SURE Guides for Preparing and Using Evidence-Based Policy Briefs
2. Prioritising topics for policy briefs

Version 2.1 – Updated November 2011

The SURE Collaboration

Suggested citation

The SURE Collaboration. SURE Guides for Preparing and Using Evidence-Based Policy Briefs: 2. Prioritising topics for policy briefs. Version 2.1 [updated November 2011]. The SURE Collaboration, 2011. Available from www.evipnet.org/sure

SURE is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative. The project involves teams of researchers and policymakers in seven African countries and is supported by research teams in three European countries and Canada. SURE is funded by the European Commission's 7th Framework Programme (Grant agreement no 222881).

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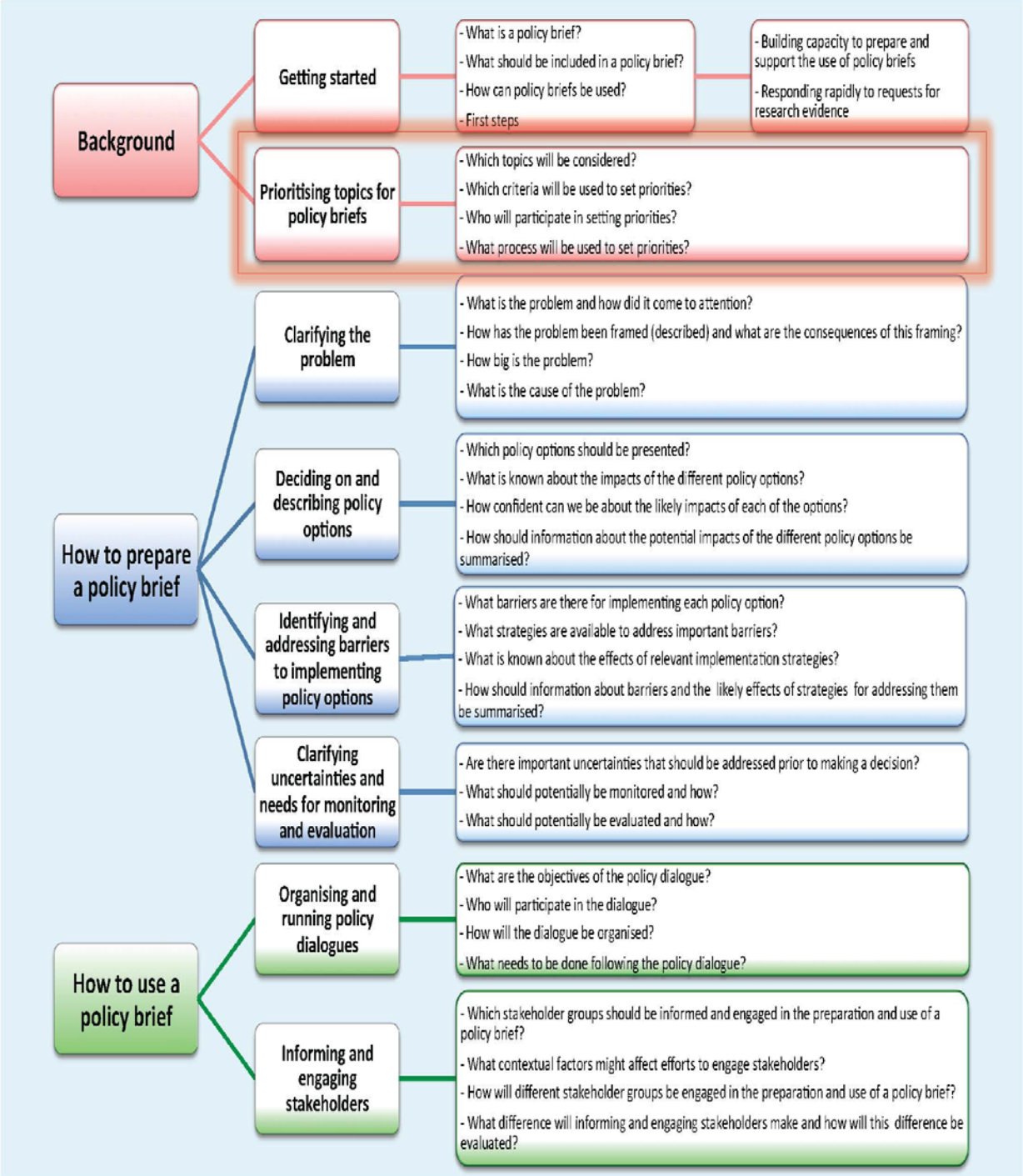
2. Prioritising topics for policy briefs



