Innovative governance in health: Priority setting to control neglected tropical diseases

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Abstract

The assessment of priority setting can lead to innovative health governance by clarifying the performance of national health systems in resource poor countries, particularly in Africa. As a means to link research to action, assessing priority setting can ensure that the needs of the very poor to access personal and public services to control neglected tropical diseases (NTDs) are considered. Controlling NTDs effectively can contribute to uplifting the health status of the African people, further, it can build human capacity to confront the numerous contemporary health challenges and efficiently seize the emerging socio-economic opportunities across the continent. Based on a literature review, this paper reveals that there is little attention paid to the assessment of priority setting in national health systems, particularly in the area of research governance regarding NTDs. Much literature about research governance focuses on research that prioritizes cost-effectiveness. Overemphasized are guidelines about accountability, transparency and efficiency, at the expense of research into the underlying health determinants to control NTDs that produce unequal health outcomes in populations. Reducing population health outcomes that are avoidable is an issue of equity. Based on existing knowledge, this paper proposes a framework to assess priority setting which links research to action in controlling NTDs by incorporating health determinants. The framework, which focuses on the processes and outcomes of priority setting, could be adapted to other health sectors. It remains important to test the proposed framework empirically.

Neglected tropical diseases (NTDs) are a diverse group of diseases with distinct characteristics that are rarely prevalent in developed nations. NTDs affect more than 1.4 billion people living on less than USD 1.25 a day mainly in Africa (Skolnik and Ahmed, 2010, p.1; World Health Organization, 2013). While that is so, priority setting to control NTDs receives very little attention within health systems of poor countries in the area of research governance. Research governance is the organized institutional social response to generate resources relating to knowledge production to deal with health conditions in health care systems and public health management (London and Frenk, 1997). Much of the literature about research governance focuses on ideas and imperatives to ensure accountability, transparency and efficiency in health research (Walsh, Mcneil and Breen, 2005; Poustie *et al.*, 2006; Crammond *et al.*, 2011; Rani, Bekedam and Buckley, 2011). Lacking are empirical studies to assess priority setting to control NTDs. 'A "priority" is, very simply, a fact or condition that is more important than another' (WHO, 2009, p.2). Priority setting in health care is commonly defined as 'the process for making decisions over the allocation of population health care resources' (Lafi, Robinson and Williams, 2012, p.771).

This paper situates itself in Health Governance and Public Health Management. The main objective is to examine how priorities in research governance are set to control NTDs, which are elaborated further below. Priority setting is an important precursor in ensuring research is linked to action in the control of health issues such as NTDs. This will be an important component in building the human capacity necessary to confront numerous health challenges and to seize emerging socio-economic opportunities across the African continent.

In a framework to assess country-level efforts to link research to action, Lavis *et al.* (2006), for instance, identified four elements. The general climate for research use; the relevance and quality of the research produced; the mix of clusters of activities involved and the evaluation of all these factors. Relying on this framework, this paper proposes to carry out a literature review in order to achieve the above objective by specifically focusing on priority setting to control NTDs in Africa. In so doing, this paper will reveal the little attention paid to the assessment of priority setting in knowledge production to fight NTDs. Although the proximal causes of NTDs are known to be parasites and bacteria (Skolnik and Ahmed, 2010), the modifiable upstream risks are rarely researched (through scoping, systematic reviews and primary studies). Most of these risks relate to underlying social determinants of health (SDH) or health determinants such as the unsanitary living conditions among the poor, lack of clean water or access to quality care (Rudan *et al.*, 2011).

This paper begins by situating priority setting within a more analytical understanding of research governance. It goes on to show that the general climate relating to research use in Africa directs much attention to the investigation of efficiency regarding research funding. The paper proceeds to demonstrate that research to increase cost-effective interventions in controlling NTDs remains essential, but the underlying health determinants are rarely investigated. Such information could provide knowledge useful to prioritizing research that is able to innovate governance in health to fight against NTDs. The four clusters of activities, proposed by Lavis *et al.* (2006), involved in linking research to action are discussed, pointing out the problems they present within the African context. Lastly, based on various studies (Gibson *et al.*, 2002; Sibbald *et al.*, 2010), the paper suggests a framework to evaluate priority setting to link research to action taking into account health determinants in specific contexts. I suggest that priority setting is essential to link health research to action and spearhead innovative governance in health able to eliminate NTDs. As an example, I argue for the assessment of priority setting as a prerequisite in strengthening research governance to identify and effectively address health determinants. This will enhance the capacity of health systems by innovating ways that increase greater coverage and reduce costs to prevent and control NTDs in Africa.

