Author’s response to reviews

Title: A systematic process for identifying components of a locally desirable and feasible health research priority setting approach: The case of Zambia.

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Author’s response to reviews:

Dear

The authors acknowledge the time and very thoughtful comments that the reviewers provided.

WE have carefully considered them and believe they have contributed to strengthening the paper. Hope it is now acceptable. Below are the point by point response to their comments.

Response to Reviewer reports:

Reviewer #1:

C1: This paper describes a participatory approach to developing a process for health research Priority Setting. It is a clear and interesting description of what sounds like a very reasonable approach, and I recommend it for publication after some additions and modifications.

R1: We appreciate this comment

C2: The approach described here includes a literature review (page 5, line 18), and I would like the authors to include more detail about the approach they took to this systematic review.

R2: We have included a detailed description of the process (Pg. 5 and Table 1)

C3: The validation of the synthesis (page 5, line 20-27) is a unique addition beyond the systematic review, and I think it is a good idea. I would like more detail in the methods section about the number of experts recruited, the response rate of experts approached, and the process by which the experts were selected.

R3: WE have included the description of the experts on Pg.7
“For purposes of this study we contacted experts for the following approaches: CAM (1), CHNRI (2), ENHR (1), JLA (2), and Listening for Direction (L4D) (1).”

C4: In the Table 1, it would be useful to me and probably make this useful to many other readers to give a more detailed description of each of the PS approaches, including the full name, brief description, and a key reference for further information. If this is too much information for a Table 1, it could be a useful web-appendix.

R4: We appreciate this comment. WE have included a summary of the steps. We developed a companion guidance manual to the approach we developed. The manual includes all the commonly used approaches, and a critical literature review of all the frameworks, as well as providing the key references. This manual is published on Macsphere and the CCGHR as a resource.

Minor issues:

C5: In the description of Workshop I (page 5, line 52) the authors state that workshop participants expressed a limited understanding of HRPS. How was this assessed?

R5: At the beginning of the workshop, participants were asked about their experiences with priority setting for health research and the systematic approaches that can be used.

C6: Page 6, line 19: step 4 refers to steps 2-4---should this be steps 2 and 3?

R6: This edit has been made

C7: Page 6, line 31: were any participants in Workshop I also participants in Workshop II?

R7: Workshop I was a kind of training of trainers. Workshop II was facilitated by the Zambian participants who participated in workshop I

C8: In the description of Workshop II (page 6, line 42) are there additional relevant details on the pre-workshop preparation that readers would find useful, such as "root binding" activities to build consensus before the start of the workshop; or the seniority of the participants, either in budget managed, management experience, or other dimensions?

R8: Pg 8 provides additional details of the workshop preparation phases.

C9: Page 9, line 7: I would like to know more about what you learned from the potential users of the approach (balanced against protecting their privacy, of course).

R9: There was a general interest in systematizing health research priority setting and facilitating ownership through capacity strengthening. However, many repeatedly highlighted the role of lack of resources for research, which hampers implementation.
C10: Table 3: it would be helpful and interesting to cross-reference these desired features against the existing methods, showing which methods achieve which feature well and not-so-well.

R10: This comment is greatly appreciated. However, would mean combining both Table 2 & 3 which is difficult to achieve without making the table complicated. We provide examples of potential frameworks that could achieve the desired attribute; however, doing this consistently is difficult and adds another layer of analysis to an already long paper.

Reviewer #2: The quest for sustainable and institutionalized priority setting for health research in a low resource setting: the case of Zambia

General comment on Background

C1: In the introduction, the authors create a bit of a caricature of research priority setting processes that are organized and/or facilitated in LIC, and then present their approach as something very different. Based upon the existing literature about research management and priority setting in LIC, and my own experience with facilitating and evaluating priority setting in several LIC, I find both this caricature and the claim that the presented approach is fundamentally different problematic.

