Meeting of the WHO Scientific Working Group on Criteria for Setting Health Research Priorities

Report to the Regional Director

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Annexes

1. PREVIEW

The Regional Director, WHO South-East Asia Region, established, in 1999, four scientific working groups in important areas of health research management. This was done in response to a recommendation made by the first joint session of the South East Asia Advisory Committee on Health Research (SEA-ACHR) and Directors of Medical Research Councils (MRC). These four areas were: Management and coordination of health research activities in the countries; Criteria for setting health research priorities; Formulation of national health research policies and strategies; and Management of health research information. The present report deals with the meeting of the Scientific Working Group on Criteria for Setting Health Research Priorities.

2. INAUGURAL SESSION

The meeting of the Scientific Working Group on *Criteria for Setting Health Research Priorities* was held at the WHO Regional Office for South- East Asia (WHO/SEARO) from 1-3 November 1999. It was attended by six members of this Scientific Working Group (two were unable to come) and three special invitees (see **Annex 1** for list of participants). The Acting Regional Director, Dr Vijay Kumar, delivered the opening address on behalf of the WHO Regional Director, Dr Uton Muchtar Rafei.

The Regional Director, in his opening address, recounted the genesis of this Scientific Working Group and elaborated its terms of reference (see **Annex 2**). The first joint session of SEA-ACHR and Directors of MRCs (or analogous bodies), held in Sri Lanka in 1998, had directed much attention to four specific areas of health research management. Scientific working groups were set up subsequently in these four areas. Criteria for setting health research priorities was one of these. The purpose of this Scientific Working Group was to develop a guideline in the field of priority setting in health research (and health problems), which would be a useful WHO document for SEAR countries and beyond. The anticipated work thereby encompassed both normative and regional aspects. It was expected to be balanced and useful for implementation purposes.

3.   INTRODUCTORY SESSION

The Chairperson of the Scientific Working Group, Professor N K Ganguly, Director-General, Indian Council of Medical Research, welcomed the participants. Professor Ganguly recalled the collaboration between the Indian Council of Medical Research and the WHO Regional Office for South- East Asia. The first joint session, held in 1998, had been important in leading to a re-examination of health research strategies in the Region, especially with regard to research management. He welcomed the establishment of this Scientific Working Group to look at the issues related to priority setting in health research, and to do so in a regional context. In general, the countries of South-East Asia should focus more on themselves as a Region. At the same time, the regional perspective ought to reflect the diversity of approaches.

Dr U Than Sein, Director, Department of Evidence and Information for Policy, WHO/SEARO, greeted the participants and placed the work of this Scientific Working Group on priority setting in the context of the other three groups in health research management. The Scientific Working Groups on *Management and coordination of health research activities in the countries*, Bangkok, Thailand, 6-8 October 1999), *Formulation of national health research policies and strategies* (Jakarta, Indonesia, 6-8 December 1999) and *Management of health research information* (WHO/SEARO, 15-17 December 1999) are interrelated.

With regard to these respective areas, it would be beneficial to consider the priority issues identified (or guidelines developed) both *per se* and as a whole. It would therefore be very useful if this Scientific Working Group were to develop a guideline containing the mechanisms, processes and criteria used for health research prioritization. In addition, it would be helpful to formulate plans of action to assist in implementation once such a guideline has been developed.

Members of the Scientific Working Group, special invitees and WHO Secretariat introduced themselves to the meeting. The Agenda (**Annex 3**) and the Working Schedule (**Annex 4**) were adopted as proposed. Members decided not to split up for purposes of group work since the group was sufficiently small and congenial for in-depth discussion.

4. BUSINESS SESSION

The business session commenced with members and special invitees delivering issue-based presentations, followed by plenary discussions in the areas of priority setting. The presentations, together with a brief synopsis, are indicated in italics under relevant issues. Subsequent discussion at the plenary is summarized in relation to each issue.

4.1 Priority Setting in Health Research

'Priority health research agenda in the context of the national health policy' was presented by Dr Somsak Chunharas, who outlined the fundamental value of priority setting. The benefits of priority setting extended not only to health research areas but also to health problems generally. This understanding was of key importance because it could render priority setting attractive to health researchers and health planners alike. Having established this perspective, Dr Somsak highlighted the substantive and the subtle aspects of establishing a priority agenda for health research within the overall national health policy.

Plenary then discussed key features as detailed below, thus setting the context for subsequent work.

(1) Why prioritize?

Resources are finite. They are finite everywhere, especially in developing countries. Different options need to be weighed before resources are allocated and a course of action decided. The overall goal is to allocate resources more effectively, a primary task for national development. Resource allocation is subject to a range of interests or requirements. How to integrate, in a reasonable way, all the information relevant to the managerial and political processes of decision-making is not yet well understood. This also holds true for priority setting in health research.

A number of organizations have advocated priority setting in health research. For example, the International Development and Research Centre of Canada introduced priority setting as an important step in its training modules on health systems research. Similarly, the Council on Health Research for Development, promoting both concept and application of Essential National Health Research (ENHR), established a working group on

priority setting. The idea is for countries to better direct the use of very limited resources for health research. It is this point which makes research prioritization one of the key nodal points in the research cycle.