PRIORITY SETTING AND RESEARCH GOVERNANCE TO CONTROL NTDS

Priority setting is one of the most important functions in the governance or stewardship of national health systems. It relates particularly to resource generation (Murray and Frenk, 2000). For our purposes, resource generation shall refer to the production of knowledge to control NTDs in the health system. Health systems implement health

action, which is any set of activities undertaken by an organization of the system to improve or maintain population health (Murray and Frenk, 2000). Two essential analytical dimensions define health action in a health system. The health conditions and the way in which organizations in a state respond to those conditions (Frenk and Moon, 2013 p.936). Conditions in this study refer to NTDs and the risk factors involved.

Mainstream governance theorists are said to conceptualize the state as a neutral entity, which acts on behalf of the public interest (Lemke, 2007). Critics of this view point to policies or measures that often suit powerful social state actors, even if they impose losses on the majority (Mahon, 1997; Graefe, 2007) raising questions about the notion that the state designs policy to ensure some transcendent public interest. If decision making in public policy is an act of power rather than simply an exercise of sorting and evaluating options, then state governance, which appears neutral, can perpetuate social inequalities. At issue is explaining how such inequalities arise (Mahon, 1997 p.194). A possible explanation is that the state does not act but rather social forces act through the state (Graefe, 2007). These forces may be networks of individuals and organizations. Networks include researchers, advocates, policy-makers and technical officials working, for instance, on NTDs. Organizations may include government and non-governmental organizations, such as United Nations agencies, foundations and donor agencies. Given this scenario, priority setting to deal with NTDs occurs in unequal power structures.

Even so, critics argue that the tendency to over-emphasize governance from the perspective of the rulers, programmers and planners alone disregards empirical reality or the inevitable gap between what is attempted and what is accomplished (Mahon, 1997). For instance, large populations are often outside the state decision-making processes. A clear example is the clientelistic practices in Africa, where patrimonial relationships based on ethnicity lead to patterns of personal dependency on the decision making power of politicians (Bierschenk and de Sardan, 2003). It implies that such governance leads to a form of social exclusion. This is especially so where participation in decision-making concerning the governance of public services is monopolised by those considered to possess the necessary expertise (Mahon, 1997). Exclusion can also be based on gender, limiting mainly the participation of women in decision making processes (McBride, 1996). According to Sen (2000 p. 27), social exclusion raises questions about the relational obstacles to be overcome, if policymaking is to be improved. For our purposes, these obstacles relate to setting priorities in research governance that would shape policy that answers to the needs of the very poor greatly affected by NTDs in Africa. In this study, governance is understood as the totality of ways in which a society organizes and collectively manages its affairs, beyond the formal mechanisms of government (United Nations Development Programme (UNDP), 1997), particularly in the health system. Thus, governance in a health system can be understood as the organized institutional social response to a series of conditions which constitute health needs among various population groups (Londoñ and Frenk, 1997 p. 7), in this study, NTDs in Africa.

Any health system of a state performs various functions. Londoñ and Frenk (1997) identify four basic functions. These are financing, provision of personal and public health services, stewardship and resource generation (human, physical and knowledge). The main sub-functions include: overall system design, performance assessment, priority setting, inter-sectoral advocacy, regulation and consumer protection (Murray and Frenk, 2000). Priority setting, the main focus of this paper, involves two major governance related elements, namely, choosing criteria for setting priorities and building a consensus around them (Murray and Frenk, 2000). Thus, to assess priority setting in health governance requires, first, an analytical understanding of research governance. This is so because consensus building involves diverse stakeholders having strong links to research and action in health governance. Second, building a consensus seems to occur in unequal relations. An analytical awareness of the political nature of these processes is required to understand how choices are made about the personal and public services to control NTDs, such as which are considered most important to be investigated or acted upon.

