

**From evidence to practice in  
countries where health policy is not  
evidence-based**



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Using evidence in practice and policy.....What is the situation in the developing countries and the Middle East?



❑ No infrastructure for developing evidence-based guidance in Ministries of Health in most of low and middle income countries.

❑ Systematic reviewers are scares and it cost money and time to train more reviewers.

❑ Databases and electronic libraries are available through the WHO for some countries.



- ❑ Most of the work in developing guidance is done by voluntary unpaid groups mostly clinicians.
- ❑ Clinicians are busy and have no time for searching or appraising primary literature.
- ❑ Summaries of guidance will more appealing for use and implementation rather than lengthy conventional guidelines



## Informal consensus GLs.

GLs are based on expert opinion. The guideline documents provide only recommendations and little background on the process by which they were developed.

## Formal consensus GLs

uses a systematic approach to assess expert opinion and to reach agreement on recommendations

## Evidence-based guideline

Links recommendations directly to scientific evidence of effectiveness.

## Explicit guideline

clarifies the rationale by specifying the potential benefits, harms, and costs of available interventions.

➤ The chair of Evidence-Based Health Care and Knowledge Translation (Saudi Arabia), developed a program to incorporate evidence into practice in the King Khalid University Hospital.

➤ The participants in the program are clinicians from departments with high patient turnover such as the emergency and the pediatric departments.



➤ The program is multifaceted and includes:

1. Identification health priority

2. Training in adaptation and summery of guidelines.

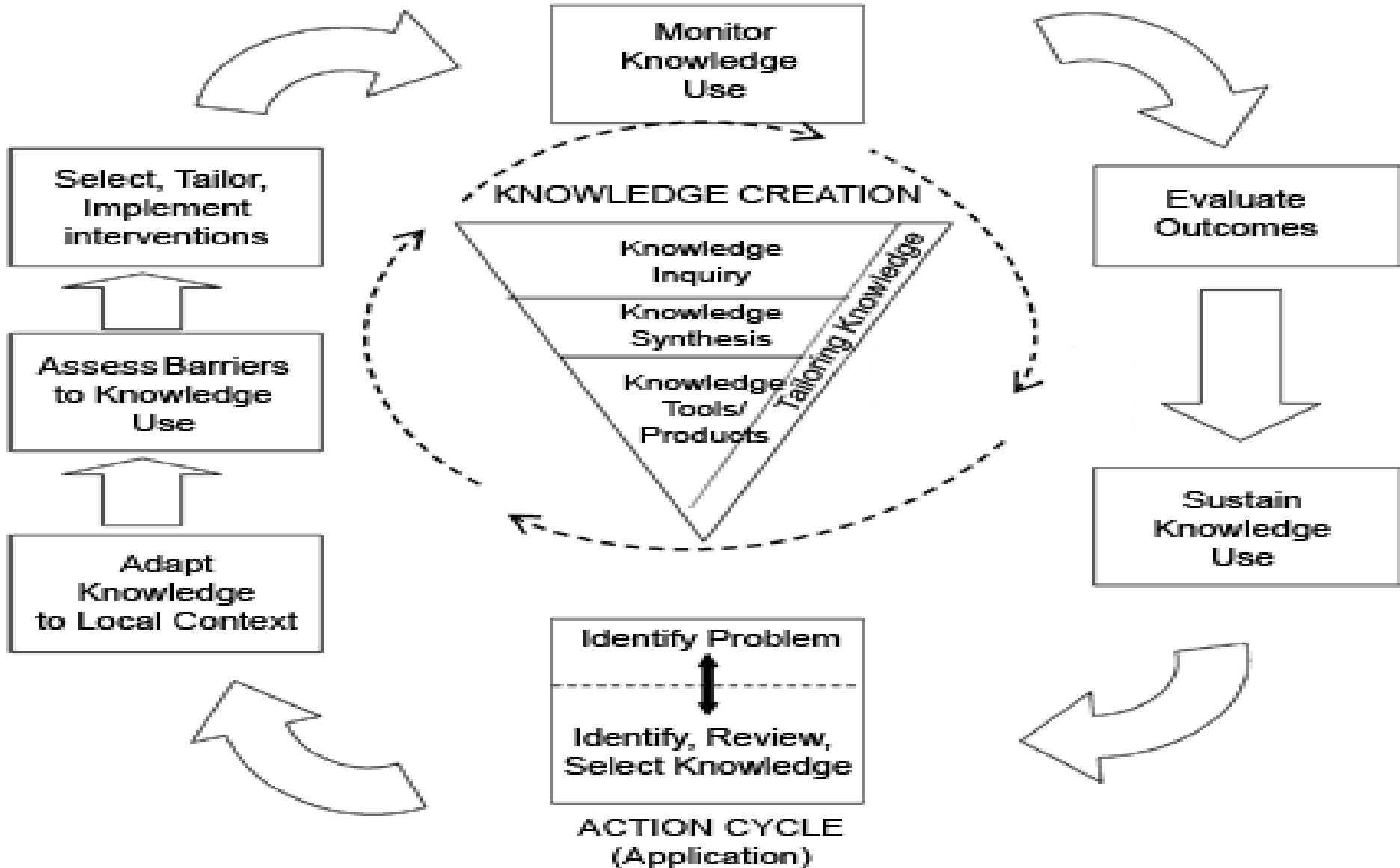
3. Training in implementation and audit of implementation of guidance.