(2) Priority setting and creativity

Setting research directions, or selecting priorities limited to those known at present, may be viewed as stifling the very creativity needed to research successfully. Priority setting processes, where embarked upon, should remain sensitive to that. To the extent possible, available options should be analysed rationally and in a way which does not hinder creativity.

Furthermore, not all health problems require further research. Research can at times be an excuse for not facing a difficult issue. The participants in priority setting processes should be well placed to make this distinction.

(3) Setting priorities in health research

Weighing options is at the heart of priority setting. The purpose is to identify problems which deserve higher attention. Planners and research planners thereby hope to direct resources to where they are most needed. Priority setting is usually most useful if done in stages. The first stage would be used to prioritize the different areas or domains. This stage is especially attractive to planners and policy-makers. Sophisticated techniques are not necessarily required. During the second stage, the different research topics *within* these areas are assembled and prioritized. This stage is particularly attractive to technical personnel and appropriate methods and tools should be considered for selection. For both stages, however, the principles of participation and inclusiveness apply.

Priority setting in two stages generates flexibility in application. Priority setting for health problems is different from priority setting for research problems. It is therefore useful to separate disease prioritization from research prioritization. Such priority setting is capable of reflecting the relative importance of diseases or health problems (stage 1) and the importance of research issues within each health problem or disease (stage 2). The stages are thus sequential and not parallel. A two-stage prioritization process may appeal to planners (stage 1 in particular) as well as researchers (stage 2 in particular). Its practical value is thereby enhanced considerably.

(4) National health policy and priority setting in health research

The national health research agenda should emanate during the development of national health development plans. It should therefore take place within the framework of national health policy and overall development efforts in the country. There are substantive and subtle aspects of establishing a priority agenda for health research within the overall national health policy, balancing technical and non-technical requirements.

Of course, if priority setting is rarely done for health programmes in general, it may be difficult to see why it should be done for health research. On the other hand, the pursuit of health research to address national needs is not a new phenomenon in SEAR countries. The Thai Research Fund, for instance, identified mellioidosis as a priority disease problem which would require research to help solve the problem. Studies on goitre, beri-beri, tuberculosis or nutritional deficiencies by the Indian Council of Medical Research, or by WHO collaborating centres in SEAR, constitute examples of need-based research as well. In Maldives, during 1992-1995, a study on the prevalence of haemoglobinopathies in different atolls is another example. However, such efforts did not necessarily result from systematic priority setting.

Furthermore, it would not be wise for any single group to claim exclusive rights on priority setting — be they policy-makers, health service managers or providers, research scientists or end users. It would be similarly unwise to try and determine scientific feasibility without the advice of research scientists.

4.2 Information Needs for Health Research Prioritization

'Information needs for health research prioritization' was presented by Professor P C Karmacharya. He focused on the requirements for information during the research cycle. Priority setting is one of the nodal points in this cycle and has therefore its own information needs.

Members discussed some of the important information requirements for priority setting.

Fundamentally speaking, information is important, exists in a context and should address equity concerns. Priority setting exercises require information concerning health status, the health care system and the health

research system. Different sources of information should be considered, for instance, vital registration, health centre or hospital records, non-health sector, academic institutions, nongovernmental organizations, civil society, private sector, etc. In general, a situation analysis is essential. It is useful to up-date this regularly, also because it would assist monitoring purposes. However, the quality of the information available is of critical importance. Indeed, quality is more important than quantity. Special attention should be given to improving the quality of information and to addressing gaps in understanding. A well-managed priority setting process would enhance information exchange between policy-makers, programme managers, researchers and end users —a key issue.

4.3   Participatory Dimension of Health Research Prioritization.

'The participatory dimension of health research prioritization' was presented by Professor Dulitha Fernando. She emphasized that a participatory approach was critical to the process of priority setting as well as during other phases of the research cycle. The plenary took up this theme further.

Participation encourages ownership of output, improves the relevance of priorities and facilitates implementation of findings. A participatory approach is therefore essential to the process of priority setting and during other phases of the research cycle. *Whose voices are heard? Whose views prevail? Whose health interests are advanced?* These critical questions help focus the process of priority setting on participatory as well as equity concerns.

Using a participatory approach, a core group is required to plan, implement and monitor the process of priority setting. A broad range of stakeholders is identified and involved in priority setting. It is necessary to consider people who can identify research needs, who can assess available resources, and who can address information requirements. Different kinds of stakeholders may be involved depending on the level at which prioritization is carried out (e. g. institutional, sub-national, national).

4.4   Criteria Development for Priority Setting in Health Research

'Criteria development for health research prioritization' was presented by Dr U Than Tun Sein, who outlined the steps in developing criteria for priority setting at global and national levels. In a national context, it may even be useful to conduct research on developing criteria itself. Throughout the process of criteria development and priority setting, the overall goals and guiding principles, such as Health for All, should not be lost sight of.

The plenary discussion emphasized the importance of this topic, as is evident from the summary below. It is at the heart of the theme of this Scientific Working Group.

(1) Why we need to develop criteria?