Studies about research governance draw from various frameworks firmly established in Western countries such as in the United Kingdom, the United States and Canada (Canada Interagency Advisory Panel on Research Ethics, 2009; Taylor, 2002). The main ideas guiding research governance in these frameworks are namely: coordination, monitoring and regulation of health research, especially in the wake of evidence-based policy making (Canada

Interagency Advisory Panel on Research Ethics, 2009). These measures are said to ensure accountability, transparency and efficiency in health research (Walsh, Mcneil and Breen, 2005; Poustie *et al.*, 2006). Emphasis is put on imperatives to set up national structures that govern research (Rani, Bekedam and Buckley, 2011). These include, for instance, country research registration systems to register all desired research; encouraging research ethics review systems to ensure research is carried out to the highest scientific and ethical standards; and designing systematic archiving databases (Poustie *et al.*, 2006). Research governance as explained above does not necessarily lead to consensus building in setting priorities to control NTDs. For instance, research shows that setting research priorities seems to happen in an ad hoc manner in Africa, led by donors and funding bodies based in the Global North (Kapiriri, Norheim and Martin, 2007). At the same time, it has been strongly argued that attention and resources follow convincing ideas of policy communities and strong institutions (Shiffman, 2009). Policy communities, which are networks of individuals and organizations that share a concern for a particular issue (Shiffman, 2009) raise important questions about how research is linked to action. This is so because research use involves interactions between various institutional health sector agencies in the delivery of personal and public services to deal with health issues, particularly NTDs in Africa. To complicate matters, these interactions include other government sectors that influence health (London and Frenk, 1997). Thus, an assessment of priority setting can be helpful to understand the various processes involving diverse sectors through which research is linked to action. Such knowledge may be used to innovate ways in implementing interventions in an integrated manner and across all relevant sectors. This can contribute to stronger health systems in achieving the prevention and control of NTDs. According to Lavis *et al.* (2006), country-level efforts to link research to action depend, first of all, on the general climate relating to research governance (Lavis *et al.*, 2006).

RESEARCH TO CONTROL NTDS: EFFICIENCY IN HEALTH SYSTEMS

Research governance includes activities by the funders of research, universities and how researchers and users of research support or place value on efforts to link research to action (Lavis *et al.*, 2006). In this section, I briefly point out that according to the literature reviewed, the general climate of research governance relating to NTDs reveals two issues. The first one is the predominant preoccupation with efficiency in decision-making concerning funding (Sridhar and Batniji, 2008; Moran *et al.*, 2009; World Health Organization, 2012). Emphasis is put on research regarding cost-effective interventions to achieve greater coverage in low-resource settings (Bryce *et al.*, 2003). The second issue is that domestic investments into research have to compete with resources needed to deliver health services (Ezeh *et al.*, 2010). Some examples of other neglected diseases can shed light on these issues. Childhood diseases, such as pneumonia and diarrhoea diarrhoea combined, are reported to cause more child deaths each year globally than deaths to smoking in all ages annually, or twice as many annual deaths as HIV/AIDS worldwide (Rudan *et al.*, 2007). Child deaths occur mainly in developing countries. For instance, according to the WHO (2014) children in sub-Saharan Africa alone were more than 15 times more likely to die from these diseases before the age of five than children in developed regions. Yet pneumonia, meningitis, and diarrhoea get less donor funding compared to HIV/AIDS, malaria and tuberculosis, which together are reported to get about 80 percent of the money (Enserink, 2009). Interestingly, in a research priority setting process about childhood pneumonia, 'barriers to care-seeking' was the highest ranked issue, which is rarely given high funding priority by international agencies (Rudan *et al.*, 2011). These findings have significant implications for priority setting regarding effective interventions to prevent neglected diseases.

Research to determine risk distribution of severe pneumonia and the health determinants shaping the referral of sick children to a hospital would, for instance, be most answerable to the needs of the poor in Africa. Also, it is most likely to be effective and carries the greatest potential for reducing the disease burden in poor populations. The mal-distribution of health care or not delivering care to those most in need is a health determinant (WHO Commission on Social Determinants, 2008, p.1). Systematic differences in access to health determinants, such as health care, shape unequal health outcomes and are likely to result in the persistence of neglected diseases in poor populations. In this situation, the evaluation of priority setting to control NTDs becomes essential. Sibbald *et al.* (2010) reveal the purpose of evaluating priority setting as to provide any organization with a simple, practical

way to better understand what it means to achieve success in its priority setting activities. Areas for scaling-up or improving equitable access to services can be identified.

