

Childhood pneumonia and diarrhoea: setting our priorities right

Rudan, Igor; El Arifeen, Shams; Black, Robert E.; Campbell, Harry

Source / Izvornik: **The Lancet Infectious Diseases, 2007, 7, 56 - 61**

Journal article, Accepted version

Rad u časopisu, Završna verzija rukopisa prihvaćena za objavljivanje (postprint)

[https://doi.org/10.1016/S1473-3099\(06\)70687-9](https://doi.org/10.1016/S1473-3099(06)70687-9)

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:105:118702>

Rights / Prava: [In copyright](#) / [Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2025-03-04**



Repository / Repozitorij:

[Dr Med - University of Zagreb School of Medicine
Digital Repository](#)





Središnja medicinska knjižnica

Rudan, I., El Arifeen, S., Black, R. E., Campbell, H. (2007) *Childhood pneumonia and diarrhoea: setting our priorities right*. The Lancet infectious diseases, 7 (1). pp. 56-61.

<http://www.sciencedirect.com/science/journal/14733099>

<http://medlib.mef.hr/196>

University of Zagreb Medical School Repository

<http://medlib.mef.hr/>

Childhood Pneumonia and Diarrhoea: Setting our Priorities Right

Igor Rudan^{1,2,3} Shams El Arifeen^{1,4}, Robert E Black^{1,5} and Harry Campbell²

(1) Child Health and Nutrition Research Initiative, Global Forum for Health Research, Geneva, Switzerland

(2) Department of Public Health Sciences, The University of Edinburgh Medical School, Scotland, UK

(3) Department of Epidemiology, Andrija Stampar School of Public Health, Faculty of Medicine, University of Zagreb, Croatia

(4) Child Health Programme, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), Dhaka, Bangladesh

(5) Department of International Health, Johns Hopkins University, Baltimore, USA

Introduction

The World Health Organization recently highlighted the continuing scandal of unacceptably high levels of maternal and child deaths in developing countries in their World Health Report for 2005 (1). This shows that 30,000 children under 5 years of age still die each day. In recent years malaria, TB and HIV /AIDS have received global attention in high profile scientific publications and major international disease control initiatives (for example the Roll Back Malaria, Stop TB, DOTS and “3 by 5” programmes) (2-4). This international response has been reinforced by significant new funding mechanisms and sources such as the Global Fund

to fight AIDS, TB and Malaria and the major financial contributions from the Bill and Melinda Gates Foundation to the development of new vaccines against these scourges. However, these conditions account for about 11% of all child deaths globally, while pneumonia and diarrhoea are jointly responsible for nearly half of all child deaths (5). This is about the same as the number of deaths from smoking, double the total number of deaths from HIV/AIDS and is 25 times the number of deaths from war globally. Despite this huge mortality, we recently found a steep decreasing trend in research publications on the global extent of these problems reflecting reduced research interest and investment over the past 2 decades (6) (Figure 1). This was in line with the report of the Global Forum for Health Research for 2004, where it was shown that diarrhoea and pneumonia research receive markedly lower investments than those allocated to other diseases that contribute significantly to global child mortality (7).

Why should there be depleted scientific interest in field studies trying to better understand these two conditions – childhood pneumonia and diarrhoea - at a time when the WHO has again shown that these remain two of the most important causes of global burden of disease in children? Why do these two diseases continue to be responsible for almost half of all child deaths globally, when interventions exist to prevent most of these deaths, interventions that were developed and proven highly cost-effective more than two decades ago (8,9)? It is clear that these interventions are not being delivered to the children who most need them (10). Programmes aiming to deliver these interventions have been inadequately funded, of poor quality, not sustained and not expanded from initial pilots often in least deprived regions (11). Our failure in delivering the interventions is caused by our lack of understanding of how to do it efficiently and creatively in low resource settings, and it is a challenge for research to generate the required knowledge.

We propose that a major reason for these failures has been the lack of recognition that low coverage is a challenge for health research, to identify effective and efficient context-specific delivery mechanisms in health services of countries with limited resources. The development and proof of effective interventions has been seen in the past as the legitimate endpoint of research. Implementation research that needs to follow (including health policy and systems research and delivery research) is methodologically challenging and may require long-term studies. It has not been ranked as highly by the scientific community or by most funding agencies as new work in basic science or intervention development. This has tragic consequences. It has been shown that up to two thirds of under-five child deaths globally could be prevented today if available and cost-effective interventions were delivered to those in need (10). This would achieve UN's Millennium Development Goal 4, and is affordable within current global financial resources (10,12).