4. Capacity building in knowledge brokering and translation.

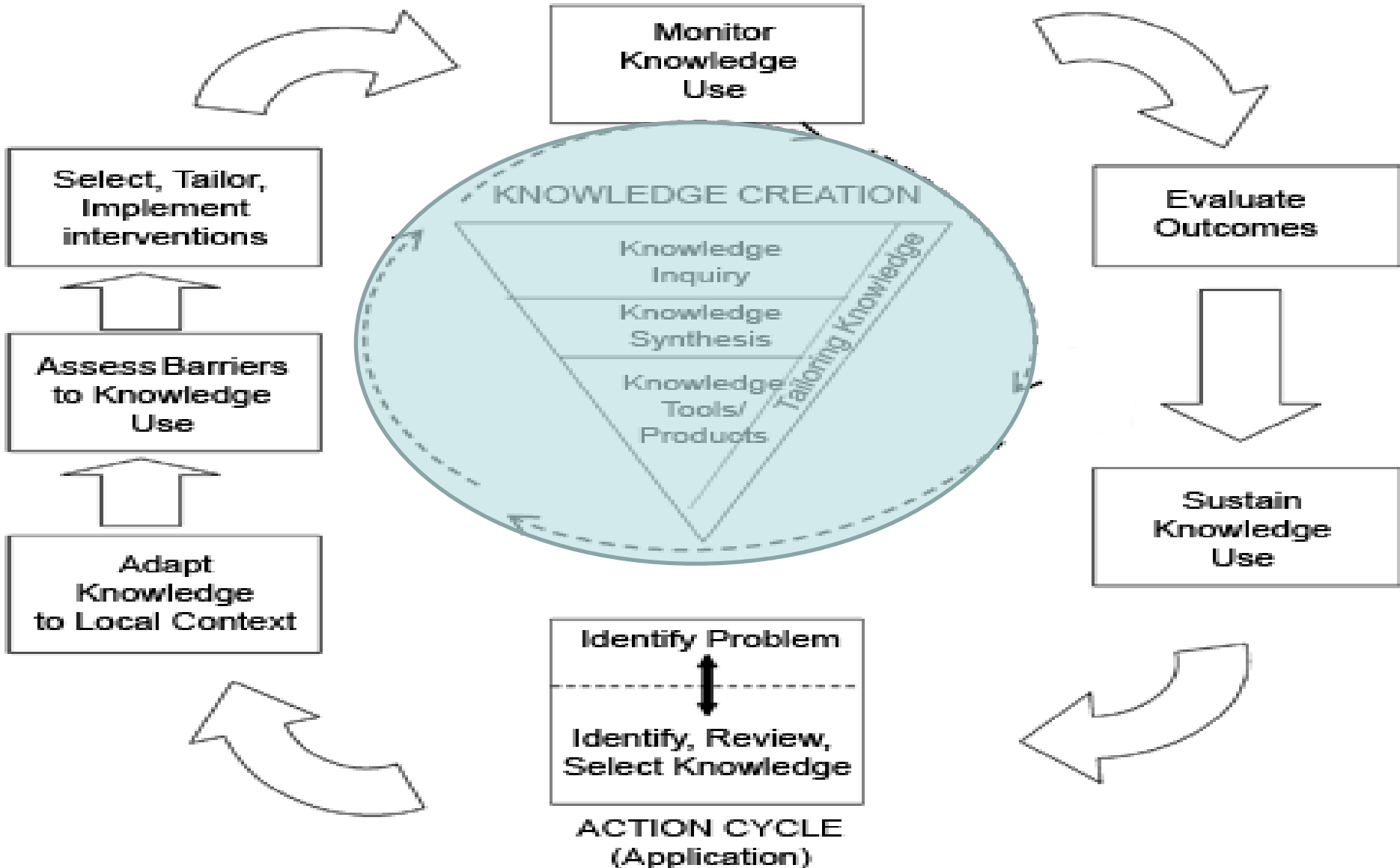




# KNOWLEDGE TO ACTION PROCESS



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# Identification Health Priority

Health priority was defined by the health problem with most frequent visits or admission to the specific department.

The department admission register was used to collect the relevant data



# Training in adaptation and summery of guidelines.

Selection of guidelines for adaptation is from the most frequently cited in the literature.

If no or few citations are found we adapted the guidelines from the National Institute of Health and Clinical Excellence



# Appraisal of the GL using the AGREE Instrument

Representatives of the clinical department had training in using the AGREE instrument and the steps of adaptation of GL, in the form of lectures and tutorials before they started to evaluate the selected GLs.



# Adaptation of the GL

The adaptation team consisted of :

1. Clinicians from all the departments concerned with the care of the specific health condition.
2. A pharmacist
3. Nurses from the concerned departments.
4. A representative from the Chair of EBHC-KT



# Adaptation of the GL

During the adaptation process, the team considered only the availability of resources and technology. Literature review for new evidence was only done for areas of disagreement between the team members.



# Stakeholders And The Draft





# Implementation of GLs

Reminders by hanging algorithms of management on walls at strategic locations in the concerned departments

Producing algorithms for management

Producing protocols and summaries of GLs

Presentation of GLs to the concerned departments during educational meeting



# Quality indicators, audit and Focus group interview



# Knowledge Brokering and Knowledge Translation



You might have wondered about the relationship between guidelines and green peppers...!!!

Well .... there isn't any



**Thank You For  
Your Attention**