I am suggesting that the assessment of priority setting can spearhead innovative governance in health through providing information about existing research gaps. Knowledge about missing data may inform a research agenda or research questions that prioritize enquiry specifically into health determinants (Snilstveit *et al.*, 2013:7). On the basis of such knowledge, research use could be strengthened by accelerating the implementation of policies and strategies that combat exclusionary dynamics. These increase the burden of NTDs among the very poor in Africa. According to Lavis *et al.* (2006), the second element in assessing country-level efforts to link research to action addresses priority setting in the production of research to ensure the needs of users are identified and addressed in scoping reviews, systematic reviews and single studies.

PRIORITY SETTING IN THE PRODUCTION OF KNOWLEDGE

Resource allocation in health care is considered the most important task in health system governance (Lafi, Robinson and Williams, 2012). The model widely used by public agencies in the West to study priority setting in health care is the 'accountability for reasonableness' (Daniels and Sabin, 1997). This model has been used to study priority setting not only in the West but also in Africa (Kapiriri *et al.*, 2007). According to this model, the goal for priority setting is legitimacy and fairness built on four conditions (Daniels and Sabin, 1997). The relevance condition is about 'fair-minded' people agreeing upon decisions based on reasons (i.e., evidence, principles, arguments) to meet the diverse needs of a covered population under the necessary resource constraints. The publicity condition specifies that these limit-setting decisions should be transparent and publicly accessible. The appeals condition requires mechanisms for conflict resolution and revision in light of further evidence or arguments. The last condition is enforcement either voluntary or public to regulate the process and ensure the first three conditions are met. Gibson *et al.* (2002) argue that the four conditions lead to six domains of reasons, people, appeals, institutions, processes and factors, shown in the diamond (Figure 1) below.

Figure 1: Accountability for reasonableness framework   (adapted from Gibson *et al.*, 2002).
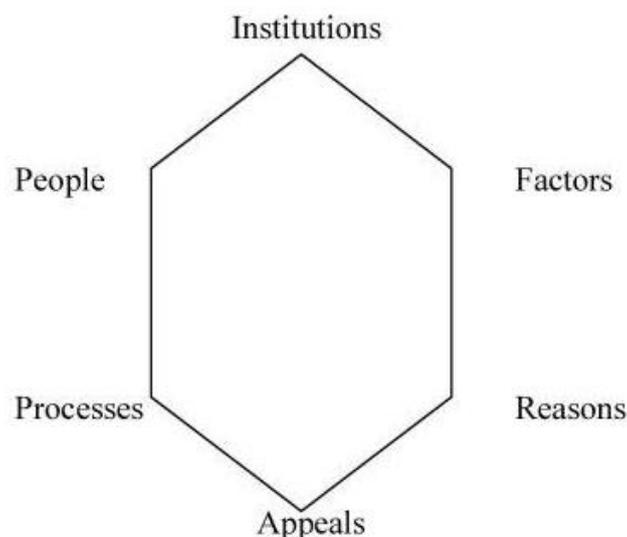
These domains can be empirically investigated to evaluate priority setting for our purposes concerning the control of NTDs. Table 1 below indicates the prevalence of 8 of the 17 parasitic and bacterial infections considered NTDs (Skolnik and Ahmed, 2010; WHO, 2013).

Table 1: Major Neglected Tropical Diseases (NTDs) Ranked by Prevalence

Disease	Global Prevalence in millions
Ascariasis (Roundworm)	807
Trichuriasis (Hipworm)	604
Hookworm Infection	576
Schis-tosomiasis (snail fever)	207
Lymphatic filariasis (elephantiasis)	120
Blinding Trachoma	41
Oncho-cerciasis (river blindness)	37
Leishmaniasis	12

Source: Adapted from Skolnik and Ahmed (2010 p. 1). (Not indicated in the table are five other NTDs, each affecting less than 10 million, namely: *Chagas disease* 8-9 Million; *Leprosy* 0.4M; *Human African trypanosomiasis* 0.02M; *Dracunculiasis* 0.01M; *Buruli ulcer* not determined. The rest of the NTDs are Dengue, Rabies, Foodborne trematodiases, Yaws.)

Seven of the most common NTDs (Ascariasis 807 million, Trichuriasis 604m, Hookworm 576m, Schis-tosomiasis 207m; Lymphatic Filariasis 120m; Blinding Trachoma 41m; Oncho-cerciasis 37m) can be found in a number of resource poor countries, but primarily in Africa. NTDs are prevalent especially in subtropical and tropical climates and are considered diseases of poverty, affecting nearly everyone in the 'bottom billion' of the poorest people (Skolnik and Ahmed, 2010). WHO (2015) has reported a number of successes. In 2014, only 126 cases of dracunculiasis were reported, signalling its eradication. In 2013 and 2014, Colombia and Ecuador eliminated onchocerciasis, respectively. Bangladesh and Nepal are said to be in position to eliminate visceral leishmaniasis by the end of 2015. Also, new cases of human African trypanosomiasis have dropped to fewer than 10,000 annually, with 6,314 cases reported in 2013 (WHO, 2015).