We believe that this experience with these two forgotten killers is a good predictor of what can be expected to occur in the future if the current research investment model is to persist (Figure 2). Effective new interventions such as vaccines against AIDS, TB or malaria may be developed in the coming decade, but the same challenge will then be faced: how to make those vaccines cheaper and more cost-effective, and how to deliver them to those most in need? The potential public health impact of these new interventions will not be realised without research on implementation.

The dominant model of research priority setting is resulting in gross under-achievement of potential disease burden reduction and is actually generating further health inequity. Current major global funding initiatives favour the areas of research interest of the scientists involved

in basic research, thus investing into options which have received the greatest level of advocacy and media coverage and whose future potential outputs appear most attractive to these communities and the agencies which support them. This is further encouraged by the greater potential for publications in high-impact journals, which is a major indicator of research quality, and also funding in the current research policy model (Figure 2). When these new research avenues lead to the successful development of new interventions, the initial beneficiaries usually are those who can afford the results of the research. More complete coverage of the population in need often lags decades behind (12-14). It is apparent that global research priorities and media pressure fuelled by an interest in highly unusual individual cases or emerging but uncertain threats are bound to generate ever increasing inequity. We believe that a major underlying problem is lack of clear principles for health research investment based on a vision of what the endpoints of such investments should be. We need a framework which values investment not only in generating new knowledge, but also in research that seeks to define how to implement and make better use of the existing knowledge leading to public health impact on burden of disease

A New Model of Priority Setting for Global Health Research Investments

The Commission on Health Research for Development was the most significant initial development in setting research priorities globally (15). It reviewed global health needs and priorities for health research in 1990 and concluded that “...less than 10% of global health research funds is devoted to 90% of the world’s health problems” (13). A number of subsequent initiatives addressed this problem by attempting to set priorities in global health research, including the recommendations from the Ad Hoc Committee on Health Research Relating to Future Intervention Options in 1996 (16), The Council on Health Research and

Development in 2000 (17), “The Grand Challenges” in Global Health supported by The Gates Foundation that emerged from World Economic Forum in 2003 (18), and the Combined Approach Matrix tool by the Global Forum for Health Research in 2004 (19). Another initiative is now underway by The Lancet itself to identify health research priorities to address UN Millennium Development Goals 4 and 5 through a two-stage Delphi study. All these approaches have in common that they are very useful for gathering information relevant to setting research priorities, but the process itself then eventually depends on a limited number of technical experts who collect this information and then recommend priorities, which makes it highly susceptible to their own individual opinions and personal interests and biases.

The Child Health and Nutrition Research Initiative (CHNRI), an initiative of the Global Forum for Health Research, is now leading a project which seeks to overcome these concerns. The major conceptual advance in this initiative is the recognition that there should be a broader definition of health research option as an activity that is not only limited to producing new knowledge, but also has a vision of implementation of this knowledge which, in the end, should help to reduce disease burden present today. From this it follows that it is important not to consider the endpoint of research as "generating new and interesting knowledge or insight", because this necessarily favours more fundamental research. Rather, the process of research priority setting should have a clear theoretical framework based on multiple endpoints coupled to a systematic process of scoring and ranking competing research options. In Figure 2, we illustrate the alternative model proposed by CHNRI, which addresses several components of a research option that can be used as criteria for setting research priorities: (i) likelihood that research option would be answerable in ethical way; (ii) likelihood that resulting intervention would be effective in reducing disease burden; (iii) deliverability, affordability and sustainability of resulting intervention; (iv) maximum potential of

intervention to reduce disease burden; and (v) effect of disease burden reduction on equity in population. We believe it is also important to acknowledge that there are three different instruments of health research (IHRs, Figure 3). For example, health policy and systems research will reduce disease burden by improving efficiency of health systems in delivering the interventions, implementation research will aim to improve existing non-affordable interventions to make them feasible and affordable in low-income settings, while other types of research will seek new and non-existing interventions. The former two types of research are not as innovative and attractive as the latter one, and their results are unlikely to be publishable in journals of high impact, but they nevertheless carry a significant potential to reduce the existing disease burden.

