Guidance for Guideline Development in Afghanistan: Conceptual Framework

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Summer 2012
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Conceptual Framework

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FOREWORD

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## Abbreviations

<table>
<thead>
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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ANDS</td>
<td>Afghanistan National Development Strategy</td>
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<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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<td>CT</td>
<td>Computerized Tomography</td>
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<td>CTAP</td>
<td>Civilian Technical Assistance Programme</td>
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<td>DfID</td>
<td>Department for International Development</td>
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<td>EPHS</td>
<td>Essential Package of Health services</td>
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<td>GDCM</td>
<td>General Directorate of Curative Medicine</td>
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<td>GDG</td>
<td>Guideline Development Group</td>
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<td>HSS</td>
<td>Hospital Sector Strategy</td>
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<td>KMU</td>
<td>Kabul Medical University</td>
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<td>MHE</td>
<td>Ministry of Higher Education</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>NGO</td>
<td>Nongovernmental Organisation</td>
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<td>NICE</td>
<td>National Institute of Health and Clinical Excellence</td>
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<tr>
<td>SEHAT</td>
<td>System Enhancement for Health Action in Transition</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. Introduction

This concept note is written for three purposes:

a) To provide a brief baseline assessment of the current clinical guideline practice in hospitals in Afghanistan.

b) To provide an aid to the guideline developers within the Ministry of Public Health (MoPH) in order to develop clinical guidelines for secondary and tertiary level of care in Afghanistan.

c) To suggest the way forward in order to achieve sustainable guideline development in the Ministry of Public Health.

This concept note will not be a comprehensive review of the current state of evidence based guideline practice in Afghanistan nor a detailed guide to the guideline developers in the MoPH. Rather, it has been prepared as a quick response to the needs of clinicians who were recently assigned to develop guidelines for the first time in their career. Although more comprehensive guidelines exist, such as NICE (National Institute of Health and Clinical Excellence) and WHO (World Health Organization) guideline development manuals, due to time and language constraints, it was felt that a shorter guidance on guideline making, in a few pages, would be more practical and useful in their efforts to produce guidelines within their specialties.

On the other hand, this note is prepared with the reality of the situation in Afghanistan in mind. Under the current circumstances, it is impossible to follow some of the steps and processes in guideline development that are practiced in the rest of the world. For example:

a) There is no reliable research evidence available from within Afghanistan to guide recommendations for future guidelines.

b) Clinicians have no access to journals, online resources and the internet which makes literature search impossible.

c) There is a general lack of knowledge and skills amongst clinicians to read research articles and to critically appraise the evidence for use in the guideline.

d) And most importantly, there are no resources, such as office space, computers, printers, secretarial help and financial support yet available at the MoPH to be used by those who are assigned to developing guidelines.
Therefore, the development of guidelines in Afghanistan for the time being will be unique and slightly different from the usual practice.

The practice of guideline development in Afghanistan has unfortunately started with no human and financial resources allocated for this purpose within the ministry. In comparison, other organisations such as the WHO recommend the following with regards to guideline development: “for a standard WHO guideline, … contract a group or individual for preparation of evidence summaries (not systematic reviews), hold a single consultation meeting - pay for writing and editing and a small print run of the final document, please allow at least US$ 100,000. If you do not have this, or are not sure it will be made available - DO NOT START.” (WHO Handbook for guideline development, March 2008). However, here in Kabul, 24 senior clinicians are assigned to perform this very exact assignment with no previous experience, training or financial support whatsoever; in a culture where per diem is the word of the day. Per diem is paid to doctors for attending any training courses even for their own career development by NGOs and donor agencies. The practice of guideline development is not supported by any such incentives as of yet. We are hoping that by the time a draft guideline is ready for publication some financial support will become available, at least for the publication of the guideline and the required training for the implementation phase.
2. Definitions

1.1 Care Pathways
Care pathways determine locally agreed, multidisciplinary practice, based on guidelines and evidence where available, for a specific patient/client group. Care pathways form all or part of the clinical record, document the care given and help to evaluate outcomes for continuous quality monitoring. (National Pathways Association, 1988).

1.2 Clinical Guidelines
Clinical guidelines are systematically developed statements designed to help practitioners and patients decide on appropriate healthcare for specific clinical conditions and/or circumstances. (Field MJ, 1992)

1.3 Policy
In short policy is the art of governance. A policy is a statement of intent, decision, principle or rule, implemented by procedures or plans, in order to achieve the desired outcome. For the purposes of this concept note, “health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: a) it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.” (WHO, www.who.int/topics/health_policy/en/) Policies are usually national policies (not district or provincial) and are not normally limited in time: one does not usually speak in terms of ‘2-year policies’ as one does of ‘2-year programs’ or ‘5-year plans’.

