Gaps in COPD guidelines of low- and middle-income countries: a systematic scoping review

Aizhamal Tabyshova, MD, John R. Hurst, MD, PhD, Joan B. Soriano, MD, PhD, William Checkley, MD, PhD, Erick Wan-Chun Huang, MD, Antigona C. Trofor, MD, PhD, Oscar Flores-Flores, MD, MSc, Patricia Alupo, MD, Gonzalo Gianella, MD, Tarana Ferdous, MPH, David Meharg, MPH, Jennifer Alison, PhD, Jaime Correia de Sousa, MD, PhD, Maarten J. Postma, PhD, Niels H. Chavannes, MD, PhD, Job FM. van Boven, PharmD, PhD, Collaborators

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Gaps in COPD guidelines of low- and middle-income countries: a systematic scoping review

Running head: Gaps in low- and middle-income COPD guidelines

Aizhamal Tabyshova MD, John R Hurst MD, PhD, Joan B Soriano MD, PhD, William Checkley MD, PhD, Erick Wan-Chun Huang MD, Antigona C Trofor MD, PhD, Oscar Flores-Flores MD, MSc, Patricia Alupo MD, Gonzalo Gianella MD, Tarana Ferdous MPH, David Meharg MPH, Jennifer Alison PhD, Jaime Correia de Sousa MD, PhD, Maarten J Postma PhD, Niels H Chavannes MD, PhD, Job FM van Boven PharmD, PhD

Collaborators: Chin Kook Rhee, Martina Ambroz, Jovan Mihajlovic, Bjorn Stahlberg, Jesper Kjaergaard, Tanja Fens, Guenka Petrova, An Le Pham, Anders Ostrem, Ioanna Tsiligianni, Kamila Zvoliska, Auliya Suwantika, Tamas Agh, Yee Vern Yong, Piyameth Dilokthornsakul, Trishul Siddharthan, Przemyslaw Kardas, Deniz Tugay, Viktoriia Y Starokozhko, Stefan Lassan, Vladimir Koblizek, Gary Parker

1. University of Groningen, University Medical Center Groningen, Groningen Research Institute for Asthma and COPD (GRIAC), the Netherlands
2. Department of Pulmonary Diseases, National Center of Cardiology and Internal Medicine, Bishkek, Kyrgyzstan
3. UCL Respiratory, University College London, United Kingdom
4. Hospital Universitario de la Princesa, Universidad Autónoma de Madrid, Madrid, Spain
5. Division of Pulmonary and Critical Care, School of Medicine, Johns Hopkins University, Baltimore, Maryland, USA

6. Department of International Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland, USA

7. Center for Global Non-Communicable Disease Research and Training, Johns Hopkins University, Baltimore, Maryland, USA

8. Woolcock Institute of Medical Research, Sydney, Australia

9. South Western Sydney Clinical School, University of New South Wales, Sydney, Australia

10. Division of Thoracic Medicine, Department of Internal Medicine, Shuang Ho Hospital, Taipei Medical University, Taipei, Taiwan

11. University of Medicine and Pharmacy ‘Grigore T. Popa’ Iasi (UMF Iasi), Iasi, Romania

12. Biomedical Research Unit, A.B. PRISMA, Lima, Peru

13. Universidad de San Martin de Porres, Facultad de Medicina Humana, Centro de Investigación del Envejecimiento (CIEN), Lima, Peru; Universidad Científica del Sur, Facultad de Ciencias de la Salud, Lima, Peru

14. Department of Medicine, Makerere Lung Institute, Kampala, Uganda

15. Department of Medicine, School of Medicine, Universidad Peruana Cayetano Heredia, Lima, Peru

16. ARK Foundation, C4, House 6, Road 109, Gulshan 2, Dhaka-1212, Bangladesh

17. University of Sydney, Faculty of Medicine and Health, Australia

18. Life and Health Sciences Research Institute (ICVS), School of Medicine, University of Minho, Braga Portugal. ICVS/3B’s, PT Government Associate Laboratory, Braga/Guimarães, Portugal.

19. University of Groningen, University Medical Center Groningen, Department of Health Sciences, Unit of Global Health, Netherlands

20. Department of Public Health and Primary Care, Leiden University Medical Center, Leiden, the Netherlands
Corresponding author

Job FM van Boven, University Medical Center Groningen, Groningen Research Institute for Asthma and COPD (GRIAC), PO Box 30001, Internal Postcode EB70, 9700 RB, Groningen, Netherlands. Email: j.f.m.van.boven@rug.nl

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None reported

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Abstract

Background

Guidelines are critical for facilitating cost-effective COPD care. Development and implementation in low-and middle-income countries (LMICs) is challenging. To guide future strategy, an overview of current global COPD guidelines is required.