Despite the above successes, women and children living in unhygienic environments with limited access to clean water and sanitary methods of waste disposal continue to be overrepresented in populations blinded, disfigured, disabled and killed by NTDs (Skolnik and Ahmed, 2010; WHO, 2013; 2015). Additionally, recent studies have shown that many people have one or more NTDs at the same time as they have HIV or malaria, worsening the intensity of those diseases (Skolnik and Ahmed, 2010, p. 2). Similarly, many of NTDs cause disability and disfigurement, which can be a source of social stigma leading to isolation in families and communities. NTDs affect not only health and wellbeing, but also the productivity of individuals and the economy (Skolnik and Ahmed, 2010, p. 2). Furthermore, NTDs have the potential to spread, as Ebola has recently demonstrated. Moreover, increasing global warming implies that NTDs may no longer be limited to tropical regions. Another clear example is dengue found in more than 150 countries (WHO, 2015). Thus, population movement and environmental change are among factors facilitating expansion of diseases spread by insects.

Priority setting to control such NTDs face major challenges arising from issues of legitimacy and fairness in the context of unequal power differences. Put differently, the 'relevant reasons' that inform priority setting, even when based on high quality evidence, may be pre-determined as a function of power differences. Power differences may, for instance, occur between the capacity of funders in terms of financial prowess, the professional status of researchers, the influential position of policy makers and the less powerful research users or the very poor in Africa. Age, gender, and ethnicity, as already observed, may constitute other pathways through which exclusionary dynamics resulting from unequal relations within state governance are expressed. It means that priority setting during consensus building can be controversial. Some individuals and groups among various public health agency sectors and actors are better positioned than others to influence the outcomes. Information about these processes

in Africa can be practical to facilitate linking research to action and enable the application of high quality evidence to control NTDs. According to Lavis *et al.* (2006), a third element in assessing country-level efforts to link research to action addresses four clusters of activities, indicated in Table 2 below.

Table 2. Linking research to action against NTDs: the four clusters of activities
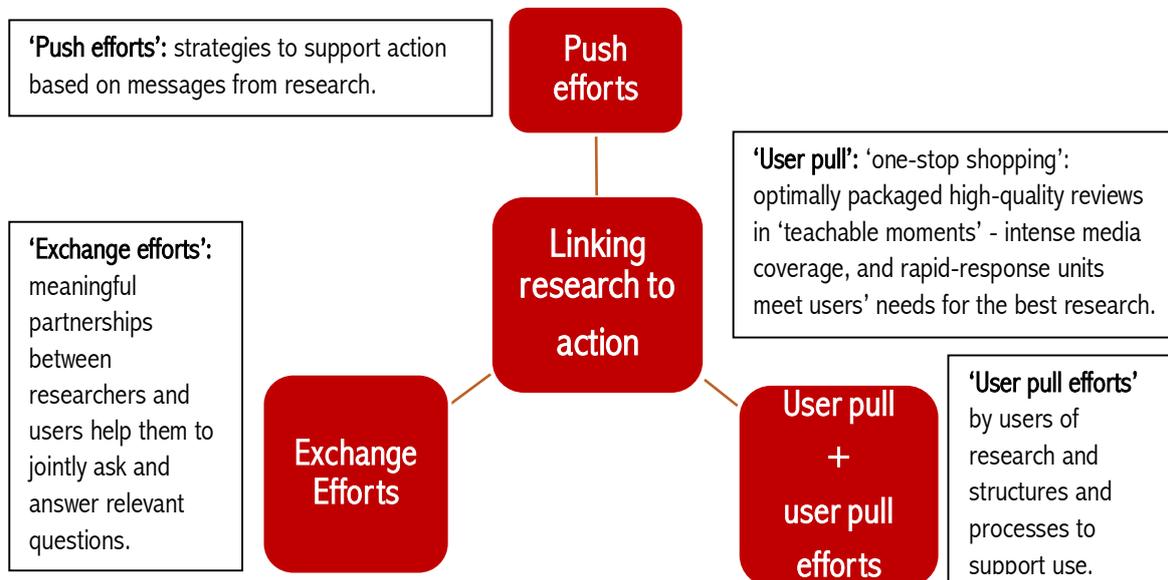
The cluster of systematic 'push efforts' in Table 2 identifies actionable messages using various strategies. These efforts, for example, support action based on focused messages from systematic reviews. The cluster of 'user pull' activities involves optimally packaged reviews of high quality and relevance put at the disposal of those supporting action based research. The cluster of 'user pull' efforts refers to how users evaluate their capacity to appropriate and apply research, such as combining the evidence with other types of information to promote the use of research in decision-making. This activity calls for developing structures and processes to help users acquire the required competences. The cluster of 'exchange efforts' involves building relationships and partnerships among researchers and research users around single studies, programmes of research, or systematic reviews. In that way, they can collectively ask and answer locally relevant questions, such as those facilitating the setting of priorities.