Summary

Resources for producing (and using) policy briefs are almost always limited. It is therefore necessary to decide which out of all the potential issues it would be helpful to address in a policy brief. A systematic process using the following questions can help to prioritise the topics for a policy brief:

- Which topics will be considered?
- Which criteria will be used to set priorities?
- Who will participate in setting the priorities?
- What process will be used to set the priorities?

Evaluating the guides

As you use the guides, please complete the evaluation form included in the 'Additional resources' section so that the guide can be improved.

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Background

Policy briefs are more likely to be useful in informing the decisions taken by policymakers and stakeholders if explicit criteria and systematic, transparent processes are used to prioritise topics.[1] A worksheet for planning a priority setting process for policy briefs is provided in the 'Additional resources' section of this guide. Further guidance on developing a priority-setting process for supporting evidence-informed health policymaking can be found in the SUPPORT Tool for priority setting. A review of priority-setting processes for evidence-based guidelines is also provided in the 'Additional resources' section of this guide.

There is no single, optimal way of prioritising topics for policy briefs. The formal priority-setting process described in this document, for example, will not occur if the stakeholder who is commissioning a policy brief has already requested a particular topic (click here to listen to a description of how a formal priority-setting process did not occur for a policy brief in Ethiopia). This example is also outlined in the 'Additional resources' section of this guide together with some more audio clips describing experiences in other countries. Policy brief topics may be derived from existing priorities; decided as part of priority-setting processes which are already in place, such as national health strategies; or they may be internationally-agreed health priorities, such as the Millennium Development Goals. Before priorities are considered, it is important to evaluate whether they are appropriate as topics for policy briefs, and to ensure that they reflect a national need. Participation in the priority-setting process may also be partially dictated by external or other processes.

There are challenges to consider when deciding on and applying a priority-setting process for policy briefs, including balancing the need for a rapid and efficient process against the need for processes that are explicit, systematic and fair.

The priorities which are set need to focus on long-term goals and strategic planning but also to be reactive and responsive to unanticipated events and opportunities. One way of achieving this is to use prioritisation criteria that capture both of these needs. For example, one criterion requiring that policy briefs address important problems, such as those associated with a high burden of disease, could be used to ensure a focus on long-term goals and strategic planning. Another criterion could specify that the policy brief should respond to windows of opportunity for change brought about by political or other events. Another approach to setting priorities that are both proactive and reactive is to use processes that allow priorities to be revised or updated quickly.

Policy briefs take weeks or months to prepare and the timeframe for a priority-setting process needs to take account of this. Thus, on the one hand it is unlikely to be useful to set priorities for policy briefs years or even many months in advance – at least not without revising or updating them close to the time when a decision is to be made. On the other hand, priority-setting processes should occur far enough in advance of decisions about which policy briefs to prepare to ensure that there is adequate time to both collect the information needed and to involve policymakers and stakeholders. One way to achieve this balance is to develop a list of priority issues that can be revised relatively quickly prior to making a decision to prepare a policy brief.

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Which topics will be considered?

Priorities should reflect the views of those who are involved in, and affected by, the decisions that policy briefs will inform. Although involving large numbers of people in decisions about which policy briefs to prepare is unlikely to be practical, it is useful to consult policy makers and stakeholders as widely as possible about which issues could be discussed in a priority-setting process. This will help to generate ideas and clarify the topics for which a policy brief could be prepared. Consultation may be within a broad area identified previously as a priority, such as maternal and child health or human resources for health, or may include any health system problem or goal.