Research question

We systematically reviewed national COPD guidelines, focusing on worldwide availability and identification of potential development, content, context and quality gaps that may hamper effective implementation.

Study Design & Methods

Scoping review of national COPD management guidelines. We assessed: (1) global guideline coverage, (2) guideline information (authors, target audience, dissemination plans), (3) content (prevention, diagnosis, treatments), (4) ethical, legal, socio-economic aspects and (5) compliance with the eight Institute of Medicine (IOM) guideline standards. LMICs guidelines were compared to those from high-income countries (HICs).

Main results

Of the 61 national COPD guidelines identified, 30 were from LMICs. Guidelines did not cover 1.93 billion (30.2%) people living in LMICs, whereas only 0.02 billion (1.9%) in HICs were without national guidelines. Compared with HICs, LMIC guidelines targeted fewer healthcare professional groups and less often addressed case finding and co-morbidities. Over 90% of all guidelines included smoking cessation advice. Air pollution reduction strategies were less frequently mentioned in both LMICs (47%) and HICs (42%). LMIC guidelines fulfilled on average 3.37 (42%) of IOM standards compared to 5.29 (66%) in HICs (p<0.05).
LMICs scored significantly lower compared with HICs regarding conflicts of interest management, updates, articulation of recommendations and funding transparency (all, p<0.05).

**Interpretation**

Several development, content, context and quality gaps exist in COPD guidelines from LMICs that may hamper effective implementation. Overall, COPD guidelines in LMICs should be more widely available and should be transparently developed and updated. Guidelines may be further enhanced by better inclusion of local risk-factors, case finding and co-morbidity management, preferably tailored to available financial and staff resources.

**Key words:** Pulmonary Disease, Chronic Obstructive, Developing Countries, Consensus, Reference Standards
Introduction

According to the Global Burden of Disease study, over 90% of COPD deaths occur in low- and middle-income countries (LMICs).\textsuperscript{1} Notably, these deaths are accompanied by a significant socioeconomic burden for patients, their families and societies.\textsuperscript{2} As such, to achieve the greatest impact in reducing premature COPD deaths around the world, efforts should focus on optimizing COPD treatment in LMICs. One of the ways in which treatment can be optimized is through effective dissemination and implementation of guidelines. Guidelines should provide standardized, evidence-based prevention, diagnosis, and management recommendations. Some countries have developed their own guidelines, and from 2001 the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Strategy Report has been established. Since then, multiple countries have adopted the GOLD updates that followed.\textsuperscript{3}

While guidelines are critical to help improving COPD care around the world\textsuperscript{4-6}, guidelines are of no use when poorly implemented. Notably, for proper implementation, several prerequisites need to be considered. According to the APEASE criteria\textsuperscript{7}, interventions can only be successful when affordable, practicable, (cost-)effective, acceptable, safe, and equitable. The ability to meet these criteria differs between (and within) countries. Interventions can be feasible in one setting, but not in another depending on factors such as demographics, infrastructure, healthcare budgets, culture and environment.\textsuperscript{8-11}

Historically, COPD guideline reviews dating back over a decade, included 15 to 41 guidelines and focused on assessing the quality of the development, content\textsuperscript{12} and specific monitoring of recommendations\textsuperscript{13}, with limited focus on LMICs.\textsuperscript{14,15} The two latest reviews of COPD guidelines assessed diagnosis and treatment criteria\textsuperscript{16}, development, authors and audience\textsuperscript{17}, but focused on European guidelines only.
We have not identified any previous review that focused on COPD guidelines in LMICs. To stimulate effective implementation of COPD guidelines in LMICs, a systematic assessment of which aspects related to development, content, quality should be targeted is critical.

We systematically reviewed national COPD guidelines, focusing on global existence as well as on potential gaps in development, content, context and quality that may hamper their implementation in LMICs. We therefore undertook a scoping review to identify the gaps/topics that should be prioritized in future focused systematic reviews.