We are concerned that the current research priority decision making is not driven by an explicit framework and value system and thus is too open to research interest bias of individuals who influence funding priorities in large donor agencies without an unbiased vision focused on reducing disease burden and improving global health inequities. The six main advantages of the CHNRI methodology presented in Figure 3 over the alternative approaches are: (i) it is systematic, and technical experts involved the process to set research priorities are asked to list and score competing research options in a highly structured way; this limits the influence of their own personal biases on the outcome, which is frequently a problem in Delphi studies; (ii) the methodology is entirely transparent; all rationales for decision making and input from each person involved from the initial to the final stages are recorded, displayed and can be viewed and challenged at any later point in time; (iii) the experts submit their input into the process independently from each other, and the results are based on their collective opinion in a true sense, thus avoiding the possibility of some individuals among them directing the process; (iv) the final result is a simple quantitative

outcome (“research priority score”), which measures the “value” of each research option when all the criteria and stakeholders’ views are taken into account; this “value” can then be combined with the proposed cost of research in order to perform program budgeting and marginal analysis and derive an optimal mix of research options to be funded from a fixed budget; (v) the methodology is well suited to simultaneously evaluate and score different types of research (e.g. health policy and systems research, implementation research and research on new interventions) using the same set of criteria; (vi) unlike all previous approaches, this methodology incorporates an efficient means of considering the voice of stakeholders and wider public, who are given the power to place thresholds and weights upon intermediate scores (which are based on collective opinion of technical experts) and in this way considerably shape the final outcome (see Figure 3).

This methodology has been recently implemented with success at both international and national levels. At the global level, CHNRI and WHO Child and Adolescent Health Department are now working together using this methodology and global childhood mortality burden estimates (provided recently by WHO Child Health Epidemiology Reference Group) to define research priorities for each of the 8 main causes of child deaths (5). This methodology has also been applied recently at the national level. A total of 63 health research options addressing 7 main causes of child deaths in South Africa were listed (9 options per cause of death) and scored by local technical experts, with their results adjusted by local stakeholders (*Tomlinson M, Chopra M and Rudan I, personal communication*). In Table 1, we present final scores and rankings of those research options that addressed pneumonia and diarrhoea. Eight research options addressing those two diseases were placed among the top 13 research priorities, thus correctly recognizing the magnitude of their effect on mortality burden in South Africa. Furthermore, the priorities identified were dominated by health policy

and systems research options to increase the coverage of the simplest and most cost-effective interventions, such as hand-washing, breastfeeding and increased usage of antibiotic treatment of pneumonia (Table 1).

Although all initiatives aiming to set priorities and invest in child health research in developing countries are welcome, it is important to understand that without an explicit consideration of the issues listed above, the health gains that can be achieved will be limited. There are signs that these issues are beginning to gain attention. Some examples include the Research Assessment Exercise in the UK, a major driver of research priorities in public sector, debating how to respond to criticisms that the system undervalues health systems research; the European Commission, announcing that there will be a new funding stream for Health Policy and Systems Research in the forthcoming 7 year research programme (FP7) and, in the field of pneumonia, the grants by the Global Alliance for Vaccines and Immunisation for public-private partnerships and related research to accelerate the achievement of high levels of population coverage of immunisation with the new Hemophilus influenzae type b and pneumococcal protein conjugate vaccines. These initiatives are welcome but there is a need for a new framework for global health research priority setting, especially in child health research. We believe that only in this way will proper attention be given to delivery of proven interventions to reduce the high childhood mortality due to pneumonia and diarrhoea.

Acknowledgement

The authors thank Mark Tomlinson and Mickey Chopra from Medical Research Council, Cape Town, South Africa, for providing selected results of national-level application of CHNRI methodology presented in Table 1.

References

1. World Health Organization. World Health Report 2005. World Health Organization, Geneva 2005.
2. Snow RW, Guerra CA, Noor AM, Myint HY, Hay SI. The global distribution of clinical episodes of *Plasmodium falciparum* malaria. *Nature* 2005; 434: 214-217.
3. Piot P, Feachem RG, Lee JW, Wolfensohn JD. Public health. A global response to AIDS: lessons learned, next steps. *Science*. 2004; 304: 1909-10.
4. Schwartzman K, Oxlade O, Barr RG, Grimard F, Acosta I, Baez J, Ferreira E, Melgen RE, Morose W, Salgado AC, Jacquet V, Maloney S, Laserson K, Mendez AP, Menzies D. Domestic returns from investment in the control of tuberculosis in other countries. *N Engl J Med*. 2005; 353: 1008-20.
5. Bryce J, Boschi-Pinto C, Shibuya K, Black RE, World Health Organization Child Health Epidemiology Reference Group. World Health Organization estimates of the causes of death in children. *Lancet*. 2005; 365:1147-52.
6. Rudan I, Lawn J, Cousens S, Rowe AK, Boschi-Pinto C, Tomaskovic L, Mendoza M, Lanata CF, Roca-Feltrer A, Carneiro I, Schellenberg JA, Polasek O, Weber M, Bryce J, Morris SS, Black RE, Campbell H. Gaps in policy-relevant information on burden of disease in children: a systematic review. *Lancet* 2005; 365: 2031-40.