Consultation methods may include:

- **A call for topics (problems or issues) using a simple, user-friendly questionnaire** – The call should allow sufficient time to collect any additional information needed to prioritise the proposed topics. This call should probably occur within one to three months of when a decision will be taken about which topics to prioritise. At this stage, the relative importance of topics is unlikely to change substantially before the decision is made
- **An email box or open phone line to which suggestions for topics can be submitted at any time**
- **Eliciting suggestions for topics at face-to-face or telephone meetings with key informants, an advisory board or a panel of policymakers, researchers and stakeholders** – This method has the advantage of facilitating the rapid clarification of proposed topics and the rapid collection of information needed to inform decisions about priorities. Meetings have the added advantage of allowing policymakers and stakeholders to interact
- **Inviting comments on proposed topics** – For example, after an initial list of potential topics has been identified, input from stakeholders might be elicited online (by posting the topics on a website) or through personal communication with key policymakers and stakeholders by email, post or telephone
- **Interviews, focus groups or surveys** – These standard methods for collecting qualitative or quantitative data may be used to consult stakeholders about their views regarding priorities. Although these methods may often not often be practical or necessary, they may occasionally be used to collect specific types of information reliably, and help to resolve disagreements or uncertainties about the relative importance of the topics proposed

Stakeholders may sometimes suggest topics unsuitable for inclusion in a policy brief (e.g. topics that are either very broad or vague). Those topics that cannot be clarified rapidly may require additional consultation steps and contact with those who proposed them or with other key informants.

Which criteria will be used to set priorities?

Different criteria are used to prioritise topics for policy briefs[1, 2, 3]; three in particular are likely to be relevant in most circumstances:

Is the topic important? – For example, issues associated with a high burden of disease, large expenditures, major inequities, important inefficiencies, or large gaps in access to effective care are likely to be important.

Are viable options available to address the topic? – For a policy brief to be useful there must be at least two feasible policy options which are potentially effective, even if compelling evidence is not available. One of the options may be the status quo.

Is there an opportunity for change? – If, for example, political or other events have opened – or could open – a window of opportunity, a policy brief is more likely to be useful than if change is unlikely. Is there, for instance, an identifiable champion for the issue? It is important that an individual or organisation is available to ensure that the outcomes of the policy brief and dialogue are acted upon. If not, there is a high risk that nothing will happen. Such a champion may be someone in the Ministry of Health or another key stakeholder.

Additional criteria to prioritise the topics to be addressed in policy briefs include:

Is there important uncertainty about the topic and potential solutions? – If there are conflicting views or uncertainty, a policy brief is more likely to be useful. Conversely, if there is already a well-founded consensus regarding a specific policy option, a policy brief is unlikely to be helpful.

Is relevant research evidence available? – Although the prioritisation of topics for policy briefs should be driven by the importance of each problem and the potential solutions, there may be pragmatic reasons for prioritising a particular problem for which relevant research evidence is available. Or, there may be good reasons for not prioritising a problem for which relevant evidence is unlikely to be found or synthesised with the time or resource limits.

Is there interest in informed deliberation about the problem and potential solutions? – A policy brief is more likely to be used if policymakers and stakeholders are genuinely interested in discussing the problem and its potential solutions. It is less likely to be useful if policymakers and stakeholders are uninterested or if their interest in the deliberation is not sincere. The latter response may occur, for example, if a decision has already been made.

Who will participate in setting priorities?

In most instances, a small group of people will carry out the final process of applying the criteria to prioritise the topics and deciding which policy brief to undertake. Ideally, this group should include: policymakers who have a broad overview of the health system and the policymaking environment; health system researchers with a broad overview of health systems research and familiarity with the policymaking environment; and key stakeholders. These stakeholders may include key non-governmental organisations, donors or international organisations, health workers, and the general public. Sometimes participation may be dictated in part by external or other priority-setting processes that are already in place. (See Guide 8. Informing and engaging stakeholders)

It may often be pragmatic for those responsible for producing policy briefs to take the final decision about which policy briefs to produce. However, there may be several advantages to having a steering or advisory group to do this. This is because they can:

- Ensure the appropriate representation of the perspectives of both the policymakers and stakeholders who are the intended users of the policy briefs, and of the potential beneficiaries of the policies or programmes that might be implemented
- Protect against inappropriate influence on decisions by the interests of those responsible for producing policy briefs, and ultimately
- Help to ensure that policy briefs address important problems and are used to inform decisions

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What process will be used to set priorities?