R1: Since the paper is based on existing approaches, there is no claim that the proposed approach is fundamentally different. The innovation in this approach is getting the would be users on board in the process of the conceptualization of the approach.

C1: The first claim in the background is that, an important reason that research priorities are not regularly set in LIC is that research managers in LIC do not know how to set a research agenda, and have a lack of knowledge about priority setting methods. I am not convinced that this is the main reason, and I do not see any references that back up this claim.

R1: As indicated in the revisions, this is one of the problems, we do not claim that it is the main reason. We have added the other factors and added supporting reference. Please see the first paragraph.

C2: The second and third claim suggest that the approach that is followed in this project is fundamentally different from other priority setting exercises in LIC. I am not convinced. The authors claim that in other PS exercises in LIC, external consultants are brought in, who introduce only one PS approach. I find this somewhat surprising, as the priority setting processes that I have been involved in, and have evaluated took a lot longer and facilitators never introduce only one approach, but always try to develop a tailor-made approach that matches the specific local needs. Selecting elements from different approaches to make something that fits best with local situation is explicitly recommended by the COHRED report on research priority setting (which also provides detailed descriptions of the available PS approaches (Montorzi, de Haan en Ijsseelmuiden 2010)).
R2: We agree with the reviewer that the approach recommended by COHRED, which we highlight in this paper; does not prescribe an approach, and know that the process involves working with participants to choose an approach. However, the current paper is based in the Zambia context and their experience to date. In view of this comment, we have revised the paper to specifically make reference to the Zambia experience. (Pg. 4)

C3: The fourth claim is that the approach that is followed in this project amounts to 'capacity building' and leads to something sustainable and institutionalized. I am not convinced that, presenting and discussing several approaches and then making a tailor-made approach is the same as building capacity for priority setting, let alone having a sustainable and institutionalized approach. (In the Ghana example, the annual process of research priority setting was halted after 7 years, because there was no more funding available for the research (a paper about this process has just been accepted for publication in this journal).

R3: As indicated above, capacity is only one of the issues, and the proposed process contributes to capacity building; funding for health research, as well as research capacity are critical. These have been added throughout the paper.

While I am critical about these claims in the introduction, I think the process that is described is potentially interesting for the readers of HRP&S.

Below, I provide some suggestions for reframing the paper and further embedding it in the literature about strengthening research priority setting and research management in LIC.

R: We appreciate this comment and the suggestions.

Background

C1: In the introduction, the paper is very brief about reasons for setting research priorities. I recommend to develop this a bit further, as deeper reasons for embarking on a research priority setting process tend to shape the selection of the most appropriate method and the organization and institutionalization of the process.

R1: We appreciate this comment and suggestions. We have revised the background to reflect the suggested references, among others and identified additional barriers to priority setting in LICs.

C2: Page 2. Background Paragraph 1, line 8-28. Please consider the claims made, and make explicit what they are based upon. If they are based upon experiences in Zambia, please make that explicit. If they are based upon studies by others, make that explicit.

R2: We have considered these comment and edited the paper to reflect that this applies to the Zambian experience. (Pg. 4)

C3: Page 2 Background, paragraph 3, line 46-52. I am not convinced that you are 'testing' a capacity building strategy. Perhaps simply describe what the paper is doing (e.g. a systematic
process for constructing a locally desirable and feasible priority setting approach (which is important and interesting!).

R3: This edit has been made. (Pg 5)

C4: Page 2 line 51. It could be helpful to precisely formulate the aim.

R4: Please see Pg. 5.

Methods

C5: Page 3 Methods: It may be helpful to use a checklist (as inspiration, not as straightjacket) when describing the methods

Page 3 Methods, line 49. Who are 'they'? Canadians? Zambians? All of them?

Page 3 Methods, line 57. It would be useful to understand who did the literature analysis and who presented the PS approaches to whom. Who are the 'we' in line 57? Who are the participants and who are the facilitators?