7. Sazawal S, Black RE. Pneumonia Case Management Trials Group. Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials. *Lancet Infect Dis.* 2003; 3: 547-56.
8. World Health Organization. The treatment of diarrhoea. A manual for physicians and other senior health workers. Geneva, 1995 (WHO/CDR/95.3).
9. Global Forum for Health Research. The 10/90 Report on Health Research 2004. Global Forum for Health Research, Geneva, 2004.
10. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet.* 2003; 362(9377): 65-71.
11. Victora CG, Fenn B, Bryce J, Kirkwood BR. Co-coverage of preventive interventions and implications for child-survival strategies: evidence from national surveys. *Lancet.* 2005; 366: 1460-6.
12. Bryce J, Black RE, Walker N, Bhutta ZA, Lawn JE, Steketee RW. Can the World afford to save the lives of 6 million children each year? *Lancet.* 2005; 365(9478):2193-200.
13. Victora CG, Hanson K, Bryce J, Vaughan JP. Achieving universal coverage with health interventions. *Lancet.* 2004; 364: 1541-8.
14. Global Forum for Health Research. The 10/90 Report on Health Research 1999. Global Forum for Health Research, Geneva, 1999.
15. Commission on Health Research for Development. Health research: Essential link to equity in development. Geneva, Switzerland, 1990.
16. Hyder A. Research and development in priority investments (“best buys”) identified by the Ad Hoc Committee on Health Research Relating to Future Intervention Options 1996-1998. Progress Report, Global Forum for Health Research, June 25, 1998.
17. The Working Group on Priority Setting (COHRED). Priority setting for health research: lessons from developing countries. *Health Policy Planning* 2000; 15: 130-136.

18. Varmus H, Klausner R, Zerhouni E, Acharya T, Daar AS, Singer PA. Grand challenges in global health. *Science* 2003; 302: 398-399.
19. Ghaffar A, de Francisco A, Matlin S (Eds). *The Combined Approach Matrix: A priority-setting tool for health research*. Global Forum for Health Research, Geneva, 2004.

