



**Global Forum
for Health Research**
HELPING CORRECT THE 10|90 GAP



Health Research for Policy, Action and Practice

Resource Modules

Version 2, 2004

Module II

Setting priorities for health research

Unit 2

Practical steps and critical issues

We welcome readers' comments to enable us to continually update and improve this material.

THE COLLABORATIVE TRAINING PROGRAMME
Alliance for Health Policy and Systems Research
Council on Health Research for Development
Global Forum for Health Research
INCLEN Trust

UNIT 2. PRACTICAL STEPS AND CRITICAL ISSUES	2
Steps in the process of setting research priorities	2
Step 1. Planning and getting started	3
Step 2. Situation analysis	6
Step 3. Identifying and involving stakeholders	9
Step 4. Selecting and using criteria	12
Step 5. The product of priority-setting processes	18
Further considerations	21
Moving from research priorities to research proposals	21
Aligning resources toward research priorities	22
Setting research priorities at the institutional level	24
Additional key issues	25
Maintaining a dynamic process	27
Tools and resources	29
1. Manuals and guidelines	29
2. Consensus techniques: round-table discussions and Nominal Group Technique	31
Sample call for proposals (letters of intent)	33
Recommended reading	41
References	43

Acronyms

COHRED	Council on Health Research for Development
ENHR	Essential national health research
GFHR	Global Forum for Health Research
HEU	Health Economics Unit, University of Cape Town, South Africa
INCLIN	International Clinical Epidemiology Network

Module II. Setting priorities for health research

Unit 2. Practical steps and critical issues

This unit presents a **practical process** for priority-setting that:

- is derived from a manual developed by COHRED based on experiences in a large number of countries
- is enhanced by lessons from the experiences of GFHR at the global level
- includes issues affecting priority-setting at the institutional level, derived from the experiences of INCLEN.

While the ideas in this module are adapted primarily from priority-setting at a national level, the steps can be applied at other levels, e.g. institutional and global.

Steps in the process of setting research priorities

[Step 1:](#) Planning the process

[Step 2:](#) Situational analysis

[Step 3:](#) Involving stakeholders

[Step 4:](#) Selecting criteria

[Step 5:](#) Products of priority-setting

Further considerations:

Moving from priorities to research [questions](#)

Aligning financial [resources](#) to priorities

Blue boxes provide practical tips from publications

Grey boxes provide illustrative examples from national experiences

Step 1. Planning and getting started

Preparatory work includes the following:

- identifying suitable leadership
- establishing a planning process that includes stakeholders
- agreeing on a work plan.

The critical issues here are the following.

Identifying suitable leadership

Those who take on the responsibility of convening a priority-setting process must:

- see the “larger picture” of the health and health research systems with their strengths, constraints and potentials
- be acceptable to the stakeholders involved
- 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.

The planning process

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

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

1. researchers
2. decision-makers at various levels
3. health service providers
4. communities.

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).

Box 1. Examples of leadership for research priority-setting at national level

The initiative for planning and organizing a priority-setting process at the national level comes in most cases, but not always, 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 entrusted 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: Benin, Cuba, Indonesia, Malawi, Nicaragua, Senegal, South Africa, Sudan
- Ministry of Health and Ministry of Science & Technology: Ethiopia, Nigeria, Philippines
- Governmental agency: Kenya (National Centre for Health Research Development), Lao PDR (Council of Medical Sciences), Tanzania (National Institute for Medical Research), Nepal (Nepal Health Research Council)
- Nongovernmental agency: Bangladesh (BRAC-ENHR B), India (BAIF Development Research Foundation), Thailand (Thai Forum on Health Research and Development).

In Latin America a wide range of institutions have taken the leadership role in consensual processes for research priority-setting. Examples include:

- national science and technology councils (Mexico's CONACYT, Colombia's COLCIENCIAS)
- institutions such as the National School of Public Health in Paraguay
- national universities, such as the National Autonomous University of Leon in Nicaragua
- the creation of national forums for the discussion and definition of a list of priorities in Ecuador
- Brazilian institutions, led by the Department of Science and Technology at the Brazilian Ministry of Health.

Agreeing on a work plan

In the discussions with different stakeholder groups, it is important to determine how each group will cooperate and in what areas. The plan should include the identification of a “core” working group, whose members are acceptable to key stakeholders. This group then has the responsibility of working out times, places, expected outcomes, etc. One important component is ensuring that resources (funding, facilitators, etc.) are available to see the process through to completion.

Centralized or decentralized planning? The most popular type of planning body is a national, centralized committee, operating with and through subnational consultations. Most countries include some subnational component in their planning process. The role and function of these consultations is mostly to collect information to be used and consolidated at the national priority-setting event, and only peripherally to create a forum or platform for feeding back the outcomes of this event to the decentralized levels of the system.

Box 2. Examples of raising awareness from national experiences

- 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 intersectoral 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.

Box 3. Preparatory work by the team convening the priority-setting process

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 nongovernmental organizations?

- 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, socioeconomic profiles and existing research information?

6. Is there credible leadership?

(Source: adapted from Okello et al., 2000:8)

Step 2. Situation analysis

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 is missing.

The critical issues in this step are the following:

- identifying information that needs to be assembled
- organizing this information so as to provide useful input for priority-setting.

Types of information

In general terms, three categories of information must be obtained for the situation analysis. These are summarized below.

Health status information: Information on health status draws on available information to describe the state of health, the **main health problems** and the common diseases affecting a country, a province or a district. The objective is to generate descriptive information about the type, distribution and trends in disease, paying attention to such issues as geography, income and social class, gender and age group. Similarly, it is important to identify, where possible, the **determinants or risk factors involved**. Sources of information include vital registration systems,

special surveys, clinical hospital records and informed opinion. Two examples of useful information sources are listed in the references. They are:

- information about the “global burden of disease” (WHO, 2001)
- information about local populations (INDEPTH Network, 2002).

Information about the health care system: Since the health care system is the mechanism responsible for delivery of care, information about its current status, deficiencies and problems is essential, particularly for research programmes with a focus on service delivery, intervention and policy. The four major functions of the health care system – governance, capacity development, financing and production and management and use of knowledge - offer a viable framework for collecting and organizing this information (Frenk and Murray, 2000). Information about the health care system can generally be found in official statistics of the country’s Ministry of Health or related Ministry.

The following criteria can be used to monitor health system performance (Ad Hoc Committee, 1996:82):

- **efficiency**, which can be gauged in terms of share of the country’s gross national product it consumes and the health outcomes, but also in terms of the cost-effectiveness of the interventions
- **equity**, to be gauged in terms of the extent to which services are accessible to the population in need of them
- **quality**, which can be gauged in its technical dimension – through the extent to which it is effective and achieves the health gains expected – and its interpersonal dimension – through the satisfaction of users.