**Methods**

*Study design*

This global COPD guideline scoping review was informed by a systematic literature search, performed and reported (Online supplement, e-Table 1) according to PRISMA scoping review standards. Given this work did not involve human subject research, no ethical approval was required. The work is part of the Global Alliance for Chronic Diseases (GACD) COUNCIL project.

*Data sources, search and inclusion*

To identify as many guidelines as possible, a sequential approach was taken. First, PubMed (Feb 15, 2019) and EMBASE (Feb 18, 2019) were searched to identify published COPD guidelines. Prior to manuscript submission (January 14, 2020) the search was repeated, but no additional guidelines were identified. References of previous reviews and identified articles were inspected to identify further guidelines. Additionally, authors and the GACD Research Network collaborators (all health professionals and/or clinical researchers specialized in lung disease) were asked to identify guidelines in their own country or guidelines they were aware of from other countries, not yet identified through the database or online searches. Also, the
guideline databases of the International Primary Care Respiratory Group, Guidelines International Network and the Tripdatabase were checked. Thereafter, authors were asked to reach out to colleagues and national (guideline) websites from all the remaining countries for which no guideline had been identified. Similar search strategies have been used by earlier GACD guideline comparisons.\textsuperscript{13}

The online search strategy in PubMed and EMBASE was based on the list of key words used in the previous GACD guidelines reviews\textsuperscript{19-21}, but with COPD as disease entity. For both databases, the search terms included “guideline” OR “consensus” OR “recommendations” OR “protocols” OR “standards” AND “COPD”. No search filters were applied and all years and languages were considered. The full search strategy is provided in online supplement e-Table 2.

Guidelines were included as long as the following inclusion criteria were met: (1) it should focus on COPD prevention, diagnosis, and management (i.e. not only focusing on specific treatments such as alpha-1 antitrypsin deficiency); (2) it should have been developed for intended use as a national COPD guideline. This could include a stand-alone document or a translation or adaption of an international document (e.g. GOLD). When multiple guidelines where identified within the same country, the guideline with the largest coverage and/or most recent update (i.e. this could be a newly developed or updated guideline version) was selected. 

\textit{Data extraction and quality assessment}

Data extraction was performed using a pre-piloted digital form. A first version, based on earlier GACD guidelines assessments, was made by JvB and AT and commented on by all authors, a combination of native English and non-English speakers with good understanding of COPD. Subsequently, small optimizations were made in an iterative process until a final version with uniform interpretation was agreed on. The final extraction form was circulated to
all authors using REDCap. Data extraction was performed by the individual authors and
double-checked by a second person. For countries and/or languages where authors did not
have expertise, additional local clinical experts from the particular country were invited to
complete and double-check the data extraction.

Data items extracted included: (1) general guideline information (name, authors, year, target
audience, dissemination plans), (2) coverage of specific COPD prevention, diagnosis and
management recommendations (local epidemiology, case-finding, smoking cessation, air
pollution, vaccination, exacerbations, comorbidity, diet, physical activity, pharmacologic
recommendations, patient education, alternative medicine, and vulnerable populations, such
as Indigenous people), (3) recommendations which addressed ethical aspects (e.g. regarding
experimental high risk treatments, or non-evidence based treatments), legal aspects (e.g.
related to end-of-life care, such as euthanasia, palliative sedation), social aspects (e.g.
addressing the role of informal care givers, family and patient organizations) and economic
aspects (e.g. costs or cost-effectiveness or reimbursement), and (4) compliance with the eight
Institute of Medicine (IOM) standards for optimal development of clinical practice guidelines,
consisting of several evidence quality indicators (transparency of funding, multidisciplinary
author composition, conflicts of interest policy, use of systematic reviews, grading of
evidence, articulation of recommendations, external review, frequency of updates). The
assessment of IOM criteria is further specified in e-Table 3 and was primarily chosen (rather
than the more commonly used, but content-wise largely overlapping AGREE II tool) in order
to be able to compare our results with previous GACD LMIC guidelines reviews that also
used the IOM criteria. Note that the IOM standards were published in 2011. Since 2016,
the IOM is known as the “Health and Medicine Division” of the National Academies of
Sciences, Engineering and Medicine of the United States.

Outcomes by income-status
Outcomes included global guideline coverage, defined as the absolute number and percentage of people in HICs and LMICs covered by a national COPD guideline as part of the total HICs and LMICs population. Additionally, the four themes as specified under data items (general guideline information, guideline content, ethical, legal, socio-economic aspects and compliance with the IOM guideline standards defined as the mean number of standards fulfilled) were assessed.