Criteria have been defined as standards by which actions can be measured. They allow comparisons to be made. Criteria are thus a key part of the prioritization process. In attempting to develop criteria for priority setting (and to help decision-makers prioritize in health research), three basic questions need to be answered. *'What to measure? Where to measure? How to measure?'*

'What to measure?' refers to the expected areas for prioritization. For example, these can be classified according to major domains of global health (such as disease conditions and health impairments; health care systems; environmental determinants; food and nutrition; and socio-cultural characteristics). Alternative kinds of classification can be adopted.

'Where to measure?' can refer to global, regional, national, sub-national, district, sub-district, institutional or departmental levels. The processes for prioritization, as well as the criteria for measurement, will differ depending on the level in question.

'How to measure?', or which criteria are to be used for measuring, depends on *'where and what to measure?'*. Criteria development should only come into play after these have been duly considered.

(2) Steps for criteria development: principal perspective

There are distinctive steps in developing criteria to prioritize health problems and health research at global and national levels. Furthermore, it may be useful to conduct research on developing criteria itself, especially in a national context. The overall goals and guiding principles, such as Health for All, should be remembered throughout.

(3) Steps for criteria development: global perspective

From a global perspective, the following steps may be considered:

- *How big is the problem?* This question addresses the extent to which a health problem is shared by many countries (at global or regional levels). In addition to morbidity and mortality measures, which one might regard as traditional, the disability-adjusted life years (DALYs) or the disability-adjusted life expectancy (DALEs) indicators can be calculated to measure disease burden in populations.

- *Why does the disease burden persist?* There may be different reasons for the persistence of disease burden. For example, inadequate knowledge, inadequate application of knowledge, inadequate tools or techniques, or failure to use existing tools effectively. Different kinds of research are required to address these. For instance, a lack of understanding about the disease(s) and their determinants can lead to basic research. Failure to use existing tools or techniques can lead to operational, health systems or health policy research. Inadequate tools or techniques can lead to intervention development if adequate knowledge about the disease exists. *Therefore, is enough known about the problem to consider possible interventions?*

- *How cost-effective can these interventions be?* Here one would consider whether the desired intervention can be developed within a reasonable time and at a reasonable cost. Would the desired intervention be cost-effective in terms of its cost per DALY averted or per DALE extended?

- *How much is already being done about the problem?* Here, one can consider whether and to what extent a particular problem is already being investigated. If known, the resources invested into a particular problem are an important consideration in this regard.

(4) Steps for criteria development: national perspective

From a national perspective, effective allocation of resources represents a primary task. Priority setting of health problems and priority setting of health care interventions are of obvious importance to health planning. Since priority health problems in the country should become priority research areas, the criteria used for prioritizing health problems indirectly influence the criteria for prioritizing research areas but can be adapted. Of course, the criteria used for either stage may differ from country to country. Generally speaking, however, both magnitude of the health problem and amenability to intervention would feature prominently in such criteria.

4.5   Tools Used in Priority Setting

Dr D C S Reddy presented 'Tools used in priority setting' on behalf of Dr Ravi Rangachari. Dr Reddy summarized important methods and tools for priority setting. These were further referred to in plenary and placed in context. Members resolved they should form part of the proposed guideline.

(1) Relationship between stages of priority setting and tools used

The methods and tools employed in priority setting should be attuned to the stage of priority setting. During the initial stage (prioritization of areas or domains), it is usually not necessary to apply sophisticated techniques. For instance, brainstorming and *Delbecq* techniques, as well as round-table discussion, could be entirely appropriate. During the second stage (prioritization of research topics *within* these areas or domains), the methods and tools are relatively more sophisticated.

(2) Potential techniques for priority setting processes

Members mentioned that a range of techniques could be employed in the context of priority setting. A number of examples were advanced.

Focus group discussion is an in-depth method to establish dialogue among participants with common interest and knowledge, recognizing the task to be achieved by discussion and analysis. The technique is therefore normative. This principle makes it different from ordinary group discussion.

Constraint analysis is more a step in the process of needs identification rather than a technique *per se.* For instance, health problems and their underlying causes are identified by constructing a "constraints tree". Even when the problems are known, constraint tree analysis helps in elucidating problems further.

Nominal group technique. This technique is used to survey the opinion of a group of experts to arrive at a group decision or consensus. The method is applied in six steps, i.e. silent generation of ideas in writing; feedback of ideas; serial discussion of ideas; preliminary vote; discussion on preliminary vote; final vote.

The Delphi techniques have been applied as methods to structure communication among groups of professionals dealing with a complex problem. They generally involve the use of questionnaires and a calculation of (non-personal) averages.

Decision tree analysis is useful for applying criteria to prioritize and shortlist the health research areas, following a sequential exclusion process.

The most common of the quantitative techniques is *scoring.* The simplest method is to assign equal scores to each criterion and by summative analysis of all the criteria. This is based on the assumption that each criterion has equal importance in determining the priority of a research issue. Of course, criteria may have variable importance as well as interdependence. Differential scoring is more appropriate in these situations. Differential scoring can be done by determining the relative importance of each criterion and then assigning differential weights to each.

For determining the relative importance of different criteria, the two available techniques are *mathematical programming* and *analytical hierarchy process.* The former is more complex and requires computer programming. In *analytical hierarchy process,* each criterion is compared with the other by using a scale ranging from equally important to much more important, for example.

