SHORT COMMUNICATION

Getting Evidence into Practice in Pakistan

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In Pakistan, 11.5 US $ are spent per year on providing health care per capita which is only one-sixth of what an average developing country spends in this sector.1 Limited financial resources make it even more vital to spend this on the most cost-effective treatments to obtain best value for money. Clinicians generally work in good faith, but if they provide ineffective treatments, they may be responsible for causing more harm to their patients and exacerbating the effects of poverty in the society.2 On the other hand, providing cost-effective treatments can help in saving more lives. According to one estimate, if interventions of proven clinical and cost-effectiveness are provided in care for babies and mothers, upto 70% neonatal deaths could be prevented in a developing country like Pakistan.3

Getting evidence into practice is by no means straightforward. However, a number of interventions including educational initiatives have been found useful in other parts of the world. Recent efforts to influence practice through training clinicians in appraisal skills in Pakistan are commendable.4 However, it is near impossible for busy clinicians, often working in both the public and private sector, seeing between 50 and 100 patients a day, to keep themselves up-to-date with all relevant evidence. Many clinicians rely on information provided by pharmaceutical companies regarding recent advances in medicines. According to one survey in Pakistan, 78% of primary care physicians rely on information provided by drug companies as the main source of information relating to any new medical technologies.5 Moreover, 90% of these physicians admitted that their practice is influenced by such campaigns. However, there are major concerns with the current reliance on such information being provided by pharmaceutical industry. The above survey also showed that vast numbers of claims made in the information provided by pharmaceutical companies were either misleading or simply wrong. Even when specifically requested, pharmaceutical companies rarely provided appropriate and accurate information on drugs in Pakistan.6 Another study reported that majority of the references in brochures provided by pharmaceutical companies in Pakistan are not traceable, inaccurate, exaggerated or ambiguous.7 Besides, information provided by the pharmaceutical industry is often accompanied by various incentives to promote their specific products.

Clinical guidance is often produced in high priority areas by WHO and other similar international agencies. WHO Model Formulary is one example of an internationally agreed independent prescribing advice. However, such guidance is often not widely available;8 it lacks local ownership and sometimes applicability due to their generic nature. Without the necessary and contextual adaptation and availability in user friendly formats they often fail to influence clinicians’ knowledge and behaviour.9 This is particularly worrying as the biased information from pharmaceutical companies is often the only source of information that clinicians can access in many developing countries.

Getting evidence into practice is challenging even in well-resourced health systems for reasons that are only partially understood. Most of the research on interventions that can support practitioners in adopting research evidence into practice has been conducted in developed countries.10 However, findings from these studies may still be of relevance to low and middle-income countries. There are at least two national level initiatives, which have been successful in developed countries and are supported by international agencies: (a) Translation of evidence into context specific guidance in user-friendly formats; and (b) Educational tools to support practitioners in implementing such guidance into practice.11 Ongoing systematic reviews of research evidence may not be the activity that national governments wish to take on due to lack of capacity and resources. However, local adaptation of international guidance or development of national guidance based on systematic reviews conducted by international collaborations like Cochrane may be feasible and useful. Such guidance can take account of local context and secure ownership by engaging opinion leaders in the process. Such initiatives have been successful in reducing variations in clinical practice and bringing evidence into practice in some developed countries.12 In Pakistan and other developing countries such approach has been adopted in developing national guidance for public health programmes such as tuberculosis. Similar guidance is required in other clinical areas as well as on emerging health technologies.

Pakistan should consider setting-up a national independent body that could provide national guidance on preventing and treating ill health. This body could

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also be responsible for helping health professionals in implementing its guidance by providing tools and educational materials. With a potential to bring huge benefits to Pakistan in terms of financial and health gains, this would only be a small investment.

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