Countries with guidelines available were grouped and compared by income status (as of June 2018). In particular, all identified countries were classified according to the World Bank Atlas method, also adopted by the Organization for Economic Cooperation and Development (OECD). The World Bank assigns a classification for all member countries (189), and all other economies with populations of more than 30,000. Economies were classified based on their 2018 gross national income (GNI) per capita in US dollars. World Bank classifications include low-income countries ($995 or less), lower-middle income countries ($996–3,895), upper-middle income countries ($3,896–12,055) and high-income countries ($12,056 or more). Thus, for our comparison, countries with GNIs per capita up to $12,055 were considered LMICs and countries with a GNI per capita of >$12,056 were considered HICs. In 2018, this classified 218 countries in the world (total population size: 7,594,270,356) in 81 HICs (37%) with a total population size of 1,210,312,147 people and 137 (63%) LMICs with a total population size of 6,383,958,209 people.

**Data synthesis and analyses**

All data were summarized per country in Excel 2010 (Microsoft Corp., Seattle, WA, USA) and presented in tables and figures for visual inspection and review. Categories were presented as absolute numbers per category and as percentages, continuous variables as mean and standard deviation (SD). Chi-squared tests and Student t-tests were performed (IBM SPSS Statistics 23) to assess outcomes by income classification, where guidelines from
Results

After searching PubMed, 3,030 titles were obtained, but after title screening only 90 were considered potentially relevant. In EMBASE, the search strategy resulted in 9,376 titles and after screening, 43 were considered potentially relevant. When removing duplicates and reading full texts, a total of 27 relevant COPD country guidelines were identified. Of note, two of these guidelines were written for two countries (Australia/New Zealand and Germany/Austria); these “two-country” guidelines were only counted once in comparisons. GACD collaborators suggested 13 additional COPD guidelines not found by the PubMed/EMBASE search. Finally, the targeted search/outreach by the GACD Research Network provided 21 more guidelines, resulting in a total of 61 identified COPD guidelines for 63 countries. The flow diagram of article selection is provided in e-Figure 1.

Global population coverage

In total, 63 (28%) of the 218 countries with a World Bank classification had COPD guidelines (Figure 1). These 63 countries covered a total population size of 5,644,031,801 (74.3% of the world’s population). Of the 61 guidelines evaluated, 30 (49%) were from LMICs, covering 30 countries and 31 (51%) were from HICs, covering 33 countries. For LMICs, this means that 30 of the worlds’ 137 LMICs (21.9%) had their own guideline. In terms of total population, these 30 countries covered 4.46 out of the 6.38 billion people living in LMICs, leaving 1.93 billion people (30.2%) without their own country guideline. In HICs, 33 of the worlds’ 81 HICs (40.7%) had their own guideline. In terms of total population, these 33 countries covered 1.19 out of the 1.21 billion people living in HICs, leaving only 0.02 billion people...
(1.9%) living in HICs without their own country guideline. Country-specific population and income data are provided in e-Table 5.

**[FIGURE 1]**

*General characteristics and target audience*

Characteristics and content of all COPD guidelines are provided in Online supplementary e-Tables 6-18. Guidelines were mostly written by a national (respiratory) association or society or by the Ministry of Health (e-Tables 6-8). In LMICs, the oldest guideline was from El Salvador (2005) and the newest was from Bulgaria (2019).

An overview of the target audience of COPD guidelines is provided in figure 2 and specified in e-Table 4 and 9. All guidelines targeted physicians, often both respiratory specialists and primary care physicians/general practitioners (GP), regardless of income group. LMIC guidelines tended to explicitly target a smaller group of healthcare professionals compared to HICs, including significantly less often nurses (37% vs 77%, p<0.05), physiotherapists (27% vs 55%, p<0.05) and dieticians (10% vs 32%, p<0.05).

**[FIGURE 2]**

*Content by income group*

An overview of the content of COPD guidelines by country classification is provided in Figure 3 and specified in e-Tables 10-12. Pharmacological treatment was the only item that was included in 100% of the COPD guidelines. Compared with HICs, LMICs significantly less frequently included recommendations regarding case-finding (LMICs: 40%; HICs: 84%, p<0.05) and co-morbidity (LMICs: 37%; HICs: 77%, p<0.05). In contrast, LMICs guidelines slightly (but not significantly) more often included alternative medicine recommendations (LMICs: 10%; HICs: 3%) and paid some more attention to management of vulnerable populations (although only in two countries, Serbia and Indonesia). Of note, while over 90%
of guidelines included smoking cessation advice, management of other airborne exposures (e.g. indoor and outdoor air pollution) was much less frequently mentioned in both LMICs (47%) and HICs (42%).