Application of a single criterion can be useful in certain situations. Cost-benefit analysis is a good example. It compares estimated research benefits and cost inputs over time for each alternative. An analysis of benefits in monetary terms can be difficult in the health sciences. Additional possibilities include expressing anticipated effects of research in terms of deaths or

disabilities avoided, or loss of productivity averted, or life expectancy gained. However, the complexity of these techniques should be borne in mind.

4.6 Linkages between National and Sub-national Settings for Priority Setting

'Linkages between national and sub-national settings for health research prioritization' was presented by Dr Soeharsono Soemantri, who placed this issue in the context of essential national health research strategies. These can be used in national as well as sub-national (state, provincial, even district) settings, involving applications of health systems research in particular. Sub-national applications of essential national health research strategies gain importance as countries move increasingly towards greater decentralization. The plenary further developed this important aspect.

The linkages between national and sub-national settings are sometimes not sufficiently considered. These apply to national and sub-national (state, provincial, district) applications of health systems research and gain importance as countries move towards greater decentralization. Generally speaking, programme-related and problem-based research (as opposed to investigator-initiated research) should be at the forefront of national or sub-national health research agenda(s). This does not mean that priorities are imposed on research scientists by policy-makers or health service managers. It means that none of these groups should be excluded from priority setting processes, be it in prioritizing health problems or be it in prioritizing research areas.

In this context, the *capacity* to carry out prioritization exercises (as well as research itself) are important considerations at *any* level. After all, the foundation of a national health research agenda lies in a solid investment in provinces and districts. The purpose of such investment would be to increase the internal capacity of different stakeholders to analyse their own health problems, to set priorities, to generate resources, to participate sub-nationally and nationally in the design, implementation and evaluation of health programmes and health research.

Further linkages between national and sub-national settings for health problem and health research prioritization relate to their partnership in all relevant components: priority setting processes, capacity building, networking,

financing, evaluation, research promotion, research utilization and sustainability.

4.7   Ethical Dimension of Priority Setting in Health Research

'The ethical dimension of health research prioritization' was presented by Professor V Ramalingaswami. He mentioned that the ethical dimension of priority setting had been somewhat overlooked in the past. It was therefore rather timely to consider this important aspect. Equity was the central issue of ethics in priority setting. Primary health care was an instrument of equity, with the issue of access tagged to equity. Equity implied a recognition of equal rights for every person. However, while rights were equal, needs were unequal. The concepts of morality, justice and fairness, which were subsumed by the concept of equity, gave this a clear human dimension. Professor Ramalingaswami proposed the concept of disparity reduction as a crucial yardstick to measure future progress towards equity. In plenary, members further developed these critical aspects, by provision of examples and by exploring their relevance to priority setting.

(1) Ethics and equity in priority setting

Members considered the ethics of priority setting to be distinct from the ethics of biomedical research *per se.* The question therefore is: *does the ethical dimension come into the picture during priority setting?*

The central issue of ethics in priority setting is *equity. Equity* will be a dominant issue during the 21st century, involving the application of the benefits of science to society. The issue of *access* to services and systems is tagged to equity. The concepts of morality, justice and fairness give it a clear human dimension, which is subsumed by equity. Progress in this area can be measured by *disparity reduction*, a crucial yardstick in the years to come.

Implied in the concept of equity is a recognition that there are equal rights for every person. For example, nutrition is a right. Once it is accepted that there are equal rights, it can be concluded that while rights are equal, needs are unequal. Differential provision may be subsumed under this conclusion.

Primary health care is essentially an instrument of equity. Primary health care is a vehicle of ethics. The essential elements of primary health care therefore have a profound moral direction; they can be said to amount to 'eight commandments'. Where primary health care is a dominant theme of a health research project, a certain degree of priority is injected into the plethora of research schemes.

(2) Individual good *and* public good in priority setting

Members agreed that a cliché juxtaposition of individual good *versus* public good should not be accepted. Both are important. Individual good *and* public good. One cannot put these in a hierarchy.

For the future, what should be considered is which public goods are going to be delivered through our actions. Studies focusing on prevention (of disease) and promotion (of health) are important. For instance, how to send good messages on health promotion will not diminish the individual. 'The greatest good of the greatest number' is a utilitarian principle. There are studies which aim for this and these ought to receive attention. Priority setting is about finding the right balance and the right emphasis within limited resources.

With peoples' rising expectations, with science becoming ever more sophisticated, the cost of health care soars. Decisions concerning opportunity cost enter. In accessing technologies, generated either within developing countries, or by partnership between developed and developing countries, cost becomes an important factor when doing health research. Both reduction and distribution of cost become key — and intertwine with ethical questions.

The issue of anti-retroviral drugs provides a potentially explosive illustration. HIV-AIDS has already cut life expectancy in some African countries, reversing previous gains. There is at present no hope that anti-retroviral drugs will be available in developing countries on anything like the scale required. The issue of patenting and the rules of the World Trade Organization (WTO) also enter: some countries may not be able to produce anti-retroviral drugs even if the scientists are there. Is this ethical? Compulsory licensing within the WTO framework may be the only option available. Effective methods of intervention at affordable cost are also issues for research. Potential partnerships with the pharmaceutical industry could aim for a provision, during the research and development process, for selling at

affordable prices. This is critical, especially for disadvantaged and vulnerable populations, be they women, children, refugees, prisoners.