The *World health report*, published annually by WHO, includes a series of data about certain aspects of the health care system, which are produced by WHO “using the best available evidence”.

Information about the health research system: Under this category, information is collected to address questions such as the following.:

- What areas of research are being developed?
- Who is doing this work?
- Where does the money come from?
- How much money is granted to different kinds of research?

Answers to these questions will provide a baseline for monitoring changes in the allocation of resources towards priority health research issues.

Organization and analysis of information

In order to provide useful input to a priority-setting exercise, the available information needs to be organized. There are no generally agreed “best practices” for organizing information. Below are examples of several organizing principles that have been used in the past.

The health problem perspective: 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 disease analysis), combined with subjective perceptions collected during the planning consultations, is presented to the participants in the national event. Major health problems are then identified by the participants and ranked using some kind of voting system. The health problem perspective ranks diseases and risk factors – and therefore lends itself better to the identification of biomedical research priorities.

The health problem combined with the health system perspective: In using this principle, information can be organized using five key questions (Ad Hoc Committee, 1996).

- What is the burden of disease/risk factor?
- Why does the burden of disease persist? What are the determinants?
- What is the present level of knowledge?
- How cost-effective could future interventions be?
- What are the resource flows for that disease/risk factor?

It has been suggested that these questions should be applied on four levels – the Combined Approach Matrix (GFHR, 2000).

- the individual, family and community
- Ministry of Health, health system and services, health research community
- sectors other than health with a major impact on health
- central government and macroeconomic policies.

What can be done with very limited data and expertise? Tanzania offers an illustration. Prior to the national priority-setting workshop and as a means of determining district-based priorities, questionnaires were sent to district medical officers, asking them to list the top 10 disease problems, the top 10 health systems/health services problems and the five major sociocultural problems (related to health) in their districts. The results of this survey were used as inputs for ranking by the participants in the national workshop of the major disease, health service and sociocultural problems.

Technical/policy areas: On the assumption that a prioritized health research agenda should relate to and reflect the information needs of the national health policy/plan, some countries have used technical or policy areas as the organizing principle for their priority-setting. Indonesia, for instance, performed 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 and priority-setting 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
- noncommunicable diseases.

A similar approach has been followed in the Philippines.

Discipline or type of research: Some countries have organized priority-setting around the disciplines or types of research required to address the research priorities (sometimes followed by a ranking of these different types of research). Nepal, for example, at its national conference on prioritization of the ENHR agenda, recommended research needs in four fields (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)
- behavioural and social research.

Step 3. Identifying and involving stakeholders

Participation is a very important aspect of setting a priority research agenda. If key stakeholders participate in developing the priority research agenda, they are more likely to “own” the agenda. With ownership, the research community is more likely to address the priority agenda, potential users of research (such as health programme managers, policy-makers, communities and other researchers) are more likely to use the findings of research; and funding agencies are more likely to direct research funds toward priority concerns.

Key issues in facilitating participation include:

- whom to involve
- how to involve them.

Whom to involve – stakeholders: Stakeholders who potentially would have an interest in priority research include:

- researchers and managers of research institutions
- health programme managers and policy-makers
- health service providers
- communities, as represented, for example, by civil society organizations and political organizations
- national, international and bilateral agencies that fund research

- private-sector agencies that fund research, including agencies that have commercial interests and those that have non-profit motivation.

Box 4. Experiences from different countries provide illustrative examples

- The Tanzania Essential Health Research Priority Setting Workshop (ENHR Secretariat, 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” (ENHR Secretariat, 1999:v).
- The National Health Science and Technology Congress in the Philippines (1999) was attended by 363 representatives from multisectoral groups from all regions. Sectoral representatives included government agencies (Science & Technology, Health, Education, Budget, House of Representatives, etc), academic and research institutions, nongovernmental organizations, health care providers, the pharmaceutical industry, international organizations and the media.

Table 1. List and number of organizations and institutions identified as stakeholders in the South African ENHR process

Organizations	Number
Universities	12
Nongovernmental organizations	10
Science councils	7
Professional associations	7
Technikons (technological universities)	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

Issues regarding participation from each category of stakeholders: The following observations have been made.

Researchers: There is seldom a balanced representation between health problem, etiology, intervention, health services and operational research.¹

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.

Noticeable absentees: Most noticeable absentees in national meetings include parliamentarians and representatives of the private sector (e.g. the pharmaceutical industry), professional associations, mass media, donor and United Nations agencies.

How to involve stakeholders in priority-setting processes

Various techniques are available (some involving experienced facilitators) to help multistakeholder groups come to an agreement about research priorities. As an example, the “Delphi method” involves several rounds of discussions among participants regarding a particular component or task. Each round of discussions is

¹ This categorization of different kinds of research was developed by Feachem et al. (1989).

captured and summarized – for example on a flip chart or in a PowerPoint presentation. This process continues until the overall goal or outcome is achieved. Several rounds of discussions may be required.

Two other useful techniques, the “round-table discussion” and the “nominal group technique” are described in the Tools and Resources section ([Consensus Tools](#)) of this unit.

Box 5. Dialoguing with the community using the focus-group technique: an illustrative example from Uganda

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. 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 15-30 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 discussing their health problems frankly. However, unlike the researchers, whose priorities were based on disease burden, the community members had more holistic views about health problems. All communities expressed the view that the emphasis should be placed 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.

(Source: COHRED, 1997:48).

Step 4. Selecting and using criteria

The next step is to move towards **identification, and possibly ranking, of research areas and/or questions**. For this purpose, it is advisable that the participating groups reach prior agreement about the criteria or guidelines that will be used.

Key issues that need to be considered are:

- which criteria are to be used?
- will criteria be assigned equal or different weights?

