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EDITORIAL

Adapting valid clinical guidelines for use in primary care in low and middle income countries

See article by English *et al* on page 156

Development of evidence-based guidelines suitable for use in resource-poor settings is a challenge for two main reasons. First, most high quality evidence originates from rich countries and may not be relevant or applicable to the needs of low-income countries[1] – and relevant evidence is difficult to retrieve. Second, the development of valid clinical guidelines is expensive, time-consuming, and requires certain expertise.[2] None of these are in abundance in low-income countries.

Adaptation of a current and valid clinical guideline to local circumstances is a solution that mainly addresses the second challenge. Adaptation also promotes local ownership and allows benefit from evidence of less quality but of more relevance to local needs. Despite advances in the methodology of developing new guidelines,[3,4] our knowledge of the validity of the guideline adaptation process is meagre.[5] The ADAPTE is attempting to rectify this situation.[6]

In this issue of the *Primary Care Respiratory Journal*, there is a report of a successful project on the adaptation of an international guideline for respiratory care to district level needs in South Africa (PALSA).[7] It has certain advantages over similar initiatives. One is the deliberate attempt to identify the barriers to good quality care and to address those barriers. The other is the iterative process in which the authors used the target users' feedback to refine the recommendations. Another advantage, missing from many high quality guidelines, is that it formally assessed the effectiveness of the developed guideline in improving quality of care.

The reported process from PALSA is less explicit than what we expect from development of original guidelines.[4] This, in a way, is the result of the immaturity in adaptation methodology as explained above. Using the AGREE instrument for choosing and appraising the original guidelines for adaptation improves explicitness.[8] The AGREE is a validated tool and has been formally translated into 20 languages (available at: http://www.agreetrust.org). It also helps target the adaptation process towards rectifying the limitations of the guideline in terms of methodology and coverage as well as applicability. Appraising original guidelines is an essential phase in any guideline adaptation. As has been shown, even guidelines developed by the WHO may lack certain quality characteristics.[9]

Developing valid evidence-based clinical guidelines is the essential step in improving quality in primary care. However, the move from guideline to improved care is in no way self-evident and smooth. Several interventions have been proposed to facilitate the implementation of guidelines, including educational meetings, audit and feedback, educational outreach, reminder systems, financial incentives, and organisational support. The evidence on the effectiveness of these interventions is patchy and, where evidence exists, not all interventions are effective.[10] Not surprisingly most of the evidence on implementation originates from a few countries with more resources and specific organisational structures.

In this situation, conceptual frameworks may help decision makers to achieve more success in improving quality of care. As part of the 'Study of Adherence to Guidelines and Evidence' we developed a thematic framework for successful implementation of clinical guidelines in primary care.[11] The framework encompasses seven key themes: credibility of content; credibility of source; presentation; influential people; organisational factors; disease characteristics; and dissemination strategy.

One theme (disease characteristics) highlights the important issue that guidelines may not be useful for all clinical problems. Three themes – credibility of content, credibility of source, and presentation – are directly relevant to the development process. Credibility of content is related to the use of evidence, flexibility of recommendations and its consistency. Credibility of source is improved by a multi-disciplinary approach to development, support from national representative organisations, avoiding conflict of interest with pharmaceutical industry, and publishing the guideline in respected sources. Clarity, simplicity and systematic presentation are the main presentational features of a useful guideline.[11]

Other themes are related to the implementation phase. Successful implementation is dependent on the support of key stakeholders (influential people). Influential people involved in the implementation of guidelines in primary care

are not limited to primary care. Addressing organisational factors includes paying attention to important resource issues, organisational structures and practice routines that may hinder implementation. The authors of the PALSA provide an excellent example of meticulous work to overcome organisational barriers.[7] And finally, dissemination strategies are about planning implementation, improving local ownership, targeting perceived needs, and supporting (and sometimes enforcing) implementation.[11]

In reality the development and implementation of clinical guidelines are not separate from each other. If not implemented, guidelines are 'words without action'.[12] Guideline developers and those who attempt to adapt guidelines should attend to implementation from early stages. The UK National Institute for Health and Clinical Excellence now considers implementation as part of its mandate,[13] while at the start NICE was focused mainly on development of valid clinical guidelines.

Improving quality of primary care based on the best current evidence in low and middle income countries is not a luxury. "It is exactly this desperate situation that justifies the need for evidence-based medicine".[14] Health systems in these countries should develop formal processes and structures that support adaptation (and occasionally) development of valid clinical guidelines and promote their implementation.

Conflict of interest declaration

The author has previously worked as a methodological advisor on the development of NICE clinical guidelines. He currently contributes to the design of a national programme of clinical guideline development for the Ministry of Health and Medical Education in Iran.

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