There is a range of related matters: capacity building in ethical matters, local expertise in conducting and evaluating clinical trials for drugs, sharing the benefits of participation in research, sharing the results of the research, avoiding research which is entirely donor-driven. Members agreed that unethical or unequal benefits should not be created for those who are vulnerable: this is an important criterion from the inception of the priority setting process. We should aim to ensure that the process, as well as the outcome, follows ethical concerns.

4.8   Essential national health research and priority setting.

The topic 'Essential national health research and priority setting: lessons learnt' was presented by Professor Mary Ann Lansang. She highlighted some of the experiences gained by essential national health research strategies in actual exercises of priority setting. In the plenary, the close linkage between essential national health research and health systems research was emphasized, as well as the usefulness of adapting these approaches to local situations and requirements.

Members reviewed some of the experience gained by health systems research strategies in actual exercises of priority setting. For example, Bangladesh, Indonesia, Nepal and Thailand have adapted Essential National Health Research strategies. They have initiated processes to promote need-based research and to link these strategies with policy.

Similarly, health systems research has been applied in the planning and implementation of expanded programmes on immunization and other health programmes in SEAR countries, as, for example, in Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. In Bhutan and in Maldives, research into the prevalence of viral hepatitis B subsequently led to the incorporation of viral hepatitis B vaccination in the respective national programmes on immunization. Research prioritization and utilization have been initiated or accepted in several countries of the WHO South-East Asia Region, including participation of stakeholders.

The Essential National Health Research Strategy, as adapted by Thailand, attempts a wider dialogue and consensus by involving stakeholders in

decision-making processes. It appears to be highly equity focused, too. This focus on disadvantaged and vulnerable populations is especially important. Similar procedures appear to be finding favour in other countries of the Region where the Essential National Health Research strategy has been adapted and adopted. Indonesia and Nepal provide further examples for this.

4.9   Framework and Guidelines for Priority Setting of Health Problems and in Health Research

Overall, members emphasized that priority setting for health problems and health research involved complex issues as discussed. This suggested a comprehensive approach. The strategies, criteria, tools and processes used in priority setting required careful consideration, both *per se* and in the context of the WHO South-East Asia Region. The different facets of priority setting, thoroughly discussed during the meeting, would be useful for developing the eventual guideline.

In developing a guideline, members considered that individual good and public good were both important. Individual good and public good should not be juxtaposed as opposites. The Scientific Working Group developed and scrutinized the draft framework for priority setting processes in health research (see **figure**). They did so both from the point of view of country and regional aspects in the WHO South-East Asia Region. The development of this guideline will represent the main product of this scientific working group.

In developing a guideline for priority setting, members emphasized the usefulness of a two-stage process. The first stage of priority setting would prioritize health problems or areas, the attractive feature being that this stage is common to health planners as well as health researchers, thus widening the scope of application considerably. The second stage would prioritize research endeavours *within* those areas and thus be unique to health research.

In addition, members concluded that a guideline would benefit from generic text. The text should be kept generic in order to preserve its normative value.

Figure: **Framework for priority setting of health problems and in health Research**
WHO Scientific Working Group on 'Criteria for setting health research priorities'
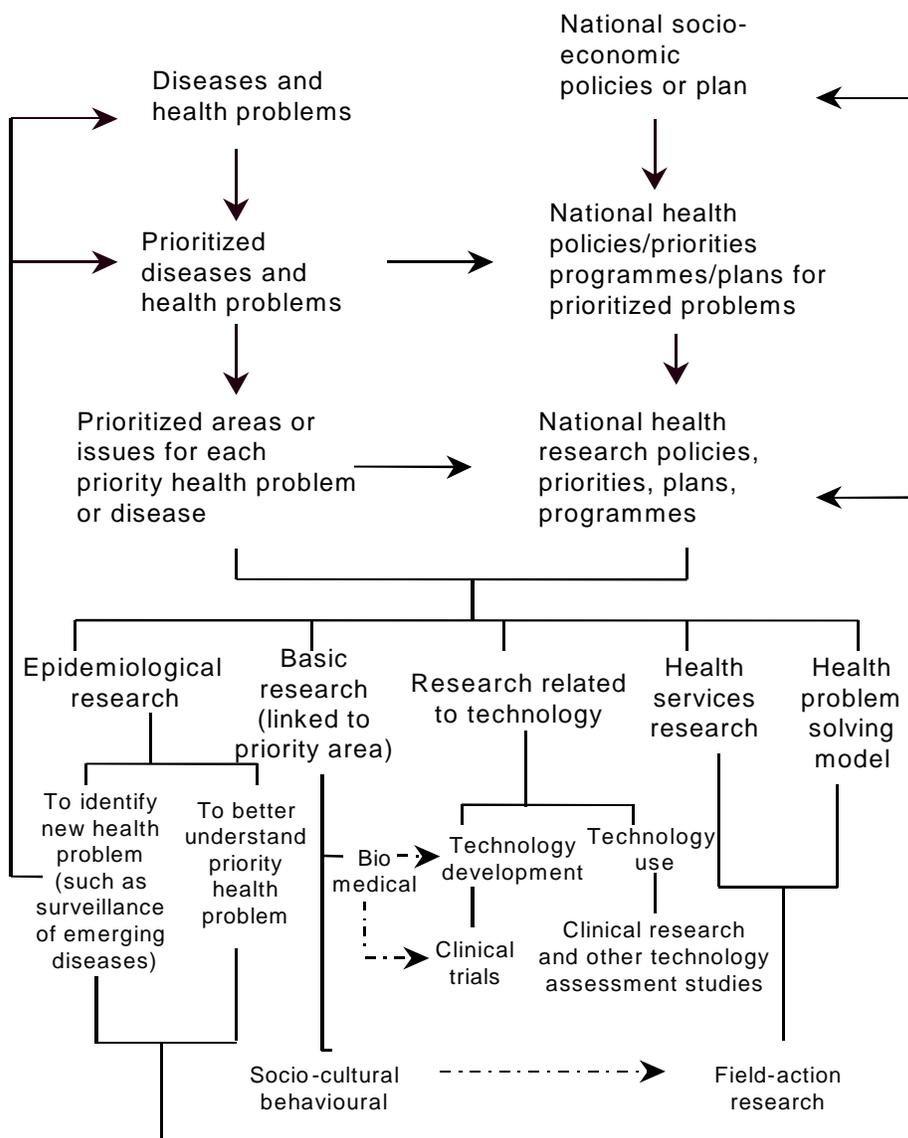
If appropriate, a guideline might be supplemented with country-specific examples to enhance regional flavour. If references are made to individual SEAR countries, these should be illustrative or relate to one or more of the following aspects: (a) the national health research system; (b) the research-planning linkage; (c) experience with prioritization processes; (d) anticipated or ongoing initiatives relevant to (a), (b) and (c). Members undertook to provide any relevant information as soon as feasible.