After it is decided which criteria for setting priorities will be used and who will be involved, a systematic and transparent process is needed to ensure that these criteria are applied appropriately by those responsible for prioritisation. An example of such a process is provided in the 'Additional resources' section of this guide. Click here to listen to how a priority-setting process in Uganda was undertaken. Group processes should ensure the full participation of all group members. Having a skilled, knowledgeable and neutral chair or facilitator is particularly important because it ensures better participation, the effective use of time, and adherence to agreed-upon processes for deciding on priorities. The role of facilitators is described in further detail in Guide 7. Organising and running policy dialogues.

Factors that are as yet unmeasured should also be considered by the group responsible for decisions about the priorities even if, as often happens, the data to inform such judgements are lacking. The data used – and any unmeasured factors – must be considered explicitly and transparently. And it is important that the chair or facilitator ensures that implicit assumptions *and* the basis for those assumptions are made explicit. Four criteria should be met to ensure the process is fair: [4]

Relevance – The rationale for decisions should be based on the reasons (criteria and information) that 'fair-minded' people agree are relevant in the context.

Transparency – Decisions and the rationale for them should be publicly accessible.

Revisions – Ideally, draft priorities should be open to comment prior to finalising the decisions.

Documentation – The process used to set priorities should be documented. This ensures adherence to the agreed process and the fulfilment of the first three criteria.

A worksheet for reporting the process used to set priorities for policy briefs can be found in the 'Additional resources' section of this guide, together with examples from Uganda and Zambia of completed versions. A worksheet for summarising the reasons for prioritising a policy brief topic is also provided. Workshop materials and a presentation on prioritising topics for policy briefs are included in the 'Additional resources'.

All the stages in preparing and using policy briefs should be evaluated, including the approach used to set the priorities, so that lessons can be learned for future priority-setting processes. This evaluation should include the views of policymakers and stakeholders about the appropriateness of the approach used to set priorities; the extent to which the appropriate priorities were set; and ways in which the approach could be improved.

Additional resources

Evaluation form

A form for evaluating the SURE guides

Glossary

A glossary of terms used in the guides

Worksheet for planning a priority-setting process for policy briefs

A worksheet for planning a priority-setting process for policy briefs

SUPPORT Tool for priority setting

Questions to consider when developing a priority-setting process for supporting evidence-informed health policymaking

Priority setting for guidelines

A review of priority-setting processes for evidence-based guidelines

Example of a lack of a formal priority-setting process in Ethiopia

Example of a priority-setting exercise in Uganda

Worksheet for summarising a priority-setting process

A worksheet for reporting a priority-setting process

Examples of priority-setting processes

Examples of completed worksheets describing a priority-setting process

Worksheet for summarising the reasons for prioritising a policy brief

A worksheet for summarising the reasons for prioritising a particular topic

Workshop materials for priority-setting for policy briefs

Guides for a workshop and a PowerPoint presentation on setting priorities for policy briefs

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References

1. Oortwijn WJ. First Things First. Priority Setting for Health Technology Assessment. In (PhD thesis) Leiden: The Netherlands Organisation for Applied Scientific Research (TNO) Prevention and Health; 2000.
2. Oxman AD, Schunemann HJ, Fretheim A: Improving the use of research evidence in guideline development: 2.Priority setting. Health Res Policy Syst 2006, 4:14.
3. Lavis JN, Oxman AD, Lewin S, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking(STP) 3: Setting priorities for supporting evidence-informed policymaking. Health Res Policy Syst 2009,7(Suppl 1):S3.
4. Daniels N. Accountability for reasonableness: Establishing a fair process for priority setting is easier than agreeing on principles. BMJ 2000; 321:1300-3.

This page was last updated November 2011