1.4 Protocols
Protocols are rigid statements allowing little or no flexibility or variation. A protocol sets out a precise sequence of activities to be adhered to in the management of a specific clinical condition. There is a logic sequence and precision of listed activities. (Joughin C., 1997)
1.5 Standards
Standards are concise sets of statements designed to drive and measure priority quality improvements within a particular area of care. (NICE, 2009) Standards are written definition, limit, or rule, approved and monitored for compliance by an authoritative agency or professional body as a minimum acceptable benchmark. (Business Dictionary)

1.6 Standard Operation Procedure (SOP)
SOPs are a detailed explanation of how a policy is to be implemented. The SOP may appear on the same form as a policy or it may appear in a separate document. The main difference between a SOP and a policy are details. An effective SOP communicates who will perform the task, what materials are necessary, where the task will take place, when the task shall be performed, and how the person will execute the task. (Lowa State University). SOP sets out the way matters must (i.e. mandatory) or should (i.e. advisory) be performed (Wirral University Teaching Hospital NHS Foundation Trust).

1.7 Strategy
Strategy is derived from the Greek word, strategia, meaning leading the army. It is the art and science of planning to use resources for their most efficient and effective use (Business Dictionary)
3. The Need for Clinical Guidelines in Afghanistan

Clinicians in Afghanistan are in need of clinical guidelines more than any other country in the world. The undergraduate teaching of medicine has not yet recovered from decades of academic disruption due to several decades of war and the postgraduate courses in some specialties are still yet to be developed. There are no Continuous Development Programs (CPD) introduced in the country and access to up-to-date medical knowledge is at best limited in most part of the country. A recent survey by the General Directorate Curative Medicine (GDCM) showed that there are major variations, confusion and controversy amongst clinicians when making a decision about management of illnesses. For example some doctors do not recommend the use of antibiotics for treatment of diarrhea in adults and children while others recommend the combination of three antibiotics simultaneously. There is also an outcry for improving the standards of care in the country to answer the need’s of the public and to reduce the number of people travelling to neighboring countries for better health care. The recent Presidential Decree No. 45 issued on 5.5.1391 (26th August 2012) requires the MoPH to standardize the care provided in hospitals in the next 6 months.

The Strategic Plan 2011-2015 for the MoPH consisted of 10 Core Values and Principle, and 9 Strategic Directions. Some of the Core Values of this Strategic Plan include Right to Healthcare without discrimination of any kind. Partnership and Collaboration of a wide range of stakeholders when taking action on health issues. Evidence based decision making when developing public healthcare policies and programs. Good Quality healthcare programs that are affordable, timely, safe, effective, efficient, and continuously improving. Transparency about how we make decisions, Sustainability of a healthcare system that can, in time, be supported by Afghanistan, both technically and financially. Dignity and respect regardless of gender, age, race, religion, ethnicity, socioeconomic and political status and equity through just and fair access to resources for healthcare. The Strategic Directions further underpin these Core Values with specific objectives to “develop package of services for the tertiary level of care” with specific Priority Interventions that emphasize standardization, regulations and evidence based decision making.

The implementation of Core Values and Principles and the Strategic Directions set out in this document requires the development of robust clinical guidelines. In the absence of
guidelines these values and principles can not only be interpreted differently by different clinicians and managers but will add further confusion and variation to the care provided by different healthcare service providers. The Essential Package of Hospital Services (EPHS) for Afghanistan (2005) also allude to the importance of guidelines in its ‘Dimension of Quality of Care’ where it emphasizes on **accuracy of diagnosis, efficiency and appropriateness of treatment, excellence of standards, continuity and consistency of care** (EPHS, page 14). The EPHS, which is currently under review, further emphasizes that “**standards MUST be established** · · · for both clinical and administrative operations in order to improve clinical and managerial performance” (EPHS 2005, page 11).

In accordance with the above principles and recommendations and in line with the National Strategy For Improving Quality in Health Care 2011-2015, Hospital Sector Strategy 2011 and the growing need for evidence based practice in the country, the General Directorate of Curative Medicine (GDCM) of the Ministry of Public Health (MoPH) who is responsible for the implementation of these policies and health care in Afghanistan, initiated the process of developing treatment protocols and guidelines in the last couple of years.

To begin with, the MoPH requested the Civilian Technical Assistant Programme (CTAP) of the Ministry of Finance to recruit a Treatment Protocol Advisor in 2011. After a series of advertisements on the internet an advisor was finally recruited for this position on the 19th May 2012, to undertake this responsibility.
4. Current Situation

1.1 Human resources
Currently there is no single person or unit at the MoPH responsible for the development and implementation of treatment guidelines or technology appraisals. In the absence of such units, various NGOs and non-governmental institutions have attempted to develop treatment protocols, guidelines and standards of care. However the MoPH is unable to collect these documents, register them on a database and make them available to either practitioners, managers or public for use or implementation. In such a situation it is possible that various organizations will endeavor to develop guidelines on the same topic without the knowledge of each other, and thus a huge waste of human and financial resources. Furthermore, it may introduce further variation and confusion in healthcare provided by various health providers.