Types of criteria²

1. The **purpose of priority-setting and its level** (global, national, district or subdistrict) will influence the type of criteria that will be suitable. A global agenda would generally have as a criterion the extent to which a health problem is shared by many countries (burden of illness), and would include a bigger share of strategic research that many developing countries may not be able to undertake on their own. On the other hand, priorities at the country level might consider relevance to the national health plan as a criterion. Or, if the research agenda is to be used as a basis for obtaining funds, then it may be important to include “fundability” by research and donor agencies as one of the criteria, although not the most important.
2. Criteria should be **defined in detail**. In practice, it is easier to apply the criteria when they are in the form of specific questions. For example, the term “cost-effectiveness” is interpreted in many ways; thus participants should try to reconcile varying notions and perceptions by working on a common definition. The next step is to formulate specific questions, for example: Is the research cost-effective? Or: is the intervention that is likely to result from the research cost-effective? These are two quite different questions.
3. To the extent possible, the criteria should be **independent of one another**. For example, the magnitude of the problem and its urgency are often interrelated. It could happen that a health problem scores highly on both criteria, but closer examination might reveal that the magnitude of the problem may be driving participants to look for urgent answers and action. Another example is the interaction between the magnitude of the problem and the expected impact of the research results; the latter may score highly because success in the research intervention affects a large proportion of the population. This “double-counting” effect may be minimized to some extent by having the participants discuss and agree on the definitions and exact limitations of the criteria used.
4. All the criteria need an **information base**, both qualitative and quantitative. The language used to describe the information base should be understandable to the community, to enable them to participate in an informed way.
5. There should be explicit criteria to reflect the **promotion of equity and development**. This is the added value of the ENHR strategy. For example, although the magnitude of a health problem is an important criterion, participants should not overlook diseases common only in marginalized groups or in a few inaccessible localities. Without consideration of equity issues, such diseases may not rank highly on priority lists, or may even have a very low

² This section is largely drawn from Tan-Torres, 1997

ranking as a result of the multiple effects of the burden of illness on other criteria, such as expected impact, urgency and cost-effectiveness.

6. The criteria should be **narrowed down to a manageable number** of independent criteria. This is because of the generally large information bases, the problem of double-counting of criteria, and the difficulty of applying a large number of criteria. One approach is to get the participants' consensus on the core criteria (perhaps six or seven of them), test these on a few research areas, and determine whether the addition of other criteria would change the priorities. (See [Box 7](#).)
7. The criteria should be expressed in a common language, which will allow them to be combined.

See the Tools and Resources section for examples of [Criteria](#).

Assigning weights to criteria

If no explicit weight is given to each criterion, then it should be considered that they all carry equal weight. However, assigning equal weights should be a deliberate decision, since it is a powerful way of expressing values and preferences. Differential weighting is another option, generally based on the importance of the criterion in making the choice. Again, this option should be exercised only after insightful deliberation and consensus among the participants.

Use of rating scales

Rating scales can be developed and used for lists of criteria. An example is shown in [Box 8](#). Also, decisions have to be taken if all criteria should have equal or different weighting and a choice has to be made between addition or multiplication for the scoring system.

Box 6. Illustrative examples of how criteria have been used at national level

1. 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
 - urgency.
2. 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, sociocultural issues, broad interventions and evaluation of interventions.
3. South Africa used as criteria for the identification of research areas and questions the steps and questions developed by the Ad Hoc Committee, namely:
 - 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?
4. 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
 - ethical acceptability.

Box 7. Examples of categories for grouping selected criteria by theme

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 duplicates 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 of the right kind and done 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?”

(Source: Okello et al., 2000:16)

Box 8. Scales for rating research topics

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 = Data very urgently needed for decision-making

Ethical acceptability

1 = Major ethical problems

2 = Minor ethical problems

3 = No ethical problems

(Source: Varkevisser et al, 2004)

Fairness in the use of criteria: 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 9](#)).

Box 9. Ensuring fairness in priority-setting

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).

(Source: Daniels & Sabin, 1997)

Step 5. The product of priority-setting processes

Key issues to be considered are:

- the type of event that would generate the product of the priority-setting process
- the type of product that would be generated
- measures to enhance the acceptability of the product.

Type of event

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

Box 10. Illustrative examples of national events that were end-points in the priority-setting process

- 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 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 includes policy statements, technical presentations (including a summary of the planning process), group work and plenary sessions on priorities and recommendations (including a draft list of priorities).

Different types of end-products have been delivered by the national meetings

At least, the product is a broad list of priority health (system) problems, for which a specific health research agenda remains to be developed.

At most, a detailed list of priority research questions is identified, including the research type and/or other relevant information (e.g. who will be the users). For example, the South African congress formulated not only specific issues and conditions in relation to the identified top 10 health problems, but also listed specific research questions for each research type (clinical, basic, social, health systems and policy).

Another illustrative example comes from Tanzania ([Box 11](#)) in which research priorities were combined into three general categories. For a detailed analysis of this particular priority-setting process, see Harrison (2000).

Box 11. National health research priorities for Tanzania, as defined by participants in the priority-setting meeting (1999)

Diseases and injury	Delivery problems	Sociocultural 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 and 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		

(Source: Harrison , 2000)

The product of priority-setting needs to be synthesized in a document of some kind, for dissemination and discussion. This should be done as soon as possible after the priority-setting event.

Enhancing acceptability of the product

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 into an appropriate governmental plan, agenda or policy.

For example, in some countries, the health research priorities have been integrated into the national development plan, the national health plan and/or the national health research plan.

Box 12. Illustrative examples of integration of research priorities into policy documents

- Zimbabwe: The National Convention on Priority Setting recommended the integration of essential national health research, and in particular the identified health research priorities, within the National Development Plan.
- Philippines: The national health science and technology agenda, as developed at the National Health S&T Congress, was formally accepted by the Department of Science and Technology and the Department of Health as the basis for planning and implementation of science- and technology-related activities in health, particularly in setting directions for health R&D, capability development and information and dissemination activities/strategies in the country.
- Lao People's Democratic Republic: 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.

Further considerations

Moving from research priorities to research proposals

It is a challenge to move from a list of priorities, through problem specification, to specific research questions and research proposals. A system would need to be established to peer review the proposals. In developing countries, specific activities might be needed.

Several approaches are possible. Illustrative examples are given below, derived from the experiences of several developing countries.

1. One approach is to issue a public call for "concept papers" on the priority topics. These could then be subjected to peer review by a meeting of researchers and

experts, as has been done in Kenya and Uganda. (An illustrative example is provided in [Box 14](#).)

2. 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. The identified priorities could be forwarded to “expert groups for verification and extension”.

3. Special committees including task force members and other experts, representing the theme of each working group in the priority-setting exercise, could develop research proposals (as in the example of Nepal).

4. In several countries, training workshops for the development of research proposals are a regular feature. Such workshops could require evidence that the proposed topics for research are in the national priority agenda.

See the [Tools and Resources](#) section for:

- an example of a [Call](#) for Proposals that provides information on the priorities of the sponsoring agency (Alliance for Health Policy and Systems Research)
- examples of a criteria list used by the agency (Alliance for HPSR) for selection of proposals.

Other examples of priority-setting for diseases and conditions have been published. In 1998, the Institute of Medicine published a report entitled, *Control of cardiovascular diseases in developing countries* (Institute of Medicine, 1998: see especially chapter 4). The report includes a chapter on “Priorities for Global Research for Development”, which lists four criteria that were used to determine research priorities. About the same time, Research for International Tobacco Control (RITC) published a report summarizing the results (related to research priorities) of discussions at several workshops held in different parts of the world, as well as from other forms of consultation (WHO/RITC, 1999). An important article was published in 2002 regarding research on childhood diseases; the article includes comments on research priorities for this area (Dabis et al., 2002).