The Scientific Working Group furthermore addressed the issue of developing a strategy for the future. This should be shaped bearing in mind that some countries of the South-East Asia Region have adopted and adapted strategies related to Essential National Health Research. However, others have not done so. To illustrate this point, members recalled that some countries introduced ENHR strategies (for example, Indonesia, Nepal, Thailand). Others have not introduced ENHR but follow their own strategies (for example, India, Myanmar, Sri Lanka). Furthermore, some countries have neither adopted ENHR nor other comprehensive research strategies (e.g. Bhutan, DPR Korea, Maldives). At its 25th session, to be held from17-20 April 2000, the WHO South-East Asia Advisory Committee on Health Research, would be expected to review the work of this Scientific Working Group and recommend a more refined strategy for guideline implementation.

5. CLOSING SESSION AND CONCLUSIONS

The Chairperson, Professor N K Ganguly, and Dr U Than Sein, in their closing remarks, thanked members and special invitees for their valuable contributions. The Scientific Working Group had been very productive in the short time available. The draft guideline would be developed accordingly. In due course, this was expected to serve as a WHO document which countries could adapt and apply in priority setting for health research.

The Scientific Working Group had discussed in detail the strategies, criteria, tools and processes used for priority setting in health research and of health problems in general. Members did so with particular reference to the countries of the WHO South-East Asia Region, having reviewed the current scenario. Members and special invitees had presented issue-based topics dealing with different facets of the theme of this Scientific Working Group. The main purpose of the meeting was to develop a guideline framework for priority setting in health research. The eventual guideline is to contain

detailed information regarding relevant technical methods, criteria, strategies and processes used for priority setting in health research in the countries of the WHO South-East Asia Region. It would therefore attempt to balance normative work with regional specificity. A framework was developed for this guideline (see figure). Members concluded that the text should be kept generic in order to preserve its normative value, referring to examples from SEAR countries as appropriate.

Once a guideline is developed, its application becomes important. In considering the development of a strategy for the future, the forthcoming session of the South-East Asia Advisory Committee on Health Research was expected to review the work of this (and the other) Scientific Working Groups. A more refined strategy for guideline implementation should emerge as a result of these deliberations.

Annex 1

LIST OF PARTICIPANTS

Chairperson

Professor N K Ganguly
Director-General
Indian Council of Medical Research
Ansari Nagar
New Delhi 110029, India

Members

Dr Ravi Rangachari*
Deputy Director-General
Indian Council of Medical Research
Ansari Nagar
New Delhi 110029, India

Dr Soeharsono Soemantri
Head
Research Centre for Ecology
National Institute for Health Research and
Development
Ministry of Health
Jakarta, Indonesia

Dr U Than Tun Sein
Director
Department of Medical Research
Ministry of Health
Yangon, Myanmar

Professor P C Karmacharya
Director
Medical Education Department
Institute of Medicine
Tribhuvan University
Kathmandu, Nepal

Professor Dulitha Fernando
Head, Community Medicine
Department of Community Medicine
Faculty of Medicine
University of Colombo
Colombo, Sri Lanka

Professor Chitr Sitthi Amorn*
Dean, College of Public Health
Chulalongkorn University
Bangkok, Thailand

Dr Somsak Chunharas
Ag Director, Bureau of Health Policy and
Planning
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi, Thailand