Legends to figures and a table

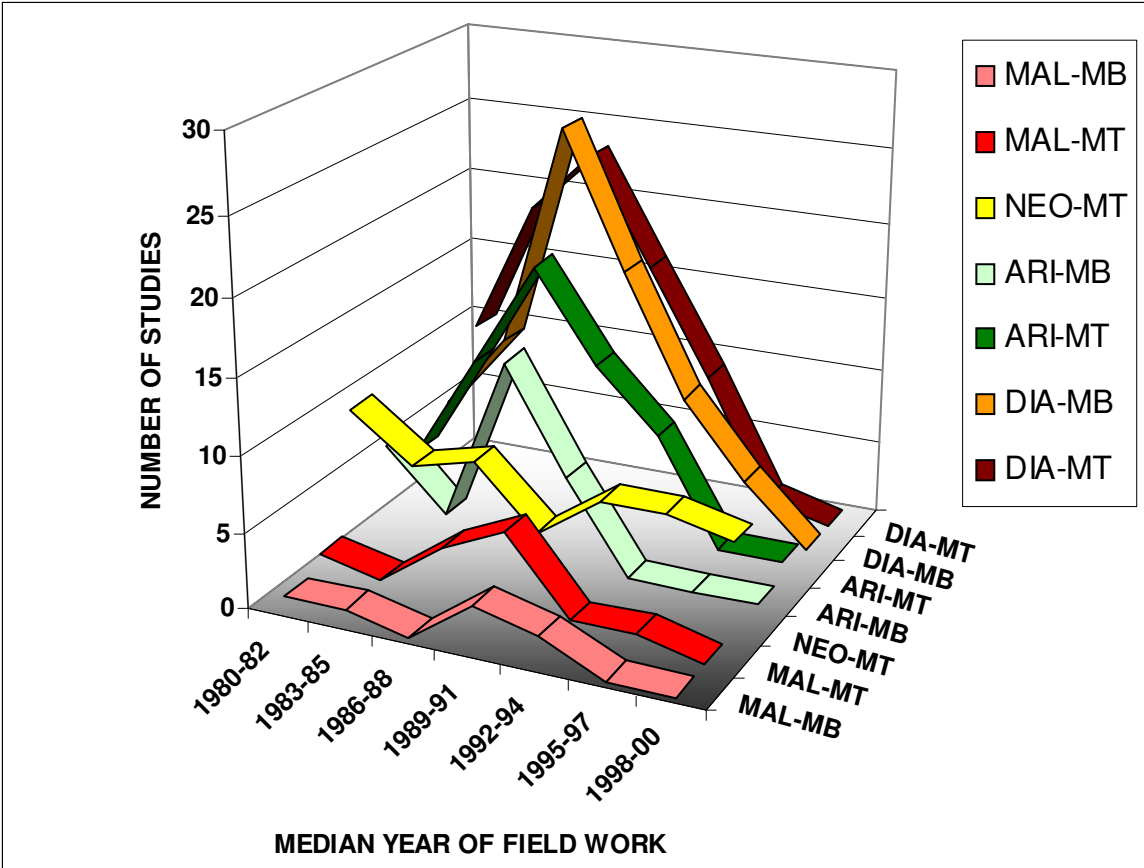
Figure 1: Number of papers with policy-relevant information on epidemiology of specific childhood illnesses in developing countries identified by WHO Child Health Epidemiology Reference Group shows depleting interest in diseases that continue to kill most children (Rudan et al., 2005) (MAL - malaria; NEO - neonatal causes; ARI - acute respiratory infections; DIA - diarrhoea; MB - morbidity; MT – mortality)

Figure 2: A diagram showing the criteria used in setting priorities in global health research investments: the current approaches (left), and the approach proposed by CHNRI (right).

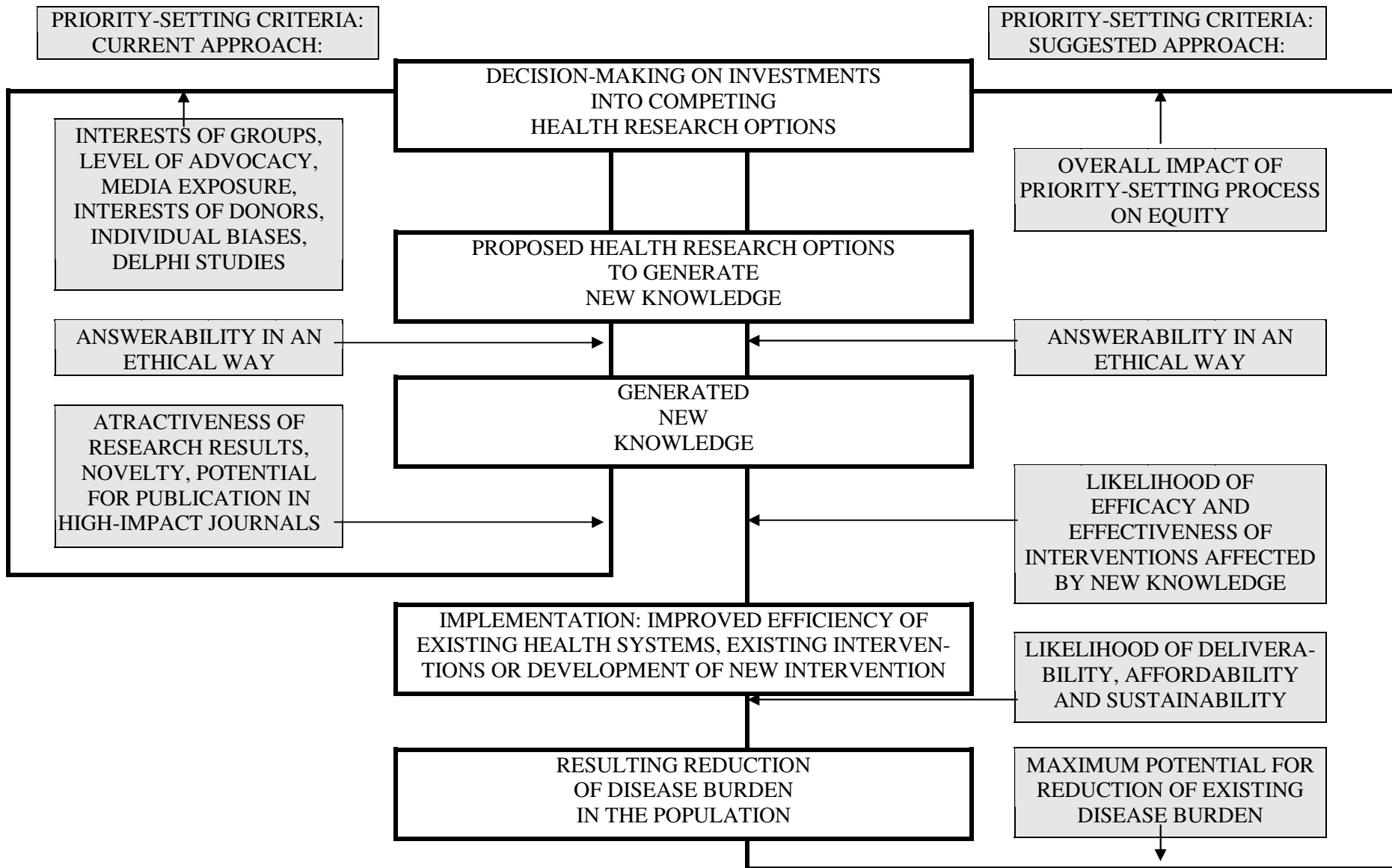
Figure 3: A figure showing all the steps of proposed CHNRI methodology at a glance: gathering a working group of technical experts who are expected to define the context (space, time, population and disease burden addressed); list research options systematically based on potential risk factors, interventions and 3 instruments of health research (IHR); score the competing research options independently and in a highly structured way, according to 5 criteria relevant to priority setting; address the input from stakeholders; and perform program budgeting and marginal analysis, to define the optimal mix of assessed overall value of research for invested funding.