1.2 Clinical guideline practice

1.2.1 At Hospital level: A survey of the current practice and the existence of medical guidelines was carried out in 12 hospitals in Kabul and the regional hospital in Herat between? May to June 2012. The questionnaire (see annex 1) was given to Hospital Directors to discuss with Heads of the following Departments: international medicine, surgery, pediatrics, obstetrics and gynecology and mental health services. 58% of Directors responded. Total response was 28. The summary of the responses were as follows:

1.2.1.1 Currently there is no approved treatment guideline in these specialist hospitals. However, 11 out of 28 responders said that they have guidelines present in their hospitals, yet 5 of the 11 did not report the name(s) of the guidelines. 6 of 11 who said that they have guidelines present in their hospitals named “bedside teaching, conferences, Harrison, Current, monographs” and so on as their guidelines. It appears that there is not only a lack of knowledge about the use of guidelines in current clinical practice, but doctors use different textbooks and a variety of resources as a guide when making decisions about patient care. All directors were asked to send a copy of the guidelines with the questionnaire and only one hospital sent copies of
4. Current Situation

guidelines drafted in their hospital. This hospital appeared to be familiar with the practice of guidelines and evidence based practice when answering the questionnaire. 7 out of the 11 who said they had guidelines present in their hospitals, were “absolutely sure” that their clinicians use guidelines when making decision about their patients care while 7 out of the 11 were sure “to a certain extent”. When asked about the use of implementation tools 4 out of 11 did not respond but the remaining 7 named “curriculum, conferences, needles, syringes, NG tube, Folly catheter, ultrasound etc…” as their implementation tools. This questionnaire revealed the lack of awareness amongst some clinicians about the practice of guidelines and their implementation tools. When asked about the audit of the guidelines, 7 out of 11 said that the use of guidelines was audited in their hospitals but no comment was made on the method or the results. 8 out of 11 said that there was a unit functioning in their hospital who monitors compliance to the guidelines but various departments like the specialization department of the MoPH and even John Hopkins University was named as their guideline monitoring unit, which may not be the case.

1.2.1.2 The 12 who responded that they had no guidelines available to them suggested the creation of a “national committee” comprising of the heads of departments, specialists and Afghan doctors who are trained abroad to develop guidelines that can be used in all hospitals to standardize medical treatment at all levels. They also suggested to use “international guidelines as a guide” when making guidelines.

1.2.1.3 However, the Reproductive Health Department of the GDCM(full name required) had started the process of developing clinical guidelines about a year ago and drafted 24 guidelines in obstetrics. These guidelines were sent to the WHO for review. The list of the topics is reported in Annex 2.

1.2.1.4 In the comments box of the survey questionnaire, the majority of respondents were pleased and indeed thankful to the GDCM who initiated this process. The most common comment noticed was that the use of clinical guidelines will not only standardize treatment in various hospitals but will raise
the capacity of professionals as well. They also suggested that those who take part in the development guideline should receive some kind of incentive.

1.2.1.5 The clinical guideline topics that were suggested by the responders are broad but topics such as emergency medicine e.g. poisoning, diarrhea in children and adults, cardiac diseases, and surgical traumas were mentioned frequently.

1.2.2 At the primary health care level: An NGO, The Management Sciences for Health (MSH), had been commissioned to develop clinical guidelines for management of medical conditions at the primary health care level. A committee compromised of specialists from different fields meets regularly and has drafted brief guidelines on 124 topics for primary health centers. These guidelines are still under consultations with various stakeholders and yet to be approved by various committees at the MoPH before it is ready for publication.


1.2.4 Work has recently been started on an Intensive Care Unit (ICU) funded by the House of Parliament of Afghanistan and as part of this project a guideline on ICU is under development by an advisor in this project.
5. The establishment of guideline development groups in the Ministry of Public Health

The first consultation with the directors of Kabul hospitals took place on 22nd May 2012 at the MoPH, to discuss the priorities and topics for guideline development. It was decided to create groups of expert professionals in the following branches of medicine, to develop clinical practice guidelines:

- Internal medicine,
- Surgery,
- Pediatrics,
- Obstetrics and Gynecology
- Psychiatry

The directors of 12 general and specialist hospitals in Kabul were asked to nominate experts in these specialties, with a specific criteria, to form clinical guideline development groups (GDG). The criteria specified in the request letter were:

- To be an specialist in his/her field,
- Preferably to be heads of the departments
- To have at least 3 years experience in the field of their specialty
- To have knowledge of teaching, training and clinical supervision
- To work voluntarily with another members
- To be flexible.

