Reviewer's report

Title: Improving the Use of Research Evidence in Guideline Development: 13. Adaptation, applicability and transferability

Version: 1 Date: 16 April 2006

Reviewer: Jako Burgers

Reviewer's report:

General
This is a well-written paper discussing the opportunities and barriers of guideline adaptation in the WHO context. Last years, the development of clinical practice guidelines on the international level has not been encouraged because of local factors influencing healthcare decisions. (Eisenberg JM. Globalize the evidence, localize the decision: evidence-based medicine and international diversity. Health Aff (Millwood) 2002;21:166-8. De Maeseneer J, Derese A. European general practice guidelines: a step to far? Europ J Gen Pract 1999;5:86-104). Therefore, adaptation of guidelines is an interesting approach to transfer global evidence in recommendations for the own context. However, the WHO is an international organisation that is active in international guideline development. The authors could be more specific in which cases this is still a good option, for instance by providing a table with topics for international guidelines (e.g. prevention and management of infectious diseases, prevention of cardiovascular disease, etc.).

On page 14, the authors describe two approaches to guideline adaptation (Graham et al. and ADAPTE). However, these two groups have merged since January 2006. They are preparing a manual for guideline adaptation integrating both approaches (draft available for comment in summer 2006). The results of the preparatory literature review, similar to this paper, will be published in the International Journal for Quality in Health Care this year.

Major Compulsory Revisions
The paper answers three questions: 1) should WHO develop international recommendations, 2) what should be done centrally and locally, 3) how should recommendations be adapted. Q 1 and 2 are quite normative and can not be easily answered by findings from literature. The literature review predominantly concerns Q 3. However, it is not clear in the paper how the findings from literature were used in the answers. Moreover, the number of individual studies found (p. 11) nor the selection process is described. Thus, this is not a systematic literature review. Studies found were used as illustrations/examples and not as empirical evidence. I do not object to this approach, but the authors should avoid the suggestion that this is a literature review. I would suggest to provide the number of selected papers in addition to the number of citations (p. 10) OR to leave these all out. Furthermore, the headings ‘Findings’ and ‘Discussion’ are misleading as there is no clear cutoff between these. I would suggest to leave out the heading ‘Findings’ and to change the heading ‘Discussion’ in ‘What should the WHO do?’ The latter could also include ‘Further work’.

Minor Essential Revisions
p. 5: the term ‘health interventions’ should be specified. These could include diagnostic procedures, drugs, surgical interventions and psychosocial techniques which require specific professional education and skills. Therefore, this is not only an economic issue. Resources include costs, materials as well as skilled professionals. These should be available locally.

p. 7: it is not clear how the authors selected the organizations (SIGN, NZGG, USPSTF). I agree with this selection but why these? Why not NICE? The selection should be motivated.

p. 7: the AGREE Instrument does not contain questions but items that can be scored using a four-point Likert scale. The domain ‘applicability’ only includes three items. However, the other
domains also have items linked to applicability. For instance, ‘The target users of the guideline are clearly defined’ and ‘The guideline has been piloted among target users’ in the domain ‘Stakeholder Involvement’, ‘The health benefits, side effects and risks have been considered in formulating the recommendation’ in the domain ‘Methodology’ and ‘The guideline is supported with tools for application’ in the domain ‘Clarity and Presentation’. The grouping of the items in the domains was determined based on the results of factor analysis, but this classification is arguable.

p. 8: I would remove ‘(objective)’ because the assessment of quality cannot be fully objective. That’s why two independent reviewers are preferred in systematic reviews.

Discretionary Revisions
p. 4: reasons for not adopting publishing guidelines: ‘lack of ownership’ could be added
p. 7-10: subtitles may help the reader (e.g. SIGN, NZGG, USPSTF)
p. 8: ref 20: I would refer to SIGN 50: A guideline developers’ handbook.
p. 8: the concept of implementability of guidelines has been elaborated by Shiffman et al. (Shiffman RN, Dixon J, Brandt C, Essaihi A, Hsiao A, Michel G, O'Connell R. The GuideLine Implementability Appraisal (GLIA): development of an instrument to identify obstacles to guideline implementation. BMC Med Inform Decis Mak 2005 Jul 27;5:23.) This article can also be used elsewhere in the text.

What next?: Accept after minor essential revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.