Special Invitees

Professor V Ramalingaswami
National Research Professor
All India Institute of Medical Sciences
Ansari Nagar
New Delhi, India

Professor Mary Ann Lansang
Professor of Medicine and Clinical
Epidemiology
College of Medicine
University of the Philippines
 Ermita, Manila 1000, Philippines

Dr D C S Reddy
Reader, Department of Preventive and Social
Medicine
Institute of Medical Sciences
Banaras Hindu University
Varanasi
India

WHO Secretariat

Dr U Than Sein
Director
Evidence and Information for Policy
WHO SEARO

Dr R J Kim-Farley*
WHO Representative to India

Dr U Myint Htwe*
RA-RPC
WHO SEARO

Dr J P Narain
RA-STD/AIDS-TB
WHO SEARO

Dr M J Wysocki
RA-GPE
WHO SEARO

Mr Abdul Muhid Meliala
SRP
WHO SEARO

Dr Stephan P Jost
TO-HSR
WHO SEARO

* unable to attend

Annex 2

OPENING ADDRESS BY THE REGIONAL DIRECTOR,
WHO SOUTH-EAST ASIA REGION

*The address was read by Dr Vijay Kumar as Acting Regional Director
on behalf of the Regional Director Dr Uton Muchtar Rafei.*

Distinguished members,
special invitees,
friends and colleagues,
ladies and gentlemen,

I have the honour to present greetings from Dr Uton Muchtar Rafei, WHO Regional Director for South-East Asia, to the distinguished members and special invitees of the scientific working group. The Regional Director would have liked to be in our midst today as the deliberations of this scientific working group are of great interest to WHO. However, this is not possible due to his preoccupation with other duties. In the circumstances, I have the honour to read his address on this occasion, and I quote:

While regretting my inability to be with you today, I take this opportunity to welcome you all to this important meeting of the scientific working group on *Criteria for setting health research priorities.* Much planning and preparation have gone into this initiative. I am grateful to the Indian Council of Medical Research for collaborating with us in this endeavour. As you know, meetings of WHO scientific working groups are formal technical meetings, and are governed by certain rules and regulations which attempt to ensure high quality output. It is, therefore, essential to get adequate input from external experts in this process. Let me now explain how we got here and why we attach importance to your deliberations.

In April 1998, the first Joint Session of the South-East Asia Advisory Committee on Health Research and Directors of Medical Research Councils and Analogous Bodies was conducted in Colombo, Sri Lanka. Some of you present here today attended that joint session. This joint session directed

much attention to issues related to health research management. The meeting looked into four specific areas:

(1) Management and coordination of health research activities in the countries;

(2) Criteria for setting health research priorities;

(3) Formulation of national health research policies and strategies; and

(4) Management of health research information.

We had four working groups deliberating each of these subjects at the joint session. They laid the groundwork in terms of concepts and approaches in these respective areas. When the working groups reported back to the plenary, the meeting desired it would be beneficial for the countries of our Region if detailed guidelines could be developed in these four areas of health research management. It was, therefore, decided to form four scientific working groups to develop the guidelines, and plans of action to implement and evaluate these.

Subsequently, a meeting of the chairpersons of the working groups of the joint session was convened in WHO SEARO to develop a planning framework. For each of the four groups, the chairpersons proposed specific objectives and expected outcome, a framework and *modus operandi*, as well as criteria for selection of members. In order to maintain continuity and quality of work, it was suggested that the chairpersons of the four working groups of the first joint session serve on the corresponding scientific working groups to be established. This has taken place. The present meeting dealing with "Criteria for setting health research priorities" is the second of the four scientific working groups to meet. Its proposed terms of reference are:

- to identify criteria in setting health research priorities at national level;

- to identify factors to be considered (and information required) in setting health research priorities at national level;

- to develop guidelines for setting health research priorities appropriate to the WHO South-East Asia Region, taking into account the above objectives;

- to develop plans of action for setting health research priorities in the WHO SEAR Member Countries; and

- to develop a framework for the evaluation of the implementation of the plans of action. If feasible, this should be done at both country and regional levels.

Ladies and gentlemen, these objectives are clearly not without ambition. Nevertheless, the output of this scientific working group can make a potentially catalytic contribution towards improving priority setting of health research activities in the countries of our Region. In developing guidelines as well as plans of action for their implementation and evaluation, a balance should be sought between normative work and regional specificity. This would help ensure that the product of your work not only stands up to scrutiny, but is relevant to the needs of the countries in our Region. After all, WHO's involvement in health research should continue to evolve in keeping with the needs of the Members States. This is important if our role is to include the promotion and coordination of health research aimed at meeting priority challenges. Therefore, we can certainly aim to make a relevant contribution by assisting Member Countries to improve their prioritization practices, which are a vital part of health research management.

I wish you well for your deliberations. I am sure all of you will contribute your best in thought and action to improve criteria development and priority setting for health research activities in the countries of our Region.

Thank you.