The first large group meeting of guideline developers took place on the 1st July 2012 in the GDCM office where 24 professionals attended. In this meeting it was decided that the obstetrics and gynecology group who were formed a year ago and were in the middle of their work, to continue on their work without disruption but can have the support of the advisor of the GDCM if needed. Each small group subsequently selected their group leaders, deputy group leaders, secretaries, coordinators, researchers and the venue for their subsequent meetings.
6. Objectives in Developing Clinical Guidelines

- To reduce controversy, confusion and unnecessary variation in practice amongst clinicians.

- To translate the values and principles set out in the MoPH Strategic Plan into reality and practice.

- To enable clinicians to provide quality healthcare services to all of our service users without any kind of financial, racial, language and gender discrimination or depend on geographical location- main cities or remote villages in Afghanistan.

- To improve the quality of healthcare according to the resources set out in the BPHS and EPHS.

- To develop a common language and transparency between clinicians, healthcare providers and the public, in the care they provide and receive.

- To update clinicians with knowledge and skills of Evidence Based Practice, in the absence of Continuous Professional Development (CPD) programmes in Afghanistan.

- To support the “fully functional national referral system” as it is set out in the Hospital Sector Strategy, MoPH, 2011 (page 17)
7. Clinical Guideline Development Process

The five areas of medicine in which to develop guideline are identified by the GDCM of the MoPH.

Guideline Development Groups are formed.

The terms of reference of each group and timeframe agreed upon.

The guideline topics are identified by consensus of the experts in the group.

The scope of guideline is defined.

Stakeholders are identified and consulted about the proposed guideline.

Evidence is gathered, formulated and presented to the group.

Guideline is drafted.

Guideline is peer reviewed by experts and policy makers at the MoPH.

Stakeholders are consulted (for a period of 4 weeks) and their comments are looked upon by the group if they are received within 4 weeks.

Guideline is checked for factual errors.

Guideline is sent to the MoPH authorities for approval.

Final product is published.

Guideline is launched in a national conference.
8. AFTER PUBLICATION

- Implementation support tools are developed in the form of lectures, workshops, slide sets (power point presentations), flow charts, care pathways, checklists etc.

- Clinicians and managers are trained (training part needs to be elaborated further).

- Standards of care are developed from the guideline.

- Clinical audit tools are developed to compare the practice with the standards introduced and in the mean time to monitor the compliance of clinicians and hospitals with guidelines.

- Guidelines are reviewed regularly to include new evidence, policies, experience and correcting errors.

- Guidelines may need to be partially or fully updated.
Key stages of guideline development

1. The MoPH instruct the development of Guideline
2. Guideline Development Group is formed
3. The GDG decides on the Topic by the consensus
4. Stakeholders identified and consulted
5. The scope is decide upon
6. Literature search is carried out
7. Guideline is drafted
8. Consultation with stakeholders and reference group is carried out
9. Prepublication check is carried out
10. Publication
11. Implementation tools are standards are made
12. Clinicians and managers are trained
13. Compliance to guideline is audited
14. Guideline is periodically updated
9. THE SCOPE OF THE GUIDELINE

The scope of the guideline defines exactly what the guideline will and will not include in terms of patients’ age, types of disease, level of care (primary, secondary or tertiary) and the aspect of treatment it will cover. This process is called ‘scoping’. For further information on how to scope a guideline read ‘WHO Handbook for Developing Guideline’, March 2008, page 7, ‘How NICE clinical guidelines are developed’, 2009, page 24-27 and ‘NICE Guideline Manual’, page 20-28, which will be made available to all guideline developers either electronically or in print.
10. The Structure of the Guideline (Guideline Template)

The structure of guidelines differs according to the topic and scope it covers, but generally it should contain the following sections:

10.1 The title of the guideline in the front cover along with the code for the guideline and date of development/printing.

10.2 Forward by the MoPH

10.3 List of guideline development members and acknowledgement

10.4 Abbreviations if necessary

10.5 Content

10.6 Glossary of terms if needed

10.7 Introduction: a short introduction explaining

- The Scope of the guideline.
- Why this particular guideline is needed in our country, for whom the guideline is intended for
- The key questions that it intends to answer
- How the guideline was developed
- The expected outcome from the implementation of the guideline.

10.8 Recommendations: this is the main body of the guideline and its content will differ according to the title and scope it covers. This part may contain important recommendation boxes, algorithms, flow charts, pictures. This part may contain various subtitles. The following subtitles are recommended as a general guide but guideline developers will have the freedom to include or exclude any of these subtitles:

- The key recommendations
- Care pathways for easy flow of patient management
- Criteria for diagnosis
- Investigation
- Examinations
- Risk assessment and risk management
• Treatment or intervention
• Community or outpatient follow up
• Referral to other disciplines or hospitals
• Preventive measures.