[FIGURE 3]

Context, dissemination and quality

Besides specific prevention, diagnosis and treatment recommendations, guidelines had non-significant differences regarding the extent to which ethical, legal and socio-economic context was considered. LMICs guidelines scored similarly on incorporation of ethical aspects (30% vs 29%, p=0.93), and non-significantly lower on the legal (20% vs 35%, p=0.18), social (27% vs 35%, p=0.46), and economic aspects (27% vs 42%, p=0.21). In LMICs, 23% of the guidelines had dissemination plans in place, while this was the case in 32% of HICs (e-Tables 13-15).

In Figure 4 and e-Tables 16-18, fulfilment of IOM quality standards for good guideline development are shown for all COPD guidelines. Statistical comparisons are provided in e-Table 4. On average, LMICs guidelines fulfilled 42% (mean: 3.37; SD: 2.09), while HICs guidelines fulfilled 66% of the eight IOM criteria (mean: 5.29; SD: 2.02) (p<0.05). For both LMICs and HICs, updating of guidelines was the worst scored criterion, with fewer than 50% of guidelines fulfilling this item but with better fulfilment in HICs (p<0.05). Additionally, guidelines from LMICs scored significantly lower compared with HICs guidelines regarding conflicts of interests (p<0.05), articulation of recommendations (p<0.05) and transparency of funding (p<0.05). If the five LMIC guidelines that were published before the IOM guidance launch (2011) were excluded, IOM criteria fulfilment was similar (mean: 3.24; SD: 2.09).

[FIGURE 4]
Discussion

We assessed the availability of COPD guidelines in LMICs and identified gaps in development, quality, content and context that may hamper their effective implementation. Regarding availability, we found a national guideline in only 30 out of 137 LMICs (21.9%), while in HICs this was the case for 33 of the 81 HICs (40.7%). In absolute numbers, this means that 1.93 billion (30.2%) people living in LMICs were without national COPD guidelines whereas of the 1.2 billion people living in HICs only 0.02 billion (1.9%) were without a national guideline. Regarding quality, LMIC guidelines fulfilled significantly fewer IOM standards for good clinical practice guideline development. LMIC guidelines scored significantly lower compared with HIC guidelines regarding conflicts of interests, updates, articulation of recommendations and funding transparency. Regarding content, risk factor management was mostly restricted to smoking cessation, while air pollution received far less coverage despite the importance of this in causing COPD in many LMIC settings. Pharmacological treatment was covered in all guidelines yet LMIC guidelines generally targeted a smaller group of healthcare professionals, mostly physicians and significantly less often nurses, physiotherapists and dieticians compared with HIC guidelines. Case-finding and comorbidities received relatively little attention in LMIC guidelines. Regarding context, incorporation of ethical, legal and socio-economic aspects in LMIC guidelines seemed numerically, but not statistically, lower than in HIC guidelines. Regarding dissemination, less than one quarter of LMIC guidelines had dissemination plans in place, compared to one third in HICs.

The difference between guideline availability in HICs versus LMICs highlights an unequivocal health disparity. Almost 2 billion people and their healthcare advisors (over a quarter of the World’s population) are not directly advised on how to manage COPD according to their country context. In particular, countries in sub-Saharan Africa have no
COPD guidelines, despite the existence of the GOLD Strategy Report which can be used as a tool to frame local guidelines. The absence of national guidelines may be partly due to insufficient resources and international aid, but also due to local health, academic and political priorities that may have historically focused more on communicable diseases such as tuberculosis, malaria and HIV. However, given increased infection control and rising life expectancy, non-communicable diseases such as COPD may become a new epidemic. Therefore, timely development of COPD guidelines seems key.

In some countries, regional or direct GOLD translations were used (e.g. Romania). While these translations are available, local physicians’ understanding may fall short and more efforts on implementation of these recommendations is required. This may not only hold true for LMICs but also for smaller HICs including Andorra, Belgium and Luxemburg that simply use translated GOLD or neighboring countries’ guidelines. Similarly, countries such as Uruguay and Panama mostly follow regional Latin American Thoracic Association (ALAT) guidelines. For LMICs this may also be the case, for example in Middle Eastern countries that use the guideline of the Gulf Cooperation Council countries and Middle East-North Africa region.