Page 4, Methods, line 27. Workshop II. Perhaps you can explain a bit more about how these participants were selected? Based upon what criteria? And perhaps you can provide some basic information about them.

R5: All the recommended additions and descriptions have been added to the methods section. (Pgs. 5-8)

C6: I think you should provide a bit more information about how you collected and analyzed the data. I did read that you recorded meetings and have ethical approval in both Zambia and McMaster. You could make that explicit in the method section.

R6: This edit has been made (Pg. 8)

Results

C7: Results section. Table 1 is clear and interesting. Perhaps you can provide a brief summary of each of the five approaches in this table? It is now unclear what these approaches entail. That would help the reader, and others who may want to use the table. (Such summaries are also provided in the 2010 COHRED document)

R8: We agree that this would be very interesting. We have included a summary of the steps. More detailed synthesis is available, as a companion to the proposed approach; to the public at Macsphere and CCGHR webpages.
C7: Page 5 The paragraphs after Table 1 are very interesting. Could you add some illustrative quotes.

R7: The small number of participants make it impossible to use quotes while preserving the participants’ confidentiality.

Result section. A common theme in the literature about research priority setting is the inclusion of different groups in the process (e.g. health workers, patients, academia, NGO representatives). This is a rather essential component and I was wondering if this was discussed. I noticed a remark about participatory approaches and including patients. Perhaps you can develop this a bit further in the result section.

R8: This was perceived as important. That was why approaches e.g the JLA which emphasized participation of vulnerable populations were perceived more favorably. However, an additional dimension was the decentralized system—the need to involve people from the sub-national level, as indicated. (Pg. 8)

C9: Page 5 Line 19. Which literature? The need to align priority setting to existing national planning systems and infrastructure is an explicit theme in the literature about research priority setting (especially in the literature that links this to health research system development. We also make this link explicitly in our paper on the research system in Guinea Bissau, Kok et al 2012, this journal)

R9: WE appreciate this comment. The necessary edits have been made and reference added.

C10: Page 6 Line 10. COHRED is not an approach. In the 2010 COHRED report, several research priority setting approaches are described. Please clarify.

R10: This has been clarified

C11: Page 6 Line 15-23. This is an important point, but seems more of a discussion point. If this came up during the workshop, you can consider providing some illustrative quotes.

R11: This was moved to the discussion

Page 6 Line 29. Why would this also be desirable for other LIC?

R: Those that are similar to Zambia. Qualified (Pg. 9)

C: Page 6. Line 59. Why LIC context, and not just Zambia? Why is this a capacity building process? How do you know that capacity has been build? In the first workshop, 3 Zambians from the MOH where involved? Is it their capacity? Please clarify.
R: Clarified Zambia: Initially capacity was built for the 3 who were then able to go and emulate the same by facilitating the capacity building in second workshop. It is the capacity of the participants in both workshops.

C: Page 7. Line 7. While I fully agree that it is important, I do not think this is novel. Please look at the publications of the COHRED staff and others about this theme.

R: deleted novel

C: Page 8. Line 10. This could be interesting. I would suggest that such an evaluation starts with making the underlying aim of the PS explicit. To make PS work, it needs to be part of a larger strategy and set of activities around research management.

R: This is a great suggestion and is proposed in the evaluation framework.

C: Page 8. Limitation section. I do think you need to point out the small number of participants that was involved in this process. In case there was any input from participants from other countries, please make this clear.

R: Please see Pg 12.

C: P 8. Conclusion. What is meant by participants? Are these the research managers who facilitate the priority setting process (usually only a few people)? Or those who participate in the PS process (typically 30-100 people, from diverse backgrounds, organizations, etc). Please clarify.

R: Those that are involved in the prioritization process; not those who are just consulted. Please see Pg. 12

I realize I gave quite a lot of comments. Please feel free in considering what you find useful. Good luck with further developing this paper and all the best for your future work.

R: Thank you for the valuable comments!