In December 2001, the Commission on Macroeconomics and Health delivered its report to the Director-General of the World Health Organization (CMH, 2001). Although this report is not primarily about global health research, it includes a section on “The supply of global knowledge in the fight against disease” (pp. 76-86). This section includes an interesting classification of three types of diseases in which the current global research effort is judged to be high, low, or very low.

Aligning resources toward research priorities

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 research on the priorities when they have been identified. So, whenever possible, the resources to conduct the research in response to identified priorities should be identified ahead of time.

Considering that research efforts “follow the money”, allocation or reallocation of resources to fill investment gaps is an essential condition for the implementation of the priorities.

Box 13. Realigning resources: illustrative examples

- A number of countries have initiated plans for realigning their national research programmes and resources with identified national health research priorities. The COHRED document *Health research in Tanzania: how should public money be spent?* (Harrison, 2000) gives not only an excellent example of how investment could be aligned with national priorities, but also makes reference to a number of practical ways in which Tanzania can seize opportunities for realizing higher returns on investments in R&D.
- Given the importance of donor funding of health research, Kenya and Uganda 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 programme.

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.

See Recommended Reading in Unit 3 for manuals and guidelines on tracking resource flows.

Box 14. Research problem specification: an example from Uganda

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 and propose methods of tackling 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 organized to discuss the merits of these proposals, bringing together Ugandan researchers and some invited guests: the COHRED Coordinator, the Executive Director of INCLLEN, 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; to help to find alternative sources of assistance for those proposals that fell outside a given international programme's mandate.

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 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 INCLLEN'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.

(Source: COHRED, 1997.)

Setting research priorities at the institutional level

Often, the research priorities of institutional groups and research teams seem to be determined simply by the interests of individual researchers, or by the availability of designated research funds. Included in this unit is a discussion of how an institution or research team can link its priorities with national or subnational research priorities, and with global priorities.

In the context of this unit, the term “institution” can be broadly defined, to include:

- departments or “units” (centres, institutes) within academic institutions
- independent research institutions, such as national research institutes or topic/problem specific institutes
- research units within ministries of health or social services
- research groups within nongovernmental organizations.

In some ways, the process of setting priorities by any institutional group can be considered as part of a larger strategic planning exercise for the institution. However, this unit will be confined to issues that affect only priority-setting.

(For those groups interested in the broader process of strategic planning, there are many resources available, including a module prepared specifically for INCLEN regional groups and units (see Tools and Resources, [Strategic planning](#)).

Additional key issues

Situational analysis – types of information required

Within the research institution: The focus of situational analysis at the institutional level should be an assessment of the strengths of the research institution, and the potential existing in the environment in which the institution operates. The strength of a research group, team or institution lies fundamentally in the ability, motivation and availability of the individuals who comprise the research team. Assessment of the strengths would include a review of achievements. This could be done by preparing an inventory which summarizes and displays the work (“track record”) and plans of individual members of the research group. A review of the curriculum vitae of each individual, key publications and membership of advisory committees would provide useful input.

National and global health research priorities: Analysis of opportunities in the environment would require the research groups to take cognisance of health research priorities at the national and global levels and the availability of research funds and priorities of funding agencies. Several tools are available to assist in this process. For example, several countries have documents describing national health research priority (see [Tools and Resources](#) section). The *10/90 reports on health research* prepared by the Global Forum on Health Research (e.g. GFHR, 2002) provides an excellent summary of the work being done by various global research networks on specific priority conditions and areas (see [Recommended Reading](#) section). Several global research groups have published statements about research priorities on specific topics or conditions (Institute of Medicine, 1998; WHO/RITC, 1999, Dabis et al., 2002).

Funding opportunities: Leaders of institutional research groups need to be familiar with the details of funding opportunities, both locally and globally. It is up to institutional groups to be familiar with research funding in their own country. As most researchers know, a variety of funding mechanisms are available at a global level. Also, the GFHR publication *Monitoring financial flows for health research* (GFHR,

2001) includes a review of donors and their areas of interest. Several countries in the “North” have special research programmes and funds that are available to research groups in low- and middle-income countries. Often these funds can be accessed by forming “partnerships” with groups and institutions in the sponsoring countries.

Involving stakeholders

Types of stakeholders: Stakeholders will vary according to the type of institution. For example, if a research unit within an academic institution is reviewing its own research priorities, it may wish to consult not only its own members, but also:

- the dean or other leaders of the institution
- other research units (to ensure complementarity and to avoid unnecessary and unhelpful duplication – or worse, counterproductive competition)
- appropriate individuals in the government – for example, an academic research team concerned with health systems research will benefit from consulting Ministry of Health officials responsible for managing and reforming health systems (See unit 3 in this module for further details of this example).

In some situations, it may be appropriate to consult community groups directly. Descriptions of approaches to eliciting community inputs are available (Jordan et al., 1998).

Issues to be addressed: It is critical to obtain the views and ideas of individuals regarding their plans for future work – both for themselves individually, and for the institution. A variety of techniques are available for this kind of inquiry. For example, each member of the research team could be invited to consider the information that has been gathered during situational analysis, and respond to a series of questions such as:

- What are the key challenges during the next five years? For yourself personally? For the institution?
- Taking into account the national and global health research priorities and the strengths of your institution, what would be the two or three most important research priority areas for the institution?

The principles of developing and using criteria would be applicable to this process. And agreement or consensus needs to be achieved about priorities over a defined time period. The consensus techniques described earlier would be applicable

Identifying the institution's “niche”

Most institutional groups will find that, by bringing together a careful analysis of the institution's **strengths**, and matching these with available **opportunities**, certain gaps become apparent. By analysing these gaps, a potential “niche” for the organization can be determined. One definition of a niche is “a position or role taken by an organization within a community” (Canadian Oxford Dictionary, 1998).

The assumption is that by defining and clarifying its “niche”, the research institution will have a greater chance of being successful in its work. That is, it has the capacity to undertake research on the defined priorities, where “capacity” includes competence of its members, an adequate infrastructure, appropriate support systems and available resources. In addition, if priorities have been defined in consultation with key stakeholders, there is a greater probability that research results will be used.

Enhancing the utility and acceptability of the product of priority-setting

A key issue is to assess whether the research priorities identified through the priority-setting exercise are feasible from a research design perspective. Three subquestions need to be considered.

Can the research problem be specified? Research problem specification is an essential (and sometimes neglected) step in the process of priority-setting. Typically, priority-setting exercises are helpful for determining general directions, but do not provide the necessary specificity about the actual research that needs to be done. The task of specification involves translating general research priority topics into more precise research questions. This task is usually carried out by technical groups or task forces. This step should include identifying the resource requirements, determining timelines and identifying the actual research groups who will implement the research.