That less than one quarter of LMIC guidelines had dissemination plans in place underlines an important, but modifiable gap. We argue that efficient, wide-scale implementation can only be successful when effective guidelines and dissemination plans are in place, with proper understanding of local infrastructure, culture and environment, additionally tailored to local COPD prevalence, risk factors and resources available. Of note, most LMICs guidelines did not include local data and lacked economic considerations. Guidelines in LMICs tend to use some “copy paste” from HICs in relation to risk factors and did not always take into account regional differences. Notably, COPD risk factors other than smoking, such as early life disadvantages, household and ambient air pollution are now increasingly recognized yet
are covered in less than half of current LMIC guidelines. Also, regional risk differences require attention. For example, in Latin America, tobacco smoking is primarily an urban problem, and not very prevalent in rural areas. These urban-rural disparities have also been observed in Uganda. Early life disadvantages such as undernutrition may also be more prevalent in particular vulnerable populations such as Indigenous and nomadic populations in both HICs (e.g. Australia or Greenland) and LMICs, as well as the lack of early detection of COPD, limited access to treatment and lack of appropriate health education and poor engagement with health resources, that is often evident in Indigenous populations. Generally, research in these populations is scarce and recommendations tailored to these sub-populations are therefore lacking.

Regarding pharmacological treatment, covered by 100% of LMICs guidelines, it is important to note that most clinical evidence to support such medicines came from trials conducted in HICs. These often included current and former heavy-cigarette smokers, that do not always represent “real-world“ COPD heterogeneity and do not necessarily have the same phenotype as non-smokers with other COPD risk factors as frequently seen in LMICs. Therefore, more trials should include LMIC populations. Furthermore, availability and affordability of recommendations should be considered, especially related to more expensive pharmacological treatment. This question was considered too detailed for this broad scoping review and a more targeted systematic review focusing on specific pharmacologic recommendations in LMIC, considering availability and relationship with outcomes, would be highly valuable.

Regarding content, the low inclusion of case-finding and comorbidity management may have to do with the relatively slower uptake of novel findings. Indeed, the GOLD report has only put more emphasis on comorbidity since 2011 and even in the current version, proper
guidance on multi-morbidity is lacking. Case-finding is only recommended from the 2019 update following a large HIC trial.\textsuperscript{33} An important finding is related to transparency of guideline development. While proper reporting of funding and conflicts of interest are important these are significantly less often addressed in LMICs. These issues are not restricted to guidelines and also include consideration on who funds the COPD training for clinicians. Of note, a future focused systematic review could examine the reduced attention to conflict of interest in LMIC guidelines and whether this may have influenced the selection of medication recommendations. Beyond COPD, similar guideline reviews comparing LMICs with HICs have been published including those for diabetes, hypertension and stroke.\textsuperscript{19-21} While the content cannot be compared, adherence to IOM standards showed similar gaps, with a mean fulfillment of just under 2.5 IOM items for LMIC diabetes guidelines versus a mean of 5.2 in HICs. Similarly, “updating” was the lowest scored item and the largest gaps between LMICs and HICs were related to transparency, evidence quality and articulation of recommendations. Given that in the vast majority of LMICs no specific COPD guideline was in place, policy makers should stress the need for a COPD guideline to be developed. In doing so, there is a strong need to harmonize the methodology of guideline production and implementation. We do however consider that stand-alone development of guidelines with standardized methodology is challenging, expensive and time consuming. This would for example include assessment of the strength of evidence with the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach.\textsuperscript{34} As such, as a minimum viable option, international guidelines (e.g. ERS, ALAT) are encouraged with local context-specific adaptations beyond simple translation.\textsuperscript{35} Developers of future COPD guidelines should pay attention to IOM (or other recognized) standards for good clinical practice guideline
development. In particular, transparency, updating and conflict of interest management are important issues to be improved. Guideline development and targeting should include multidisciplinary experts and contain views from patients’ organizations and a public consultation process. Guidance should be provided on dissemination and implementation, including what are the minimal standards of care for each level of the healthcare system.

Regarding implementation, guidelines should include what evidence the suggestions are based on. Suggestions based on studies from a country with very different context may not be implementable at all. Therefore, guidelines should include guidance on approaches to facilitate cultural adaptation and effective collaboration with vulnerable populations such as Indigenous people, particularly within colonized countries.