These four clusters of activities present various problems in linking research to action in the African context. The cluster of 'push efforts' to provide actionable messages to control NTDs, for instance, raises the question of 'whose' reasons are relevant to decide what should be actionable messages or the priority message. Similarly, in 'the user pull' activities concerning high quality reviews, who decides what constitutes the subject of a high quality review useful to control NTDs? This is important because most of the centres of excellence, including the best universities that drive research, are concentrated in the rich industrialized countries, highlighting inequalities in the global knowledge economy. By contrast, African universities are characterized by poor research infrastructure and management (Ezeh *et al.*, 2010). Similarly, 'user pull efforts' present problems concerning the structures and processes available to do so in Africa. The shortage of senior African social scientists available to lead or manage research undermines the ability of Africa to interpret and solve its socio-economic and public health problems. Wright, Ahikire and Kwesiga (2014) show that much social science research in Africa is conducted in the form of small, individual consultancy projects. While this may be a positive step in the right direction, questions remain about the real contribution of these projects in building strong institutional research capacities to strengthen the prevention and control of diseases, specifically NTDs.

In addition to the institutional problems raised by 'user pull efforts', exchange efforts present issues of a different nature. Specifically, do partnerships in exchange efforts involving a broad range of stakeholders imply automatically achieving the goal of legitimacy of having fair-minded participants? This is important because the issue of who should be included in the process is different from whoever is included should contribute to enhancing the priority setting decisions (Sibbald *et al.*, 2010). Put differently, are the voices of the very poor burdened with NTDs in specific contexts heard in research? This is important in light of additional obstacles raised by some researchers. Stewart and Sewankambo (2010), for instance, observe a fundamental collision of the logic of biomedical research with the logic of local social relationships in Africa. They show that researchers in Africa perform their role as a transaction, while the participants expect transformative actions after their participation in research. It implies that developing and implementing effective interventions call for evaluating priority setting to clarify the above problems. This is a precursor to innovative health governance that promotes health equity. A fourth element in linking research to action addresses approaches that support country-level rigorous evaluations (Lavis *et al.*, 2006).

Evaluations of efforts to link research to action against NTDs

Rudan *et al.* (2007) observe that evaluations of existing health interventions are rarely seen as a research priority by funders. Despite that, there are various examples to show that research evaluations have contributed to improvements in health. For instance, routine use of Vitamin A treatment to reduce the incidence of both blindness and fatality as well as to better outcomes in HIV infected children with diarrhoea have improved child health in Africa (Dabis *et al.*, 2002). The routine use of Vitamin A resulted from evaluations of evidence-based interventions from observational studies that revealed the success such interventions. Additionally, the clinical use of antiretroviral treatment to prevent mother to child transmission of HIV has improved child health in Africa. It has been facilitated by evaluations from observational studies that have demonstrated its effectiveness (Dabis *et al.*, 2002). Furthermore, evaluations based on research contributed to the development of low cost interventions against malaria such as the use of insecticide-treated nets (Dabis *et al.*, 2002). In these cases, evaluations led to further research, which was described as fundamental to later improvements. If that is the case, a common conceptual framework for evaluating priority setting would be useful to account for the successes and failures to deal with health issues in Africa. A framework to evaluate priority setting of NTDs could be adapted to other areas in the health system. Given the contextual differences in which, for instance, NTDs are experienced, it remains difficult to reach a consensus about the meaning of successful priority setting. As a result, any framework to evaluate priority setting should take into account the specific context in which those greatly affected with NTDs live in Africa.