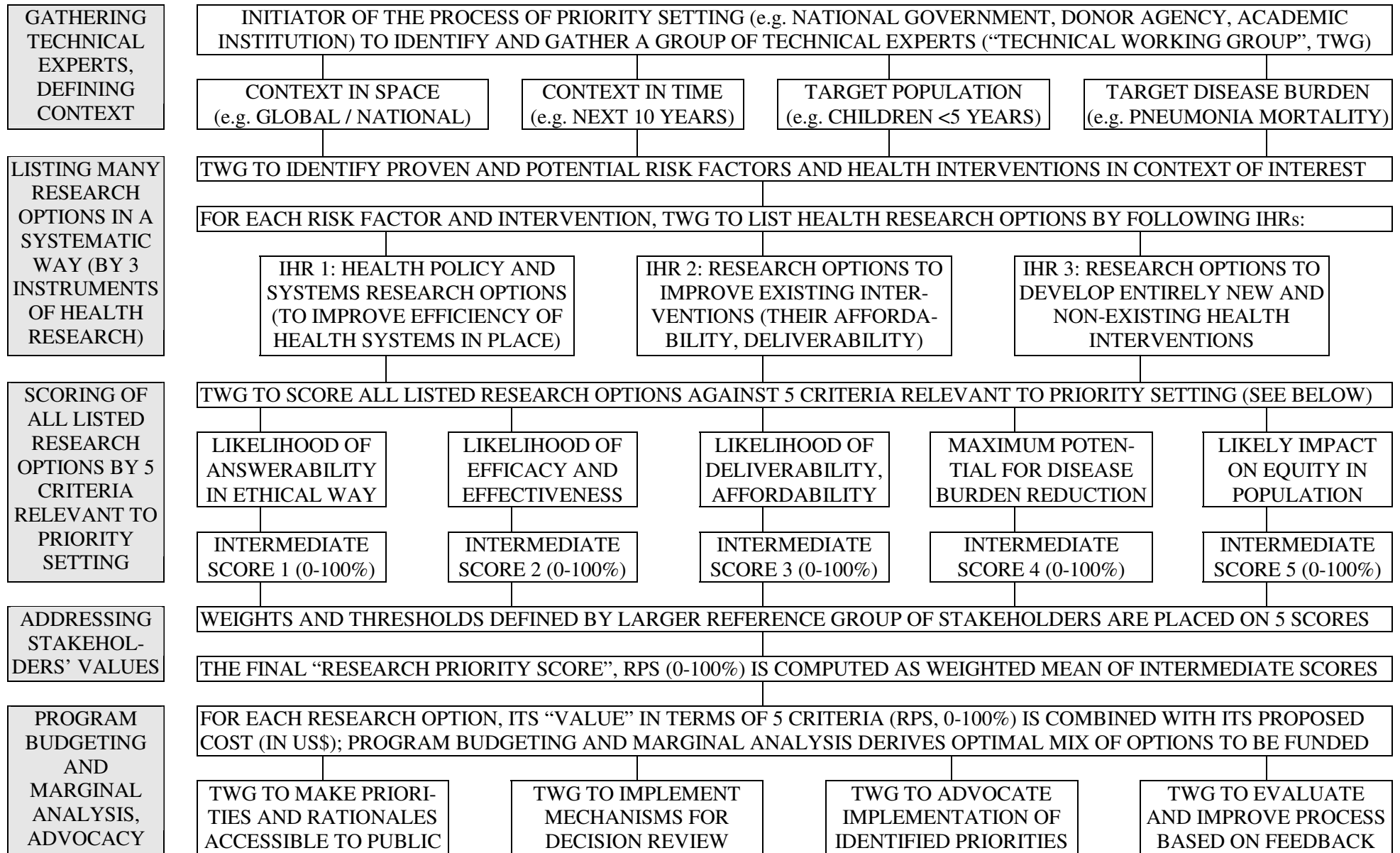
Table 3: Selected results from research priority setting exercise conducted in April 2006 to address South African child health research priorities (covering 7 major causes of child deaths in the country: HIV/AIDS, malnutrition, neonatal problems, diarrhoea, pneumonia, congenital and genetic disorders, accidents and injuries). For each cause of death, 9 research options

