Chongtrakul, P and the COHRED Working Group on Priority Setting) 2000. A Manual for Research Priority Setting Using the ENHR Strategy. Geneva: Council on Health Research for Development. COHRED Document No. 2000.3. Pg. 8.)

1. Is the country/state/district/institution ready for priority setting? Is the process of setting priorities adequately understood? Has the need for priority setting been explicitly stated?
 - If so, what is the evidence?
 - If not, why not?
2. Have the key groups and constituencies been identified and contacted? Particular care should be taken to ensure that vulnerable groups and the lay community are represented.
3. Is there enough support from political decision makers, government bodies and NGOs?
 - If so, in what form? What is the evidence?
4. Do the groups represented understand the key elements of priority setting? These elements are: inclusiveness and partnership, focus on equity in research, transparency and consultative processes.
5. Is there enough background information such as health statistics, socio-economic profiles and prior research information?
6. Is there credible leadership?

Step 2: Situation Analysis (Assembling the Needed Information)

This is an important step that needs to be done well, since it will facilitate better achievement of subsequent steps. Essentially, "situation analysis" refers to finding out what information is already available, and as a corollary, what's missing.

In general terms, three categories of information must be obtained, as part of the situation analysis step:

- **Health status information:** The actual information needed is determined in part by the population whose health is expected to benefit from the proposed research program. Two examples of useful information sources are listed in the Tools and Resources section. They are:

- information about the "global burden of disease" (WHO 2001). (Please see Unit 6 in this module for more details about the progress on work regarding the "global burden of disease" being done under the auspices of the Global Forum for Health Research.)
- information about local populations (INDEPTH Network 2002).
- **Information about the health care system:** Examples of information about health systems include the World Health Report 2000 (WHO 2000) and various publications about health sector reform (WHO 1995).
- **health research system:** A major emphasis at the International Conference on Health Research for Development in October 2000 in Bangkok, was the concept of "effective health research systems" at the national, regional and global levels. Users of this unit are referred to the conference summary for more details (International Organizing Committee 2001).

Readers are also referred to Unit 4 in this module for more details on guidelines for priority setting at the institutional level.

Step 3: Identifying and Involving Stakeholders

This step includes considerations such as the following:

- **Who to involve:** Again, this depends on the level of priority setting. The list of stakeholders for an institutional exercise will be shorter and more focused than the list of stakeholders in national and global priority setting processes. For comments and examples about who to involve at a national level, please see Unit 5; at a global level, please see Unit 1 (which reviews three priority setting models, including the "who should be involved" question for each).
- **How to involve them:** This can vary considerably. An example of community involvement at an initial problem identification stage can be found in Case Study 1.

Various techniques are available (some involving experienced facilitators) to help multi-stakeholder groups come to agreement about research priorities. As an example, the "Dephi method" involves several rounds of discussions among participants regarding a particular component or task. Each round of discussions is captured and summarized—for example on a flip chart or PowerPoint presentation. This process continues until the overall goal or outcome is achieved. Several rounds may be required until this happens.

Another example, the "nominal group technique" is described in Box 1 in Unit 4. Still another approach, the "round table discussion" is presented in Box 2 (below).

Box 2: Round Table Discussions

(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 50.)

The 'round-table' approach, as the name implies, is used to bring people together from different points of view and experiences, in order to discuss a common problem or situation. Typically this involves a relatively small number of individuals who have not met before, usually not more than 20 or 30. Successful round tables are usually scheduled for two days or more, and are held in a quiet, relaxed setting.

The goals include both content and process components. For example, given the task of agreeing on the problems to be included in a national health research programme, the first part of a round-table discussion is devoted to learning about the expertise, experience and point of view of each individual regarding the task. But the round-table discussion also seeks to create a context for change, where new insights are realised from collective experience, innovative ideas are proposed which may change the way individuals and organisations will do things in the future, and possible agreement can be reached on how collective thought and action can be moved forward.

Successful round tables require careful preparation and skilful facilitation. Also, it is important to have a writer (or rapporteur) who is skilled in note-taking and in preparing reports, a draft of which is distributed for comment to round-table participants soon after the event.

Step 4: Selecting and Using Criteria

Useful descriptions are available regarding the selection and use of priority setting criteria. Readers are referred to the following sources:

- Tool 1.0 in Unit 1 provides a list of 28 examples of criteria that have been used in health research priority setting at a national level (These are reproduced from the COHRED Manual (COHRED 2000:13)).
- The COHRED Manual clusters possible criteria under four categories. These are reproduced here in Box 3. In the Manual, examples are provided where these four categories are applied to various depths (full, short and "mini") – see Annexes 1, 2 and 3 in the Manual.