10.9 References: the reference for recommendations and the names of guidelines reviewed in preparation for the guideline

10.10 Index

10.11 Appendices if any.

**Good Clinical Guidelines should be:**

- Valid: leading to results expected of them.
- Reproducible: if using the same evidence, other guideline groups would come to the same conclusion.
- Cost-effective: reducing the inappropriate use of resources.
- Representative/multidisciplinary: by involving key groups and their interests.
- Clinically applicable: patient populations affected should be unambiguously defined.
- Flexible: by identifying the exceptions relating to recommendations as well as patient preferences.
- Clear: unambiguous language, which is readily understood by clinicians and patients, should be used.
- Reviewable: the date and process of review should be stated.
- Amenable to clinical audit: the guidelines should be capable of transition into explicit audit criteria.

11. TERMS OF REFERENCE OF GUIDELINE DEVELOPMENT GROUPS

Group Membership:

All guideline developers need to fulfill the following criteria:

- To be a specialist in the field of his/her work and preferably a trainer or policy maker.
- Trainee representative and individual enthusiastic trainees with good command of English language and computer skills are also welcomed but should not exceed more than two in each group.
- All guideline developers need to have at least 3 years of clinical and/or teaching experience in the field they work and represent.
- To have an interest in academic work and be committed to the task given.
- Attend at least 90% of the meetings to benefit from the credits and rewards at the end of the assignment.
- All group members are required to sign a confidentiality form.
- To have the time, willingness and commitment to search for evidence and guidelines from other countries and present their findings in a specific formulation to the group.
- To be flexible, have excellent team working and communication skills.
- To be familiar with the MoPH documentations and strategies.
- To utilize his/her knowledge, experience and skills for the best interest of the patients and not to act as a representative of their professional bodies or institution.
12. Roles and Responsibilities of Guideline Development Groups

- The groups to be as multidisciplinary as possible in the current situation in Kabul.
- Groups are made up of 6-10 healthcare professionals whose specialty is covered by the guideline. The groups may invite experts and clinical advisors from MoPH, MHE, KMU, WHO, NGOs, and private sector when advice is needed on specific topics or issues.
- Representative of pharmaceutical companies can attend the meetings when invited for consultation but cannot be permanent members of the group to avoid conflict of interest. They can submit their views and inputs in writing to the group as important stakeholders in the development of guidelines.
- Groups will decide on the topics and scope of guidelines to be developed early on in their formation. Criteria to be considered when making decisions about the topics are high burden of disease, morbidity and mortality, controversy and variation in treatment amongst clinicians, particularly about the use of drugs and medical equipment (e.g. CT or MRI scan) for investigation.
- Each group will select their own leader/chair, deputy leader, secretary and coordinator in their first meeting. The leader will hold the group together, chair the meetings of the group and keep a register of the members’ attendance. The registration needs to be passed to the GDCM after each meeting. Selection of the Chair is a key to the function and success of the group. Chairs with strong views and opinion may personalize the guideline. The group may function better if the Chair is a good facilitator, communicator, and is aware of all stages of a patient’s journey and leads by example.
- All group members will be involved in all parts of the process including writing the draft of the guideline.
- Each group should develop one clinical guideline, implementation tool and training material in the first three to four months of their formation and at least three clinical guidelines in the first year.
Due to urgent needs of the country for clinical guidelines and growing demand for better health care by the public, groups will meet 2 days a week initially to produce the deliverables quickly and may reduce their working time to at least once a week after three months.
13. How to Make Clinical Guideline Development and Practice Sustainable in Afghanistan?

Our experience so far in developing guideline development groups in the MoPH shows that in order to make the practice of guideline development successful and sustainable at a national level, a core team at the MoPH is needed on permanent basis to take the responsibility for the following: creating and leading the guideline development groups, compiling/formulating the inputs/recommendations of each group, reviewing documents, drafting the guidelines, consulting with the public and stakeholders, publishing guidelines, monitoring their implementation process/compliance and organizing the review(update) of the guidelines. This suggestion is well aligned with the Strategic Plan (2011-2013) for the MoPH, Strategic Direction on Strengthening Human Resources Management and Development, Strategic Objective 1 (S-1): “To develop new categories of health workers and increase the size of the workforce in each major skill category” which itself stems from one of the core elements of Afghanistan National Development Strategy (ANDS), which requires the MoPH to “Facilitate Human Resource Development”. (Strategic Plan 2011-2015, Page 25-26)