From a research perspective, more work on barriers and facilitators to effective implementation of guidelines in LMICs is required. This would include local data collection and strategies to facilitate local adaptation and implementation of evidence taking into account environmental, demographic, social, cultural, legal, and economic dimensions. In addition, guidelines should address the cultural needs of Indigenous populations in HICs where colonization has resulted in health inequities. Lastly, when guidelines are in place, frequent updating and monitoring of adherence to specific recommendation is essential. Periodical auditing may facilitate improvement of adherence to guidelines and ultimately more cost-effective COPD care. Ultimately whether, after adjusting for income and other factors, countries with a national country-tailored guideline have better COPD health outcomes should be explored.

Strengths and limitations

To our knowledge, this is the first global COPD guideline scoping review and informs future guideline development around the world as well as more targeted systematic reviews. Authors
and guideline reviewers represented all continents and made use of local understanding of clinical practice. Although extensive searches were performed, for some countries, general (non-communicable disease) treatment guidelines are in place that may include treatment of various chronic diseases, including COPD. Also, guidelines that were published in English and traceable using online data sources had a higher likelihood of being included. For some guidelines, we could only find main documents and we may have therefore missed some specific recommendations only provided in appendices of the main document. GACD network members actively reached out to colleagues in countries for which no guidelines had been identified through online searches. Still, in some LMICs, we had no direct contacts, therefore the establishment of a wider network of contacts is required. Having this network in place would also allow for further qualitative, in-depth data collection on physicians’ expectations and actual implementation barriers on a local practice level, and allows more targeted approaches to wide scale guideline implementation. It should however be mentioned that given many guidelines were only identified through the GACD network, it is not possible for independent researchers to obtain the set of guidelines used for our analysis simply by repeating the database searches with the exact search criteria. Also, we acknowledge that the AGREE-II tool is currently more commonly used to assess guideline quality. However, data items covered to largely overlap with the IOM standards. As such, we do not expect that this part of the scoping review would have resulted in much different messages when the AGREE II tool would have been used instead. Regarding the content of COPD care covered by the country guidelines, we should acknowledge the review focus on broad COPD management guidelines but that in fact, for some aspects of COPD care, separate guidelines may be in place in some countries (e.g. exacerbation management). Finally, we note that a wide range of guideline publication dates were found (2005-2019). While we aimed to minimize potential
time-related differences by performing a sub-analysis for the IOM quality criteria in LMIC, this still warrants careful interpretation of the content of care comparisons.

Interpretation

Several development, content and quality gaps exist in COPD guidelines from LMICs that may hamper large-scale effective implementation. Of note, COPD guidelines in LMICs should be more widely available and should be transparently developed and updated. Furthermore, they may be enhanced by more focus on the inclusion of local risk-factors, case finding and comorbidity management, preferably tailored to financial and staff resources available.

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country guideline. AT, JvB and JRH drafted the first version of the manuscript. All authors comments on the draft and approved submission. JvB is the guarantor of the study.
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Figure legends

Figure 1: World map showing countries with and without COPD guidelines

Light blue: high-income country without country guideline; dark blue: high-income country with guideline; light red: low- and middle-income country without guideline; red: low- and middle-income country with guideline

Figure 2: Overview of target audience of COPD guidelines around the world

*significant difference, p<0.05; GPs: general practitioners; HICs: high-income countries; LMICs: low- and middle-income countries

Figure 3: Overview of coverage of COPD management recommendations met by COPD guidelines in high income countries and low-and middle-income countries

*significant difference, p<0.05, HICs: high-income countries; inf: influenza; LMICs: low-and middle-income countries; pneu: pneumococcal

Figure 4: IOM guideline quality standards met by COPD guidelines in high income countries and low-and middle-income countries

HIC: high-income countries; IOM: Institute of Medicine; LMIC: low-and middle-income countries
Abbreviations list

AHP: Allied health professionals

ALAT: Latin American Thoracic Association

COPD: Chronic obstructive pulmonary disease

GACD: Global Alliance for Chronic Diseases

GNI: Gross national income

GOLD: Global Initiative for Chronic Obstructive Lung Disease

GP: General practitioners

HIC: High-income countries

IOM: Institute of Medicine

LMIC: Low- and middle-income countries

OECD: Organization for Economic Cooperation and Development