Box 3: Examples of Categories for Grouping Selected Criteria by Theme

(Source: COHRED (Okello, P. Chongtrakul, P. and the COHRED Working Group on Priority Setting) 2000. *A Manual for Research Priority Setting Using the ENHR Strategy*. Geneva: Council on Health Research for Development. COHRED Document No. 2000.3. Pg. 16.)

Category 1: Appropriateness – Should we do it?

- The theme of this category is whether the proposed research is well suited to the target society and whether it does not duplicate past studies.
- The key question for this category is “Should we do it?”

Category 2 – Why should we do it?

- The theme is to ensure that the proposed research is the right kind for the right people, and that it is pertinent to the health problems of the community, without disregarding equity issues.
- The key question is “Why should we do it?”

Category 3 – The Chance of success – Can we do it?

- The theme is to assess the strength and resources of the research team.
- The key question is “Can we do it?”

Category 4: Impact of the research outcome – What will the stakeholders get out of it?

- The theme is to estimate the benefit of using or implementing the research results, and evaluate the merit and usefulness of the research outcome.
- The key question is “What will the stakeholders get out of it?”

- Rating scales can be developed and used for lists of criteria. An example is shown in Box 4. Also, decisions need to be taken regarding the weighting of criteria (should criteria have equal or different weight), the scoring system to be used (addition or multiplication, averaging in subsets, and so on). For a more detailed discussion about scoring systems, see the COHRED Manual (Section 4).
- It is also recommended that a "prioritization module" is produced as a first draft, then tested on one or two topics, with participants working as a group or individually. This provides an opportunity to test different approaches to weighting. Also, certain criteria may prove to be less useful and important in the testing phase, and thus can be discarded. With the completion of a preliminary testing step, a final working model can then be prepared and used.
- Some writers have urged that the issue of “fairness” be considered as a special criterion. An example comes from the writing of Daniels and Sabin (1997) (see Box 5).

Box 4: Scales for Rating Research Topics

(Source: Varkevisser, C.M., Pathmanathan, I., Brownless, A. 1991. *Designing and conducting health systems research projects. Module 3: Identifying and prioritizing problems for research. In: Health Systems Research Training Series. International Development Research Centre and The World Health Organization. 2(Pt 1): 34.*)

Relevance

- 1 = Not relevant
- 2 = Relevant
- 3 = Very relevant

Avoidance of duplication

- 1 = Sufficient information already available
- 2 = Some information available but major issues not covered
- 3 = No sound information available on which to base problem-solving

Feasibility

- 1 = Study not feasible considering available resources
- 2 = Study feasible considering available resources
- 3 = Study very feasible considering available resources

Political acceptability

- 1 = Topic not acceptable to high level policy-makers
- 2 = Topic more or less acceptable
- 3 = Topic fully acceptable

Applicability

- 1 = No chance of recommendations being implemented
- 2 = Some chance of recommendations being implemented
- 3 = Good chance of recommendations being implemented

Urgency

- 1 = Information not urgently needed
- 2 = Information could be used right away but a delay of some months would be acceptable
- 3 = Date very urgently needed for decision-making

Ethical acceptability

- 1 = Major ethical problems
- 2 = Minor ethical problems
- 3 = No ethical problems

Box 5: Ensuring Fairness in Priority Setting

(Source: Daniels, N., Sabin, J.E. 1997. Limits to health care: Fair procedures, democratic deliberation and the legitimacy problem for insurers. Philosophy and Public Affairs 26(4):303-502.)

Ensuring that priority setting processes are acceptable is as important as developing the evidence base. For this purpose, the Accountability for Reasonableness Framework, developed by Daniels and Sabin, is appropriate. Priority setting decisions may be considered legitimate and fair if they satisfy the following four conditions:

Publicity. Limit setting decisions (e.g. the funding available for a given area) and their rationales must be publicly accessible.

Relevance. These rationales must rest on evidence, reasons and principles that fair-minded parties (policy makers, donors, researchers, community advocates) can agree are relevant to deciding how to meet specific needs in the face of resource constraints.

Appeals. There must be a mechanism to challenge decisions and for dispute resolution regarding limit setting decisions, including the opportunity to revise decisions in light of further evidence or arguments (e.g. an essential national health research (ENHR) committee).