The other benefit of a novel guideline development centre will be that with such an identity, the MoPH can build relationships with similar organizations around the world, for instance the National Institute of Health and Clinical Excellence (NICE) in the UK for mutual support and coordination. This relationship, of course, can be implemented after an agreement or Memorandum of Understanding (MoU) is signed between the two organizations. The NICE have worldwide experience in guideline development, in developed and developing countries, and are already supporting China, India and Thailand in Asia and African countries with UK government financial support-Department for International Aid (Dfid). Afghanistan could potentially be part of this international initiative. This relationship will not only give Afghanistan an opportunity to train our guideline developers in one of the NICE centers, either in the UK or in the neighboring countries in the future but also to receive technical support of the NICE International for guideline development. A proposal for this purpose needs to be submitted to the health donors.
The creation of this office in the next year (2013/1393) will also be the best way of using the time of the current Treatment Protocol Advisor who is recruited by CTAP for the MoPH, to transfer knowledge and experience to new counterparts that are recruited solely for this purpose. This will ensure that after the advisor has left, the local partner can continue the same programme on a permanent basis. The office can be a subunit of the Curative Medicine Directorate in the short term. But, in the long term it would be better if it is developed as an independent directorate of MoPH or an independent institution- Clinical Guideline Development Centre;

At the moment, unfortunately, there is not a single unit or person at the MoPH to collect and register clinical guidelines developed by various NGOs and institutions. Therefore, it is possible that more than one organization is attempting to develop the same guideline without the knowledge of each other. The creation of a new central department at the MoPH will not only allow to develop a database of guidelines, treatment protocols and standards but will avoid duplication of work and waste of time and resources.

It is recommended that the centre, initially, consist of the following staff in the Tashkeel (organizational chart) of the MoPH for the coming year (1392/2013):

a) A director
b) A deputy director
c) A Secretary
d) A database officer/IT specialist
e) Two researchers
f) A driver?
g) A porter/cleaner?

Job descriptions and salaries for these posts need to be developed after further discussion with the Curative Medicine, Human Resources and Finance and Admin Departments of the MoPH. It is worth reiterating that the development of such a centre and the cost of it are included in the System Enhancement for Health Action in Transition (SEHAT) 2013 – 2018 project of the MoPH. It is going to be submitted to the USAID and World Bank for funding. The first part of proposal is reproduces in Annex 2.
پرسشنامه‌ی ارزیابی از وضعیت فعالی رهتمود‌های درمانی در شفاخانه‌های افغانستان:

از دقت و وقتی که در خانه پری این پرسشنامه به واسطه رسانه‌های فیل، تشکر می‌گویم.

1- لطفاً بفرمائید که شفاخانه‌ی شما دارای کدام رشته‌های تخصصی است؟ لطفاً نام بگیرید.

2- آیا بیمارانی که با عین مشکل یا تشخیص به شفاخانه‌ی شما مراجعه می‌کنند به صورت معیاری و نا-حدی طور یکسان از خدمات طبی شما بهره می‌برند؟

(انجام نمی‌شود)

3- آیا عرض مراقبت و تداوی بیماران تا ان شفاخانه رهتمود‌های درمانی (Treatment Guidelines و Standard) یا معیار وجود دارد؟

(انجام نمی‌شود)

4- در صورتی که جواب تان بله باشد لطفاً عنوان رهتمود‌ها و معیارها را همراه با تاریخ های تدوین آنها در اینجا لست نموده و یک کانال آنرا ضمیمه یا این پرسشنامه بپیام‌های عمومی طب معالجوی بفرستید.

5- آیا پرسونل صحتی تان در زمان عرضه خدمات صحتی از این رهتمود‌ها استفاده می‌کند؟

(انجام نمی‌شود)

6- در صورتیکه جواب شما بله باشد تا چه اندکی مطمئن‌تر بررسی قبیل شایسته تا ان در زمان تصمیم گیری تداوی از این رهتمود‌ها استفاده می‌کنند؟

(انجام نمی‌شود)
7- آیا از کارآمد وسیله ی تطبیق كننده (Implementation Tool) غرض اموزش كارمندان تان و استفاده ی مؤثر از رهنمودها در شفاخانه ی تان استفاده می کنید؟ لطفا نام بگیرید.

8- آیا از تطبیق رهنمودها تا کنون کدام ارزیابی، خصوصاً، صورت گرفته است؟

9- اگر جواب شما بله باشد پرسونل مسلکی صحی تان که از این رهنمودها استفاده می کنند، تا چه اندازه آنها را مؤثر و قابل استفاده میدانند؟

10- برای آخرين بار چه زمانی این رهنمود باز نگری و تجدید نظر شده است؟

11- آیا فکر می کنید که رهنمود های موجود در شفاخانه ی شما ضرورت به بازنگری و تجدید نظر دارد؟

12- در صورتی که جواب شما بله باشد، این باز نگری چگونه می تواند صورت بگیرد و این وظیفه را چه کسی و یا کسانی به عهده خواهد داشت؟ لطفاً توضیح دهید.
13- آیا واحدهایی که از تطبیق رهنمود های عرضه ی خدمات صحت در شفافیت ی شما حمایت و نظارت نماید وجود دارد؟

بله    نه  

14- در صورتیکه جواب تان بله باشد، لطفاً نام این واحد را بنویسید.

