Reviewer’s report

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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Reviewer: Maarten Kok

Reviewer’s report:

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

This paper describes the identification of a method for priority setting in Zambia. It reports findings from a pilot project in which different priority setting methods were identified and systematically discussed in two workshops and turned into a PS approach that was deemed most useful for the specific local situation in Zambia.

Some strong elements of the paper are that it focuses on a process that is seldom studied, it provides an overview of several priority setting methods, it describes a systematic approach and gives insight into the process of developing a tailor-made priority setting method that works in the local situation in a LIC.

I am less comfortable with the overall framing of the paper, the cryptic case description and method section.

Below, I try to briefly explain my concerns with the framing of the study. I will then provide some specific comments for each section of the manuscript.

General comment on Background

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.

The authors make four claims in the abstract and background of the paper.

1. An important reason that research priorities are not regularly set in LIC is that research managers in LIC do not know how to do this, and have a lack of knowledge about priority setting methods.
2. In standard priority setting exercises in LIC, it is common that external consultants are flown in, present a single priority setting method, as part of a process that typically lasts 2 weeks and that is disconnected from the local health system.

3. The approach that is followed in this project is fundamentally different than previous priority setting exercises in LIC by others.

4. The approach that is followed in this project amounts to 'capacity building' and should lead to a 'sustainable' and 'institutionalized' approach (title).

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. For decades, analyses of the development of research systems in LIC suggest that, the main reasons that research priorities are not regularly set in LIC have to do with the lack of funding for locally led research, years of dependence on international funders and the historically dominant role of foreign researchers (e.g. Kok et al, 2012 in this journal, & Hasnida et al. 2016 in Lancet Global Health). Why set priorities if there is no research money? What is the point? There are several examples that suggest that, once funding for locally led research is available, a lot of capacity, including for setting priorities, is available. I can point to several examples, such as the national research program in Ghana, that was aligned to locally set national research agenda (from 1999 onwards).

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 Ijsselmuiden 2010)).

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).

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.

Background

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.

In the literature, one can find several reasons for setting priorities, such as aligning research to local needs (including those of specific groups that tend to be marginalized), increasing the likelihood that results are used, providing a communicative infrastructure for research producers and users that facilitates ongoing interaction and trust, avoiding duplication and research waste, etc.

There are empirical papers about these reasons for priority setting, including one analysis (by me and others, please feel free to ignore this if you do not find it useful) that shows that health research that is aligned to national priorities in a LIC is more likely to be used and contribute to action (Kok et al 2016, this journal).

In the case of health research in LIC, there is the additional issue of the dominant role that researchers from the North have often played in shaping the research that is done in LIC. This has inspired all kinds of initiatives to set research priorities in the South, and a series of initiatives to strengthen national health research systems. One function of such a NHRS is providing stewardship (by having a national research policy, setting priorities, etc). This literature of research system development is currently ignored. Because this paper aims to say something about the sustainability of priority setting, I think it should at least touch upon the literature about research system development.

An important question for the background/introduction of this paper, (and for understanding the reasons for PS in LIC in general) is what led to the research priority setting initiative in this specific case. Understanding the underlying forces is key to understanding the reasons for priority setting initiatives, and for understanding how to institutionalize such processes in LIC. This remains rather unclear in this paper. What led to this specific research priority setting initiative? Why are there four Canadians involved? Who took the initiative? Where does the funding come from? Will there be funding for research? From Whom? etc.
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!)).

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

Methods

Page 3 Methods

It may be helpful to use a checklist (as inspiration, not as straightjacket) when describing the methods. An example can be found at: https://www.equator-network.org/reporting-guidelines/coreq/

I understand that the researcher participants are co-investigators on this project. Are all three Zambian participants in the first workshop also co-investigators of the project? Where all of them involved in the second workshop as well?

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

Page 3 Methods, line 57. If I understand correctly, there was a first workshop with four Canadians and 3 Zambians, of which at least two researcher participants are also co-investigators. 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.

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.

Results

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)

Page 5 The paragraphs after Table 1 are very interesting. Could you add some illustrative quotes.
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.

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)

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

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.

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

Discussion section

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.

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. You can also look at the literature that we refer to in our papers on research system development in Guinea Bissau, and research use in Ghana, such as the book and articles by Wolffers (reference list of Kok 2016 this journal).

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.

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.

Page 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
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.

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