Enforcement. There must be either voluntary or public regulation of the process to ensure that the first three conditions are met (e.g. laws and statutes).

Step 5: Setting Priorities

Following on from the steps of planning, situation analysis, stakeholder involvement and selecting and testing criteria, the step of actually setting priorities can be taken. That is, the stakeholders involved can now apply the criteria and put forward suggestions for research topics and issues.

Obviously, the results of this step will vary considerably, depending on the criteria and process used. Box 6 displays one example of national health priorities that were defined by participants in a priority setting process in Tanzania in 1999. In this example, participants decided to cluster research priorities into three general categories. For a detailed analysis of this particular priority setting process, see Harrison 2000 in the Tools and Resources section).

The product of this work should be a synthesis document of some kind, for dissemination and discussion. This should be done as soon as possible after the priority setting event.

Box 6: National Health Research Priorities for Tanzania, as defined by participants in the priority setting meeting (1999)

(Source: Harrison, D. 2000. Health Research in Tanzania: How Should Public Money Be Spent? Geneva: Council on Health Research for Development. COHRED Document No. 2000.9.)

Diseases and injury	Delivery problems	Socio-cultural determinants
1. Malaria	1. Poorly trained personnel	1. Food taboos in pregnancy
2. Upper respiratory tract infection	2. Lack of equipment & drugs	2. Poor latrine usage
3. Diarrhoeal diseases	3. Lack of transport for supervision & distribution	3. Poverty linked to individual behaviour
4. Pneumonia	4. Allocation of funds for preventive services	4. Polygamy
5. Intestinal worms	5. Low impact of health education	5. Ignorance and high illiteracy
6. Eye infections	6. Impassable roads	6. Gender inequality
7. Skin infections	7. Poor building maintenance	7. Witchcraft
8. Sexually transmitted infections	8. Inadequate water supply	8. Inheritance of widows
9. Anaemia	9. Poor environmental sanitation	9. Low acceptance of family planning methods and high fertility
10. Trauma/accidents	10. Too few health facilities	10. Use of local herbs
11. Bilharzia		
12. TB/HIV		

Step 6: Resource Allocation and Priority Setting

The process of setting health research priorities is a somewhat "hollow" exercise, if resources (primarily financial) are not available to implement the actual research. No doubt, the process will raise expectations, particularly among researchers, that funds will be immediately available to proceed with the research on the priorities identified. So, whenever possible, the resources to conduct the research in response to identified priorities should be identified ahead of time.

In fact, it is the experience of many that failure to allocate resources often subverts the entire process of priority setting. More analysis is required about how institutions and national governments make resource allocation decisions regarding health research in general, and regarding research on specific health problems in particular. Readers are referred to Unit 2 in the Knowledge Management module for further notes on the processes used by decision makers for allocating resources.

Step 7: Implementing & Reviewing Priorities

The challenge here is to move from a list of priorities, to problem specification by research groups, translating the established priorities into specific research questions. One approach to this task is to invite researchers to prepare “concept papers” that describe proposed research projects for specific problem areas identified in the priority setting process. Box 7 describes this approach as it was used in Uganda.

Another approach is to address the broad priorities from the perspective of specific disciplines. This was done in South Africa where priority disease conditions were addressed by “research type” – basic research, clinical research, social sciences, and health policy and systems research [see Unit 5, Case Study 2].

Box 7: Research Problem Specification: An Example from Uganda

(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 50.)

In 1995, the Uganda National Council for Science & Technology (UNCST) called on Uganda researchers to prepare concept papers for projects on topics on the ENHR priority list (which had been prepared at an earlier national ENHR workshop). In these concept papers, researchers were asked to describe a problem statement, and the proposed methods to tackle the research problem. Thirty-eight papers were submitted, covering the four previously determined priority areas for research: maternal and child welfare and nutrition; communicable diseases, including HIV/AIDS; water and sanitation; and health policy.

A workshop was organised to discuss the merits of these proposals among Ugandan researchers, together with some invited guests: the COHRED Coordinator, the Executive Director of the International Clinical Epidemiology Network (INCLIN), and the Director and Programme Administrator of the International Health Policy Program (IHPP). Through a cooperative initiative, the three external programme representatives agreed:

- to help the Ugandan investigators to develop their proposals further;
- to find donors who could support those resulting high quality proposals that would fit their programme’s terms of reference; and
- to help to find alternative sources of assistance for those proposals that fell outside a given international programme’s mandate.