Does the research require multidisciplinary teams? In many instances, important research questions can be adequately answered only if several disciplines are involved in the process. The process of assembling multidisciplinary teams is a challenge in itself. It may require workshops, with invited resource persons or facilitators, to help the research groups recognize where technical competences complement one another.

Does the proposed research meet ethical standards and guidelines? The issue of ethical guidelines has, quite appropriately, received increasing attention in recent years. While clearance of research proposals by ethics committees or review boards is a standard and accepted procedure in many countries, in other countries (particularly where health research systems are relatively new), ethical considerations have come to prominence only more recently. Helpful reviews and examples are available (Nuffield Council, 2002).

An illustrative example of priority-setting in a research institute is provided in [Box 15](#).

Maintaining a dynamic process

Finally, a reminder that a statement of priorities is not “set in stone”. Situations change. New problems appear. So research institutions should set themselves the task of reviewing their research priorities on a regular basis – probably every three to four years.

Box 15. An illustrative example of institutional priority-setting: Health Economics Unit, University of Cape Town, South Africa

The Health Economics Unit (HEU) at the University of Cape Town conducts an annual strategic planning retreat. Most commonly, a SWOT analysis (strengths, weaknesses, opportunities, threats) is used to initiate these discussions. Every two or three years, the meeting includes a review of the institution's health research priorities.

These deliberations are influenced by two sets of activities.

- Members of the HEU meet quarterly with officials from the Directorate of Health Financing and Economics of the National Department of Health. The HEU provides information on current research and on preliminary findings. The Department of Health officials, in their turn, discuss the key current policy and planning issues. They also request specific inputs from HEU in the form of short-term research or technical support for selected policy processes. These meetings are critical in ensuring that the research is relevant to policy.
- HEU also maintains extensive communications with other research units working in the area of health economics and health policy in South Africa. This includes regular updating about one another's new research projects (some of which are collaborative in nature). These communications serve to prevent unhelpful duplication of research effort.

The HEU group attempts to balance the need to respond to immediate Government priorities (often related to immediate policy objectives), with the need to be proactive in undertaking research that is likely to be important for future policy-making. This proactive strategy (often based on an analysis of current health systems challenges) is important to avoid the syndrome of constant “fire fighting”.

An important challenge in HEU's priority-setting process is the fact that almost all the research (95%) is funded through research grants. Frequently, funding is not readily available for short-term policy-relevant work. Rather, considerable funding is available for the economic evaluation of particular interventions that are not public health priorities (particularly to evaluate new pharmaceutical products). While HEU has been relatively successful in meeting this challenge to date, there is an important lesson here.

The critical need for assured funding for priority-driven health policy and systems research must be recognized, so that scarce research expertise is not diverted into nonpriority work, simply to “pay the bills”.

(Source: Adapted from notes provided by Di McIntyre, Director, HEU)

Tools and resources

1. Manuals and guidelines

Okello D et al. (2000). *A manual for research priority setting using the ENHR strategy* (COHRED document 2000.3). Geneva, Council on Health Research for Development, p.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.

Examples of criteria used in health research priority-setting (Source: Okello et al., 2000:13)

This list of criteria could facilitate brainstorming and decision-making about criteria, to be used in a specific health research priority-setting process.

- adequacy and usefulness of current knowledge base (avoiding duplication)
- applicability of the research outcome
- availability of cost-effective interventions
- capacity of the system to carry out the research
- community concerns/demands
- economic impact
- environment health and sociopolitical effects
- equity focus
- ethical and moral issues
- feasibility
- funding support
- human rights issues
- impact on health
- impact on development
- justification of cost/investment
- justification of time
- legal aspects
- magnitude of the problem
- obligation and professional responsibility

- operational effectiveness
- partnership-building
- persistence of the problem
- political will/acceptability/commitment
- relevance
- responsiveness to the national health policy or national goals
- research capacity-building
- research utilization
- urgency

Neufeld V (2002). *Strategic planning* (INCLEN Leadership & Management Program, Module 1).

This module introduces some models of and concepts about strategic planning from the general leadership and management literature. It also sets out and explains six principles of strategic planning: involving stakeholders, analysing the context, developing a vision, preparing action plans that work, measuring things that matter and ongoing “learning while doing”. Available online at:

<http://www.inclentrust.org/LAMP%20Modules.htm> (accessed August 2004).

Challenge Dialogue System

The Challenge Dialogue System (CDS) is “a comprehensive organizational performance improvement system” to help teams or stakeholder groups collaborate to accomplish complex tasks. This eight-step process, developed by Dr Don Simpson, has been successfully tested in Europe, Asia, Africa and North America. It can be used to improve performance in a three-hour meeting, a three-day project, or a three-month initiative. The eight steps include: determining a key challenge, setting the scene for collaboration, exploring options and determining priorities, practising innovative leadership, making sure that measures matter, choosing and using appropriate information and communication technologies, taking concrete action and soliciting feedback and practising disciplined follow-up. For more information, see <http://www.innovationexpedition.com/> or contact Don Simpson at dsimpson@innovationexpedition.com.

2. Consensus techniques: round-table discussions and Nominal Group Technique

Box 16. Round-table discussions

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, usually not more than 20 or 30, who have not met before. 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 organizations 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 preparing a report, a draft of which is distributed for comment to round-table participants soon after the event.

(Source: COHRED. 1997:50)

Box 17. The Nominal Group Technique (NGT)

This technique allows a group or team to come quickly to a consensus on problems or issues, by completing individual importance rankings and incorporating these into an overall statement on team or group priorities.

The technique has the following features:

- builds commitment to the group choice through equal participation
- allows individual rankings without pressure from others
- puts quiet individuals on an equal footing with more dominant persons
- makes group consensus visible, so that major areas of disagreement can be discussed.

The process includes the following steps:

- generate the list of problems or issues to be prioritized
- write these on a whiteboard or flip chart
- eliminate duplicates and/or clarify meanings of any statement
- record the final list of problems, issues or statements (on a whiteboard, flip chart or individual worksheets)
- each person (stakeholder) records the corresponding letters (A, B, C, etc. designated for each problem or issue) and orders them by rank
- the rankings of all persons are combined, and displayed, and can then be discussed for further clarification.

There are, of course, variations on these steps, such as reducing a large number of problems by half, for example from 20 to 10, before actually prioritizing.

(Source: COHRED, 1997:51).