Annex 3

AGENDA

Inaugural Session

Inaugural Address by the Regional Director,
WHO South East Asia Region

Introductory Session

(1) Welcome address by Professor N K Ganguly, Chairperson

(2) Introduction of participants of the Scientific Working Group

(3) Introductory remarks by Dr U Than Sein, Director, Evidence and Information for Policy, WHO South-East Asia Regional Office

(4) Adoption of agenda and working schedule for this session

(5) Nomination of the report drafting group

Business Session

(1) Priority health research agenda in the context of the national health policy
   — *Dr Somsak Chunharas*

(2) Information needs for health research prioritization
   — *Professor P C Karmacharya*

(3) Participatory dimension of health research prioritization
   — *Professor Dulitha Fernando*

(4) Criteria development for health research prioritization
   — *Dr U Than Tun Sein*

(5) Existing and emerging tools used in priority setting
   — *Dr D C S Reddy*

(6) Linkages between national and sub-national settings for health research prioritization

 — *Dr Soeharsono Sumantri*

(7) Ethical dimension of health research prioritization

 — *Professor V Ramalingaswami*

(8) Essential national health research and priority setting: Lessons learnt

 — *Professor Mary Ann Lansang*

(9) The future of priority setting

 — *Professor Chitr Sitthi-amorn*

(10) On developing criteria and setting priorities for health research in SEAR. Background document (SEA/SWG-PRIOR/M)

Closing Session

(1) Remarks by Director, Evidence and Information for Policy, WHO South-East Asia Regional Office

(2) Closing remarks by Chairperson

Annex 4

WORKING SCHEDULE

	Morning Session (9.00 a.m. to 12.00 noon),	Afternoon Session (1.30 p.m. to 5.00 p.m.)
Monday 1 November 1999	**Inaugural Session** Inaugural address by the Regional Director, WHO, South-East Asia Region **Introductory Session** Welcome address by Chairperson of the Scientific Working Group (SWG) Introduction of members of the SWG Introductory remarks by Director, Evidence and Information for Policy, WHO SEARO Adoption of agenda and working schedule for the session Nomination of the report drafting group **Business Session** • Priority health research agenda in the context of the national health policy (Dr Somsak Chunharas) • Information needs for health research prioritization (Professor P C Karmacharya)	• The participatory dimension of health research prioritization (Professor Dulitha Fernando) • Criteria development for health research prioritization (Dr U Than Tun Sein) • Existing and emerging tools used in priority setting (Dr D C S Reddy, on behalf of Dr Ravi Rangachari) • Linkages between national and sub-national settings for health research prioritization (Dr Soeharsono Sumantri) • The ethical dimension of health research prioritization (Professor V Ramalingaswami)
Tuesday 2 November 1999	• Essential national health research and priority setting: lessons learnt (Professor Mary Ann Lansang) • The future of priority setting (Professor Chitr Sitthi-amorn) • On developing criteria and setting priorities for health research in SEAR	Scientific working group to develop the framework and guidelines for priority setting in health research in SEAR

	Morning Session (9.00 a.m. to 12.00 noon),	Afternoon Session (1.30 p.m. to 5.00 p.m.)
Wednesday 3 November 1999	Scientific working group to develop the framework and guidelines for priority setting in health research in SEAR Scientific working group to develop plans of action to improve the prioritization of health research in SEAR Member Countries	**Closing Session** • Remarks by Director, Evidence and Informations for Policy, WHO, South-East Asia Regional Office • Closing remarks by the Chairperson

N.B. *The time schedule will be flexible so that agenda items may be advanced or postponed as appropriate.*

Annex 5

LIST OF WORKING AND INFORMATION DOCUMENTS

1.	List of participants	SEA/SWG-PRIOR/A
2.	Provisional agenda	SEA/SWG-PRIOR/B
3.	Working schedule	SEA/SWG-PRIOR/C
4.	Priority health research agenda in the context of the national health policy —Dr Somsak Chunharas	SEA/SWG-PRIOR/D
5.	Information needs for health research prioritization —Professor P C Karmacharya	SEA/SWG-PRIOR/E
6.	The participatory dimension of health research prioritization —Professor Dulitha Fernando	SEA/SWG-PRIOR/F
7.	Criteria development for health research prioritization —Dr U Than Tun Sein	SEA/SWG-PRIOR/G
8.	Linkages between national and sub-national settings for health research prioritization —Dr Soeharsono Sumantri	SEA/SWG-PRIOR/I
9.	Ethical dimension of health research prioritization —Professor V Ramalingaswami	SEA/SWG-PRIOR/J
10.	Essential national health research and priority setting: Lessons learnt —Professor Mary Ann Lansang	SEA/SWG-PRIOR/K

11. Setting research priority   SEA/SWG-PRIOR/L

    —Sathirakorn Pongpanich, Chitr Sitthi-amorn and
      Wattana S Janjaroen

12. On developing criteria and setting priorities for health   SEA/SWG-PRIOR/M
    research in SEAR

    —Background document

    Framework for the background document   Related to
                                                                 document
    —Indian Council for Medical Research in collaboration   SEA/SWG-PRIOR/M
      with WHO SEARO

13. Research prioritization   SEA/SWG-PRIOR/P

    —Dr U Myint Htwe

14. Essential national health research and priority setting: SEA/SWG-PRIOR/Q
    lessons learnt

    —Council on Health Research for Development
      (COHRED), 1997