FRAMEWORK FOR EVALUATING PRIORITY SETTING TO CONTROL NTDS

Gibson *et al.* (2002) propose a trans-disciplinary model to evaluate priority setting that incorporates both ethical and empirical considerations. From this perspective, the assessment of priority setting need not only include the dominant economist's view where legitimate priority setting is based solely on cost effective analyses grounded on rational assumptions. Other disciplines with different ethical traditions, particularly that of health equity, are included to shape the assessment of priority setting. The WHO Commission on Social Determinants of Health (2008) considers health inequities to be systematic differences in health care that are unfair and unjust, if they can reasonably be avoided. This study proposes a framework in Table 3 below including ethical principles to evaluate priority setting to control NTDs based on the six domains previously referred to from Gibson *et al.* (2002), namely: reasons, people, appeals, institutions, processes and factors.

Table 3. Framework to assess priority setting to control NTDs

	Elements
Process	• People - who should be included beyond whoever can contribute • Reasons - consideration of dominant ideas, as well as clear and transparent information management • Institutional framework across various sectors • Use of explicit process • Values - political environment • Revision /appeals mechanisms
Outcome	• Medication and treatment • Greater understanding of needs • Equity relating to access to health determinants/socio-demographic factors (age, gender and ethnicity and others) • Reallocation of resources according to needs

An evaluation framework proposed by Sibbald *et al.* (2010), which this study has adapted, has two important dimensions: the process and outcome. The process includes the procedures involved in the priority setting such as choosing the participants or people to participate in decision-making. In the framework above, the question that needs to be asked is who should be included. Additionally, it is important to inquire about which dominant ideas (such as efficiency, equity and cost-effectiveness) informed the process. This is important to identify the research gaps particularly regarding what health determinants relating to NTDs were left out. Questions about information management are essential, specifically regarding clarity and transparency, the disclosure of conflicts of interest, fair access to decision-makers, and fair chairing and leadership of the priority setting group. Since Africa clearly has weak infrastructure to support centers of research excellence, assessment of priority setting should include questions about the interactions between the existing institutional frameworks or sectors to find out how they fulfill their mandate of setting priorities. Variations between institutional cultures do affect priority setting (Gibson *et al.*, 2002) during consensus building. The use of deliberative processes may transcend some of the difficulties encountered in consensus building. It means that questions should be raised about the explicit process concerning whether state officials, the external advisers and the local population collaborated to acquire and use the best available evidence to inform decisions, for instance, about the coverage for health services or the allocation of resources for personal and public services.

A major difficulty is that deliberative exchanges between researchers, public health actors, members of civil society and all other interested parties involve values. Values shape deliberations. Questions should be raised about the values that determined the decision making to control NTDs in a specific context. These can also refer to factors that include among others benefit, cost, evidence, arguments, principles, cost-effectiveness and equity considered important by priority setting decision-makers (Gibson *et al.*, 2002). Other questions should be asked about whether the priority setting was open to review. Thus, a process to assess priority setting should be comprehensive and evidence-informed (Sibbald *et al.*, 2010, p. 2).

The outcomes of the priority setting process are important. Priority setting should inquire about the effect of decisions to increase the coverage of treatment to control NTDs and if there was a greater understanding of the needs of the beneficiaries across the socio-demographic factors. It is also important to ask if the re-allocation of the resources was based on the personal and public needs of the specific population. A major weakness of this framework is its normativity. It should be tested empirically to generate evidence that can link research to action to control NTDs in real world conditions, taking into account health determinants.

CONCLUSION

By situating priority setting within a more analytical understanding of research governance, this paper demonstrated the weak institutional research capacities within an unequal global knowledge economy, which define the general climate regarding health research use in Africa. The production of knowledge is often governed by research that prioritizes cost-effectiveness focusing on guidelines about accountability, transparency and efficiency at the expense of research into the underlying health determinants. The assessment of priority setting can lead to innovative governance in health by providing the required information to link research to action in order to strengthen the capacity for prevention and control of NTDs. The framework to evaluate priority setting accounting for health determinants is only a proposal and an initial attempt to ensure that the very poor have access to the personal and public services they need to control NTDs. The framework needs to be tested in the real world in which the very poor live to collect data about health determinants across socio-demographic indices such as gender, age, and ethnicity.

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