Sample call for proposals (letters of intent)

Introduction

The Alliance for Health Policy and Systems Research was established in November 1999 as an initiative sponsored by the Global Forum for Health Research in collaboration with the World Health Organization, to contribute to health development and the efficiency and equity of health systems through research on and for policy. Among its tasks, the Alliance is contributing to develop health policy and systems research (HPSR) and promote national capacity with particular emphasis on countries that currently have limited capacity to participate and benefit from HPSR but that are strongly committed to improvement.

The Alliance calls for its second round of letters of intent for small grants aimed to support capacity development, good quality research and its impact on policy.

Objective

Grants will aim to contribute to improved health by encouraging relevant, valid, and sustainable research and its application to the health policy and management process.

Grants

Two types of grants will be awarded:

Young Researcher Grants. These grants aim to support the growth and potential of HPSR in the medium term by funding projects of young researchers working as part of a research team, or the projects of students who are doing Masters or Doctoral level dissertations in a relevant subject. Close co-ordination will be sought between the academic and methodological support provided by the host academic programme or senior researchers and Alliance training and grant requirements.

Research to Evidence Grants. These grants aim to strengthen capacity for the application of HPSR to the policy process. Financial support will be provided to teams of experienced researchers and policy/decision makers to undertake short research projects involving empirical study or analysis of existing data. Projects should take the form of an interaction between researchers and policy/decision makers, which fosters the production of evidence for the policy process.

Besides financial support for research, the Alliance will organize training and development workshops for proposal development and writing up and communication of research results to influence the policy process.

Research topics

The Alliance encourages submissions in a number of specific topic areas (see below), identified on the basis of partner priorities, emerging and widely acknowledged problems, Alliance consultations over the past year, and demand for funding as reflected in the response to the first round call. However, letters of intent on any other HPSR topic will also be considered. Selection will be based on the scientific merit of the proposal, its justification with respect to country priorities, and the

extent to which it contributes to a critical mass of research on particular topics. In addition, applications are particularly encouraged from low-income countries, with limited HPS research capacity but demonstrating researcher and policy maker commitment to building up capacity in HPSR.

Health policy and systems research is defined broadly as the production of new knowledge and applications to improve how societies organize themselves to achieve health goals, including how they plan, manage and finance activities to improve health, as well as the roles, perspectives and interests of different actors in this effort. The health system functions of regulation, organization, financing and delivery of services are the focal subjects of HPSR. Broader determinants directly affecting the health system are also considered within the purview of HPSR. Outside the scope of HPSR would be research focusing on environmental, political, cultural and economic determinants and processes that affect health indirectly.

Submissions on the following topics are especially encouraged

A. Impact of social policies against poverty and exclusion, and consequences of globalization

There are multiple direct and indirect linkages between globalization and health requiring further research. The direct effects include impacts on health systems and policies directly (e.g., the effects of the WTO General Agreement on Trade in Services) and through international markets (e.g., the effects of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights); and direct effects on other influences on health at the population level (e.g., cross-border transmission of infectious disease and the marketing of tobacco). The indirect pathway includes effects operating through the national economy and on population levels of health risks.

B. Innovative approaches to health financing for the poor

Health financing encompasses collecting money to fund health systems, pooling contributions from different sources to allow financial risks to be shared, and paying service providers. Effective health financing seeks to ensure that all individuals have affordable access to appropriate public health and personal health care services, to pay providers fairly for the services they deliver and to set the right financial incentives for service users and providers.

Many different approaches to health systems financing and research are needed to assess what works best in particular circumstances. Specific areas for research might include:

- the impacts on equity and service utilization of alternative approaches to revenue collection such as general taxation, hypothecated “health” taxes, social insurance, private insurance and out-of-pocket payments,
- issues around approaches to risk-sharing (pooling) such as insurance (risk-rating, reinsurance, underwriting and ways to address moral hazard while maintaining access to necessary care), the optimum size of risk pools, how to include the poor in risk pools, moving from small-scale voluntary risk pools to

- larger pools that encompass the whole population, the use of medical savings accounts and ways to deal with adverse selection problems,
- the impacts of alternative approaches to paying service providers (such as line item budgets, fee-for-service, case-based payments and capitation), their feasibility in developing countries and their effects on service users and providers, and
 - institutional arrangements for health financing, such as capacity development, regulation of insurance markets and information to support effective financing.

C. National health accounts (NHA): country methodological developments

NHA has been recognized as a strategic tool to monitor, evaluate and outline potential planning avenues in health systems. In most countries only first estimates are available, imposing the need to search for feasible ways to fulfill policy requirements. Research is required to establish if the NHA models being developed satisfy the four basic questions: who pays? for what? produced by whom? for whose benefits? There is also a need to identify the most cost-effective ways to obtain reliable and sufficient data with the appropriate breakdown by region, socio-economic strata, disease, and provider. Other important issues include: use of existing data to simulate the effects of restructuring financing and delivery systems or re-allocating resources; data projections to identify future resource needs; other health policy uses of NHA.

D. Research on human resource development

Staffing costs and wages represent usually about three quarters of recurrent health expenditure in most countries. Effective health service delivery requires the efficient use of the skills of a well-motivated health sector workforce. The health sector workforce is complex, with several health specific professional groups with distinct roles and their own educational and regulatory structures. Each professional group also has a specific culture, which sometimes is the main obstacle to bringing them to agree to changes, or work in a co-ordinated manner. Research will be considered that provides evidence on the following issues:

- staff shortages due to geographical maldistribution, migration, and other factors,
- effective approaches to health sector reform and readjustment which improve health worker performance and cost effectiveness, and improve quality of care, through new working patterns and changes in staffing and skill mix,
- improving the gender balance of all levels of the health work force,
- staff maldistribution by specialty, by level of care, and by type of institutions,
- improving staff motivation and performance through effective use of pay and non-pay incentives, the provision of education and career development opportunities, flexibility in working schedules, and a safe working environment.

E. Scaling up malaria control and prevention: challenges for financing and health system strengthening

Populations exposed to malaria require rapid access to proven first line treatment and preventive interventions, which may be delivered by non-traditional actors such as consumer good distribution networks. Public, voluntary and for-profit private sector stakeholders brought together through Country Roll Back Malaria (RBM) partnerships have outlined plans for increasing their scale of operation. These plans aim to provide improved access to RBM interventions by 60% of at risk populations by 2006 in order to reduce the burden of disease of malaria by 50% by 2010. Research providing guidance on how RBM action at country level can be enhanced is required in the following areas:

- embedding novel approaches to control high burden diseases within strategies such as health sector reforms, sector wide approaches and decentralization,
- challenges for the global and local mobilization of additional funding for scaling up malaria control,
- allocation and management of additional resources to non-traditional health sector actors, specially practical contracting and financial accounting systems.