Box 7: Continued

Subsequently, after discussions with various donor agencies, three clusters were identified for further support. A group of five papers on health financing were accepted for support by the IHPP; since the five researchers had similar ideas on health financing research, a single larger proposal was prepared collaboratively. The study is now being carried out.

Another group of seven researchers received a favourable response from INCLEN's Reproductive Health fund. These proposals were developed further, with methodological help from the Clinical Epidemiology Unit (CEU), for subsequent funding. The third group of four researchers, who had prepared papers dealing with malaria, were encouraged by the WHO Special Programme on Research and Training in Tropical Diseases (TDR) to prepare more detailed proposals. For the remaining proposals, no source of funds was immediately identified; nevertheless, the researchers were encouraged to continue working on their proposals.

References

- INDEPTH Network. 2002. *Population and Health in Developing Countries*. Volume 1: Population, Health and Survival at INDEPTH sites. Ottawa: International Development Research Centre.
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- WHO (World Health Organization). 1995. *Achieving Evidence-based Health Sector Reforms in Sub-Saharan Africa. Report of an Inter-country Meeting. Arusha, Tanzania (20-23 November 1995)*. Geneva: World Health Organization.
- _____. 2000. *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: World Health Organization.
- _____. 2001. *The World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva: World Health Organization, Geneva. [See Annex Table 4: Healthy Life Expectancy (HALE) in all Member States; estimates for 2000].
- _____. 2002. *National health research systems: report of an international workshop (Cha'am, Thailand, 12-15 March 2001)*

Tools and Resources

1. 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, Pages: 47.

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, criteria 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.

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

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 program, in mobilizing and allocating their research resources and in strengthening local research capacity. This monograph, is the outcome of the work of COHRED's 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 research for development.

3. The Working Group on Priority Setting/COHRED. 2000. Priority setting for health research: Lessons from developing countries. *Health Policy and Planning* 15(2).

This paper is a review of the issues around research priority setting, especially as they relate to health problems of developing countries. The paper proposes a strategy of priority setting, based on lessons learned from ENHR approaches attempted in several developing countries. With equity in health and development as its goal, the proposed model is demand-driven and involves multi-dimensional inputs and multiple stakeholders. Various steps of the process are discussed and the paper concludes with a discussion about the gap between national research priorities and the agenda set at regional and global levels.

4. Harrison, D. 2000. *Health Research in Tanzania: How Should Public Money be Spent?* Geneva: Council on Health Research for Development, COHRED document No. 2000.9, Pages: 64.

In 1999, the National Forum on Health Research conducted a process of priority setting for health research, which resulted in a list of ranked topics considered to be of high importance in Tanzania. The challenge now remains to translate the list into a research agenda expected to realize greater social benefits. This involves two iterative steps. The first is to define a public investment portfolio of R&D expected to maximize improvements in health. The second is to ensure efficient implementation of the portfolio, so that expected benefits actually materialize. The purpose of this paper is to describe how each step can be carried out.

The report reveals striking opportunities to realize 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. 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. Third, communication is constrained by tangible deficiencies in infrastructure, as well as by invisible barriers between research organizations.

Case Studies

Case Study 1: Dialoguing with the Community. Using the Focus Group Technique: An Example from Uganda

(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 48.)

Four districts, one from each region of the country, were selected for consultation regarding community perceptions of health problems. However, because of insecurity in the northern region, only three districts participated in these discussions. These were: Iganga district in the east, Mukono district in the south and Hoima district in the west.

A two-day seminar was held in each district, which involved the District Planning Committee and the district health team. Some members of the Planning Committee were local politicians representing rural communities. The seminars were used to select communities for focus group discussions in the district. Two or three discussions were conducted in the villages, each involving 15 to 30 participants. Participants were selected to provide a heterogeneous mix of men and women, young and old.

The focus group discussions revealed the deep interest of the communities in frankly discussing their health problems. However, unlike the researchers, whose priorities were based on disease burden, the community members had more holistic views on health problems. All communities expressed the view that the emphasis should be put not only on diseases, but on underlying factors that predispose to ill health. For example, community concerns included low family income, lack of markets for produce, and population growth leading to overcrowding. They were also worried about bad roads, harmful cultural practices and the unsatisfactory distribution of health facilities.

Specific health problems of concern to the community included malaria, diarrhoea and respiratory tract infections. Others were promiscuity leading to AIDS, tuberculosis, skin diseases and intestinal worms.