15- هرچند بار این واحدها غرض بهبود و نظارت بر تطبیق رهنمود های درمانی جلسه میکنند؟

ماه یکبار    فصل یکبار    سال دوبار    هیچ

لطفاً نام اعضای این رادارینجازالست نموده و یادداشت های جلسات را اگر در دسترس داشته باشید به این پرسشنامه ضمیمه نمایید.

16- در صورتیکه جواب تان به سوال سوم (۳) نی باشد، آیا ضرورت به موجودیت رهنمود های درمانی را در شفافیت ی تان احساس می کنید؟

بله    نه  

17- در صورتیکه جواب تان بله باشد چطور میتوان این رهنمود ها را تدوین کرد؟ لطفاً توضیح دهید.
18- اگر بخواهید رهنمودی را بسازید، در مرحله اول به کدام رهنمود و برای تداوی کدام مرض (امراض) نیاز مبرم و ضروری احساس می‌کنید؟ لطفاً به ترتیب اهمیت آن نام بگیرید.

در بخش داخله

1-  
2-  
3-  

در بخش جراحی

1-  
2-  
3-  

در بخش ولادی و نسائی

1-  
2-  
3-  

در بخش اطفال

1-  
2-  
3-  

در بخش صحت روان

1-  
2-  
3-  

و غیره

1-  
2-  

وزارت صحت عامه در نظر دارد کمیته هایی را برای تدوین و تطبیق یک تعداد رهنمود ها در آینده ی نزدیک ایجاد کند. از ریاست محترم شما تا گنبدی را که از دکتران و استادان با تجربه ی تان را همراه با شماره های تماس کمربندی برای برقراری اشتباه در این پروژه مهم می‌باشد در رشته‌های این رشته به مبتنی بر ریاست عمومی طب معلق کند. معرفی نمایید.

1- 

2- 

3- 

20- اگر به این ارتباط پیشنهادی و یا تبصره ی داشته باشید لطفاً آنرا انجام مشابه بسپارید.

از زحمت تان در تکمیل این پرسشنامه یکبار دیگر تشکر می‌کنیم.
ANNEX 2

System Enhancement for Health Action in Transition (SEHAT) 2013 - 2018
Clinical Guideline Development Project

The MoPH has continuously emphasized on improving the quality of health care in the country, enhancing the (professional) capacity of healthcare providers, and developing treatment guidelines, standards and protocols in the documents produced since 2003. In the most recent documents, such as Strategic Plan 2011-2015, these issues have been highlighted again as the main priority of MoPH. However, the focus has so far been on improving primary health care services and expanding the health care coverage in the country. Now that the MoPH has been, to a certain extent, successful in this area, attention has been directed towards improving hospital services and the quality of treatments provided at secondary and tertiary levels.

Making an accurate diagnosis and planning a comprehensive and evidence based management plan are key to achieving the above objectives. Afghanistan has seen many years of turmoil and unrest which have left most clinicians detached from current medical knowledge, skills and health policies developed in the rest of the world during this time. The best way to quickly update doctors and allied health professionals in their professions in Afghanistan today is to provide them with up-to-date diagnostic and treatment guidelines that are based on best evidence available, their own expertise and the Afghan people’s values and interests.

However, unfortunately no such body of an organization exists in the MoPH to develop national clinical guidelines, treatment standards, train clinicians in implementing guidelines and monitoring the use of this process. In the absence of a central body of organization in the MoPH various hospitals, whether public or private, institutions and NGOs are currently attempting to develop clinical guidelines and standards. Unfortunately, there is not even an office or database in the MoPH to register the guidelines developed by various institutions in the country to find out who is doing what.

Furthermore, in the absence of a central database and accepted treatment guidelines approved by policy makers at the MoPH, there are huge variations in the health care provided
for the same condition by various clinicians in various part of the country or even in the same hospitals. In a survey of 12 hospitals in Kabul and heart, that is currently underway, the initial responses show that doctors use various textbooks, mostly old editions, and even their old notes from medical schools as a guide when deciding how to treat their patients (results of the survey will be available soon). Secondly, it is possible that more than one institution are developing the same guidelines concurrently at a huge cost to the government or donor agencies, which results in unnecessary duplication of work and further variation in the health care offered. Finally, in the absence of a central body of organization in the MoPH to overview treatment guidelines it will be impossible to monitor validity, importance, usefulness and cost effectiveness of clinical guidelines developed by various public or private hospitals and NGOs. Medical education and postgraduate training in various parts of the country is also not standardized. Therefore, it is very likely that those who graduate from various medical schools; mostly junior doctors who run outpatient clinics and wards, in most cases with no direct support or supervision from a senior doctor or mentor, will put patient’s lives at risk due to a lack of experience, knowledge, skills and direction. Clinical guidelines, technology appraisals, diagnostic and treatment algorithms or protocols will be the only tools that can help doctors to make better decision when caring for their patients, whether in a busy hospital or in a remote area of the country alone if they had access to one.