F. Research on road traffic injuries: policy development and implementation

Road traffic injuries represent the tenth leading cause of death world-wide and account for the largest fraction of the global burden of injuries. By the year 2020, it is expected that road traffic crashes will account for the third highest cause of the global burden of disease. The predicted sharp rise in road traffic crashes will occur predominantly in developing countries. Crucial risk factors such as driving under the influence of alcohol; speeding; under-utilizing seat belts and child restraints; and poor road design and roadway environment are all avoidable phenomena. Priority research areas are:

- stakeholder analysis and participatory research to explore risk factors and interventions for road traffic injuries,
- policy responses to burden of disease measurements for road traffic injury at the national level, and
- research on the acceptability of proven interventions.

Who can apply

Young Researcher Grants. Applicants must be enrolled in a Masters or Doctorate programme and the proposed research project should be an integral part of the requirements for graduation. The letter of intent can be submitted by an academic supervisor or by the junior researcher, in which case the supervisor should endorse the proposal. Only developing country nationals normally residing in a developing country are eligible, although they may be enrolled in an academic programme abroad.

Research to Evidence Grants. The individual applicant should have or be able to establish collaboration with another institution or internal unit leading to the formation of a team with at least one researcher and one policy/decision maker. The

supporting member(s) of the team should endorse the letter of intent. Applications will be accepted only from institutions in developing countries, but teams including developed country institutions are eligible.

Current Alliance grantees are not eligible to apply as principal investigators.

Project selection and technical support

Letters of intent will be selected by the Alliance on a competitive basis. In the first phase, up to 30 letters of intent are expected to be selected on the basis of relevance and technical merit. Applicants will then be invited to develop a preliminary proposal and present it at one of two protocol development workshops to be held in the week of September 17 and October 1 2001. Participants will submit final proposals in English for the award phase within two weeks of the assigned workshop. In this phase, approximately 25 proposals will be selected for funding on the basis of their technical merit. After the preliminary research report is submitted, the principal investigator will be invited to a second training and development workshop to support write-up and the design of dissemination and application strategies. Projects will be offered technical support during execution as required.

Budget, duration and contractual arrangements

Grants will be awarded for up to one year with a modest budget to support field work and office support. Young researcher grants have been supported in the past at an average of US\$8,200 (\$13,000 maximum) and Research to Evidence grants at an average of \$19,400 (\$31,200 maximum). Grants will be awarded by the Alliance through a contract between the Global Forum for Health Research and the applicant's institution. Payment will be in one tranche at the beginning of the contract.

How to apply

Letters of intent should be received by the Alliance not later than 5PM GMT on 29 June, 2001. Awards will be announced by July 13. Letters are preferred in English, but Spanish or French can also be used. Only electronic submissions will be accepted. Submission through the Alliance Web site is preferred, but letters are also accepted by e-mail. Use only one medium for submission. The Alliance will confirm receipt of letters as they are received.

The letters should contain the following information and not exceed **2,000 words** (excepting the CV as an annex):

- General information
- Type of grant requested (*State which:*)
- Young researcher
- Research to evidence
- Priority area chosen (refer to one or more from the list below):
- Impact of social policies against poverty and exclusion, and consequences of globalization
- Innovative approaches to health financing for the poor

- National health accounts (NHA): country methodological developments
- Research on human resource development
- Scaling up malaria control and prevention: challenges to funding and health system strengthening
- Research on road traffic injuries: policy development and implementation
- Other (please specify).
- Project title
- Contact information of applicant
- Name
- Post
- Telephone
- Fax
- Email
- Address (including zip code if available)
- Details of supporting institution/unit:

For young researchers:

- Name of academic institution
- Name of Masters' or Doctoral program
- Name of supervisor/thesis director

For Research to Evidence Grants:

- Name of research institution
- Name of policy partner's institution
- Is your institution a partner in the Alliance-HPSR?

Yes

No

Research project information:

- Aim
- Objectives
- Justification
- Describe relationship of proposed project to HPSR priorities at country level.
- For Young Researcher Grants: specify the role of the research within the academic program and for professional development.

- For research to evidence grants: state potential application of research to national policies and the health system.
- Conceptual framework
- Methodology
- Data analysis plan
- Budget
- Funding requested from the Alliance (state global budget only, in US dollars)
- Funding to be obtained from other sources

13. Duration in months (projects should be completed in one year or less)

Annex: Brief curriculum vitae of principal researcher only (not more than three pages).

Send letters by Web posting or e-mail only.

www.alliance-hpsr.org

alliancehpsr@who.int

For queries please address correspondence to:

Alliance for Health Policy and Systems Research

Office No. 3148

World Health Organization

CH 1211 Geneva 27 Switzerland

Tel: (+41 22) 791 2890/2840

Fax: (+41 22) 791 4328

Sample criteria used to select the proposals

Introduction

The Alliance second call for letters of intent for small grants is set to close on June 29, 2001. Two types of grants will be received: Young Researchers and Research to Evidence. While six priority areas were identified, the Alliance will give equal attention to all letters received within any HPSR topic as defined in the call. Reviewers will be able to score for priority on the basis of their knowledge of country and regional priorities as well as on the basis of the justification provided in the letter. The Alliance secretariat will have screened all letters to ensure that they fall within the broad scope of HPSR.

The selection process will be in two phases: A. Ranking for quality, relevance and strength of research team/academic program; B. Selection of topics and regional balance. Phase A will be undertaken by reviewers on the basis of their topical and regional expertise. Phase B will be undertaken by the Alliance Board on the basis of letters short-listed after the review in Phase A and following Alliance policies.

Review procedure

Review of letters will be based on the following steps:

- Screening for completeness and relevance within the broad HPSR framework (Secretariat).
- Identification of letter topic(s) (Secretariat).
- Screening for quality and relevance to produce a ranking of letters. (Reviewers).
- Reclassification of topics as necessary. (Reviewers).
- Ranking of letters by averaging each regional reviewer's scores. (Secretariat).
- Short listing of letters with above average scores.
- Grouping of short-listed letters into topics and type of grant (Secretariat).
- Mailing of short-listed letters to Alliance Board committee.
- Discussion through teleconference to make final selection of between 30 and 35 letters for proposal development. (Board committee).
- Announcement to selected researchers (Secretariat).

Reviewers

A group of reviewers has been assembled by inviting highly trained and experienced researchers or policy makers with research training. Regional HPSR networks collaborated in this selection. Reviewers were consulted on the topic areas to be reviewed and were grouped whenever possible by region of expertise (Asia, Africa, LAC and Middle East). WHO programs collaborating for the six priority areas have also been invited to participate.

Each letter will be reviewed by at least two experts and up to three whenever possible. Each reviewer will be assigned not more than 15 letters and ideally between 5 and 10.