were proposed for scoring by local experts (3 for each of the three instrument of health research, IHR). The final research priority scores (RPS) were based on scoring by technical experts and adjusting the scores according to the system of values of 30 members of larger reference group representing the stakeholders in the country. The rankings of 18 research options that addressed childhood pneumonia and diarrhoea are presented.



PRIORITY SETTING IN HEALTH RESEARCH INVESTMENTS TO ACHIEVE UN's
MILLENNIUM DEVELOPMENT GOAL 4 – REDUCING CHILDHOOD MORTALITY BY TWO THIRDS BY 2015





RPS (x100)	Rank	Disease	IHR	Research option
87.8	2/63	Diarrhoea	1	Health policy and systems research to increase hand-washing with soap
87.7	3/63	Pneumonia	1	HPSR to achieve increased usage of antibiotic treatment for pneumonia
84.2	5/63	Diarrhoea	1	HPSR and education/behaviour modification research to increase exclusive breastfeeding in first 6 months
83.5	6/63	Pneumonia	1	HPSR to improve existing ways of training health workers to deliver pneumonia standard case management
83.3	7/63	Diarrhoea	1	HPSR to increase awareness of indications for treatment and access to ORS sachets at all times and sites
80.3	10/63	Diarrhoea	2	Research to reduce costs /improve deliverability and sustainability of piped safe water systems
77.6	12/63	Diarrhoea	2	Research to develop ways of sewage treatment systems affordable to developing countries
75.6	13/63	Pneumonia	1	HPSR to increase zinc supplementation coverage
68.4	24/63	Diarrhoea	3	Low cost no electrical/no fuel consuming refrigerators to storage food at home level
68.3	25/63	Diarrhoea	2	Increasing availability of appropriate complimentary foods
67.5	26/63	Pneumonia	2	Reducing the cost of Hib vaccine
63.0	37/63	Diarrhoea	3	Develop interventions that will reduce bacterial contamination of crops irrigated with contaminated water
61.8	40/63	Pneumonia	2	Developing existing vaccines with needle-free delivery
59.2	41/63	Diarrhoea	3	Developing shigella vaccines
58.0	44/63	Pneumonia	3	Developing RSV vaccine
56.9	47/63	Pneumonia	3	Developing “common protein” pneumococcal vaccine
54.4	52/63	Pneumonia	3	Developing new antibiotics that would overcome bacterial resistance
49.7	59/63	Pneumonia	2	Research to reduce the costs of oxygen therapy and make it more available to the general public