Being aware of these difficulties, the General Directorate of Curative Medicine has just started the initiative of gathering a list of guidelines developed both for BPHS and EPHS levels and created groups of experts in the fields of internal medicine, surgery, obstetrics and gynecology, paediatrics, emergency medicine and mental health to start developing treatment guidelines in these areas. The Guideline Development Groups have just been formed and will start finding the best research evidence, consulting with experts in the field and other stakeholders in order to produce evidence based treatment guidelines for the first time in the country. During this initiative, we came across a number of challenges that need to be attended to in order to facilitate the process of developing treatment guidelines. These challenges are as follows:

A) Lack of office space and equipment such as office furniture, printers, photocopier, telephone and internet access.
B) Absence of a central office, database or even a single person to co-ordinate, collect and register guidelines under development or being developed in the country.

C) Shortage of human resources such as office clerks, IT technicians and secretaries with fast typing skills in national and English languages.

D) Financial means to support the process.

Suggestions
To support the current initiative of the General Directorate of Curative Medicine of the MoPH to develop a number of treatment guidelines and make the use of guidelines feasible and effective, and in order to improve the quality of healthcare provided by the MoPH , the following suggestions need to be included in the SEHAT project:

1. To develop a resource centre at the MoPH or outside the ministry building with enough space to accommodate the meetings of Treatment Guideline Development Groups with a couple of small rooms and a larger meeting/training room. This resource centre should be equipped with furniture, computers, printers, and telephone and internet connections. This centre can be used as ‘hot desks’ for guideline developers and other policy makers in the MoPH and related hospital.

2. To develop a database or a web tool in order to register the guidelines developed in the country.

3. To develop either a separate website to publish the guidelines, technology appraisals, standards and implementation tools for easier access to doctors and the public to these materials, or the information to be uploaded on the MoPH website.

4. To allocate a budget for the training of guideline developers in the areas of: researching evidence online, understanding research methods and statistics, critically appraising research articles and writing evidence based guideline.

5. To make finances available for the publication of guidelines, implementation tools and related training materials.

6. To allocate a budget for the expenses of guideline developers; such as transport costs, refreshment and stationary.
7. A budget for a field trip for guideline developers (up to 20) to an appropriate neighboring country or further away in order to exchange information and better observe these various stages of guideline development and implementation.

8. To budget for recruitment of foreign consultants if needed in the areas of medical practice where there is no expert in the country.

9. Budget for first hand or primary research and audit in the country where the guideline developers feel they need to develop or gather evidence.

10. Budget for paying membership of important journals and websites in the areas of research and clinical guidance.

11. Budget for the training of doctors, nurses, midwives, clinical psychologists, occupational therapists, social workers, policy makers and mangers and other allied medical professionals in various parts of the country in order to make guideline implementations, monitoring and audit cycles feasible and fruitful.

12. A budget to carry out patient satisfaction surveys and studies whether the introduction of guidelines are useful and improve the quality of their lives.

13. Finally, to have finances available to recruit experts and guideline developers in various fields of clinical care to continuously update guidelines and design training courses in various hospitals in the country.

The MoPH in various documents, especially in the Strategic Plan 2011 – 2015, recommends Continuous Professional Development (CPD) of clinical staff which can be included in this project at the present moment and will further enhance the capacity of clinicians at all levels of postgraduate training and beyond.
1. Basic Package of Healthcare Services, MoPH, Afghanistan, 2010
8. Iowa State University, Food Safety, http://www.extension.iastate.edu/foodsafety/toolkit/communication/OverviewofSOPs.pdf
12. National Strategy for Improving Quality of Health Care in Afghanistan, Improving Quality in Health Care Unit, General Directorate of Curative Medicine, Ministry of Public Health, Afghanistan
16. The Essential Package of Hospital Services for Afghanistan 2005 (1384).
   http://www.businessdictionary.com/definition/strategy.html#ixzz2JlkRzVKc
• "Right to Health without discrimination of any kind; Partnership and Collaboration with a wide range of stakeholders when taking action on health issues; evidence based decision making when developing public health policies and programs; quality of health programs that are appropriate, affordable, available and timely, safe and consistent, effective and efficient, and continuously improving; transparency about how we make decision; Sustainability of a health system that can, in time, be supported by our own people, both technically and financially; dignity and respect regardless of gender, age, race, religion, ethnicity and socioeconomic and political status and equity through just and fair access to resources for health" are some of our Core Values at the Ministry of Public Health.

• Our specific objectives are to "develop package of services for the tertiary level of care …" with specific Priority Interventions that emphasize “standardization, regulations and evidence based decision making…”.

The Strategic Plan 2011-2015,
Ministry of Public Health, Afghanistan

How to obtain this guideline

This guideline is going to be uploaded in the Ministry of Public Health website. You can download this guideline from: www.moph.gov.af/CG001

If you would like to order a hard copy of this guideline please write to:

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