Review dates

June 25 & July 2. Reviewers to receive letters of intent and scoring forms

July 5. Last date for reviewers to return their scores to the secretariat

Recommended reading

COHRED (Council on Health Research for Development) (1997). Essential national health research and priority setting: lessons learned (COHRED document No. 97.3), Geneva. 66pp.

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 programme, 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.

COHRED Working Group on Priority Setting (2000). Priority setting for health research: lessons from developing countries. Health Policy and Planning, 15(2):130-136.

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 multidimensional 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.

GFHR (Global Forum for Health Research) (2002). The 10/90 Report on Health Research 2001-2002. (Chapter 8: Some networks in the priority research areas). Geneva: Global Forum for Health Research.

Chapter 8 of the report describes several global research coalitions that promote and coordinate research on specific priority conditions. Several of the research coalitions mention the process of priority-setting, either directly or indirectly. For example, the Child Health and Nutrition Research Initiative (CHNRI) has as one of its objectives "to promote priority research discussion with a broadened approach to child health, nutrition and development" (p.182). This group plans to use "established methodologies for priority setting" to achieve this objective. The chapter also provides an excellent up-to-date summary of the work being done by these coalitions on a number of priority areas identified by various reports over the past 12 years. The diseases and conditions include the following:

- tuberculosis (pp. 139-145)
- HIV/AIDS (pp. 146-149)
- cardiovascular health (pp.150-157)
- malaria (pp. 157-166)
- mental health and neurological disorders (pp.166-171)

- *reproductive health* (pp. 172-175)
- *road traffic injuries* (pp. 176-180)
- *child health and nutrition* (pp.181-187)
- *sexual violence against women* (pp.187-191)
- *health policy and systems* (pp. 193-200).

GFHR (Global Forum for Health Research) (2000). The 10/90 report on health research 2000, Insert 5.2, Epilepsy - risks, obstacles and opportunities for interventions: application of the five steps for priority-setting. Geneva.

This table presents the results of a research priority-setting exercise undertaken by the mental health programme in WHO, using the combined matrix approach.

IOC (International Organizing Committee) (2001). Report of the International Conference on Health Research for Development, Bangkok, 10-13 October 2000. Lausanne.

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.

TFHRD (Task Force on Health Research for Development) (1991). Essential national health research. a strategy for action in health and human development. Geneva.

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.

WHO (World Health Organization) (2000). Operational guidelines for ethics committees that review biomedical research. Geneva.

WHO (World Health Organization) (2000). The world health report 2000. Health systems: improving performance. Geneva.

WHO (World Health Organization) (2002). National health research systems: report of an international workshop (Cha'am, Thailand, 12-15 March 2001). Geneva.

Yepes FJ, Sanchez LH, Ramirez ML (2001). Funding research for policy in Colombia's reformed health sector (Alliance for Health Policy and Systems Research Working Paper No. 11). Available online at: <http://www.alliance-hpsr.org> - Services - Alliance Information Products - Working Papers (accessed August 2004).

References

- Ad Hoc Committee (Ad Hoc Committee on Health Research Relating to Future Intervention Options) (1996). *Investing in health research and development* (document TDR/Gen/96.1). Geneva, World Health Organization.
- Canadian Oxford Dictionary* (1998). Toronto, Oxford University Press.
- CHRD (Commission on Health Research for Development) (1990). *Health research: essential link to equity in development*. New York, Oxford University Press.
- CMH (Commission on Macroeconomics and Health) (2001). *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization.
- COHRED (Council on Health Research for Development) (1997). *Essential national health research and priority setting: lessons learned*. Geneva.
- COHRED Working Group on Priority Setting (2000). Priority setting for health research: Lessons from developing countries. *Health Policy and Planning*, 15(2):130-136.
- Dabis F et al. (Working Group on Women and Child Health) (2002). Improving child health: the role of research. *British Medical Journal*, 324(7351):1444-1447.
- Daniels N, Sabin JE (1997). Limits to health care: fair procedures, democratic deliberation and the legitimacy problem for insurers. *Philosophy and Public Affairs*, 26(4):303-350.
- ENHR Secretariat (1999). *Tanzania Essential National Health Research Priority Setting Workshop, Arusha International Conference Centre, 15-21 February 1999. Final report*. Dar es Salaam, National Institute for Medical Research.
- Feachem RG, Graham WJ, Timaeus IM (1989). Identifying health problems and health research priorities in developing countries. *Journal of Tropical Medicine and Hygiene*, 92:133-191.
- Frenk J, Murray CJL (2000). A framework for assessing the performance of health systems. *Bulletin of the World Health Organization* 78 (6): 717-731
- GFHR (Global Forum for Health Research) (2000). *The 10/90 report on health research 2000* (Insert 5.2, Epilepsy – risks, obstacles and opportunities for interventions: application of the five steps for priority-setting). Geneva.
- GFHR (Global Forum for Health Research) (2001). *Monitoring financial flows for health research*. Geneva.
- GFHR (Global Forum for Health Research) (2002). *The 10/90 report on health research 2001-2002*. Geneva.
- Harrison D (2000). *Health research in Tanzania. How should public money be spent?* (COHRED document 2000.9). Geneva, Council on Health Research for Development.

INDEPTH Network (2002). *Population and health in developing countries. Vol. 1: population, health and survival at INDEPTH sites*. Ottawa, International Development Research Centre.

Institute of Medicine (1998). *Control of cardiovascular diseases in developing countries: research, development and institutional strengthening*. Washington, DC, National Academy Press.

Jordan J et al. (1998). Health needs assessment. Whose priorities? Listening to users and the public. *British Medical Journal*, 316:1668-70.

Nuffield Council (2002). *The Nuffield Council report 2002. The ethics of research related to healthcare in developing countries*. Available online at: <http://www.nuffieldbioethics.org/developingcountries/index.asp> (accessed August 2004)

Okello D et al. (2000). *A manual for research priority setting using the ENHR strategy* (COHRED document 2000.3). Geneva, Council on Health Research for Development.

Tan-Torres T (1997). Criteria for priority setting, In : COHRED. *Essential national health research and priority setting : lessons learned*. Geneva

Varkevisser CM, Pathmanathan I, Brownlee A (2004). *Designing and conducting health systems research projects – Vol. 1 and 2, Proposal development and fieldwork & Data analyses and report writing*, Ottawa, International Development Research Centre, and Amsterdam, KIT

WHO (World Health Organization) (2001). *The world health report 2001. Mental health: new understanding, new hope*. Geneva. (See Annex Table 4: Healthy Life Expectancy (HALE) in all Member States; estimates for 2000.)

WHO/RITC (World Health Organization/Research for International Tobacco Control) (1999). *Confronting the epidemic: a global agenda for tobacco control research* (document WHO/NCD/TFI/99.12). Geneva, World Health Organization.