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As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice To identify gaps in national stroke guidelines that could be bridged to enhance the quality of stroke care services in low- and middle-income countries. We systematically searched medical databases and websites of medical societies and contacted international organizations. Country-specific guidelines on care and control of stroke in any language published from 2010 to 2020 were eligible for inclusion. We reviewed each included guideline for coverage of four key components of stroke services (surveillance, prevention, acute care and rehabilitation). We also assessed compliance with the eight Institute of Medicine standards for clinical practice guidelines, the ease of implementation of guidelines and plans for dissemination to target audiences. We reviewed 108 eligible guidelines from 47 countries, including four low-income, 24 middle-income and 19 high-income countries. Globally, fewer of the guidelines covered primary stroke prevention compared with other components of care, with none recommending surveillance. Guidelines on stroke in low- and middle-income countries fell short of the required standards for guideline development; breadth of target audience; coverage of the four components of stroke services; and adaptation to socioeconomic context. Fewer low- and middle-income country guidelines demonstrated transparency than those from high-income countries. Less than a quarter of guidelines encompassed detailed implementation plans and socioeconomic considerations. Guidelines on stroke in low- and middle-income countries need to be developed in conjunction with a wider category of health-care providers and stakeholders, with a full spectrum of translatable, context-appropriate interventions. Identifier les lacunes présentes dans les directives nationales de prise en charge des accidents vasculaires cérébraux (AVC), ainsi que la manière de les combler afin d'améliorer la qualité des soins dans les pays à faible et moyen revenu. Nous avons analysé systématiquement une série de bases de données médicales et sites Internet de sociétés médicales. Nous avons également contacté des organismes internationaux. Toutes les directives nationales de prévention et de prise en charge des AVC, publiées dans n'importe quelle langue entre 2010 et 2020, étaient admises dans cette analyse. Nous avons examiné chaque directive incluse à la recherche de quatre composants clés de la prise en charge des AVC (surveillance, prévention, soins intensifs et rééducation). Enfin, nous avons évalué le degré de conformité avec les huit standards de l'Institut de médecine pour les directives de pratique clinique, mais aussi la facilité avec laquelle ces directives étaient appliquées et la manière dont elles étaient censées être diffusées auprès du public cible. Nous avons étudié 108 directives retenues provenant de 47 pays dont quatre à faible revenu, 24 à moyen revenu et 19 à haut revenu. Globalement, le nombre de directives concernant la prévention primaire des AVC était moins élevé que d'autres volets de soins, et aucune ne recommandait une surveillance. Les directives relatives aux AVC dans les pays à faible et moyen revenu ne répondaient pas aux exigences en matière de développement des directives; d'étendue du public cible; d'intégration des quatre composants de prise en charge des AVC; ni d'adaptation au contexte socioéconomique. La transparence des directives nationales était moins souvent assurée dans les pays à faible et moyen revenu que dans les pays à haut revenu. Moins d'un quart des directives comportaient des plans de mise en œuvre détaillés et des considérations économiques. Les directives relatives à la prise en charge des AVC dans les pays à faible et moyen revenu doivent être renforcées avec le concours d'une plus large catégorie de prestataires et d'acteurs du secteur de la santé. Elles doivent en outre prévoir une gamme complète d'interventions transposables sur le terrain et adaptées au contexte. Identificar las lagunas en las directrices nacionales sobre accidentes cerebrovasculares que podrían subsanarse para mejorar la calidad de los servicios de atención a los accidentes cerebrovasculares en los países con ingresos bajos y medios. Se realizaron búsquedas sistemáticas en bases de datos médicas y sitios web de sociedades médicas y se contactó con organizaciones internacionales. Se incluyeron las directrices específicas de cada país sobre la atención y el control de los accidentes cerebrovasculares en cualquier idioma, publicadas entre 2010 y 2020. Se revisó cada directriz incluida para la cobertura de cuatro componentes clave de los servicios por ataques cerebrovasculares (vigilancia, prevención, atención aguda y rehabilitación). También se evaluó el cumplimiento de los ocho estándares del Instituto de Medicina para las guías de práctica clínica, la facilidad de implementación de las directrices y los planes de difusión al público objetivo. Se revisaron 108 directrices elegibles de 47 países, incluyendo cuatro de bajos ingresos, 24 de medianos ingresos y 19 de altos ingresos. Globalmente, la prevención primaria de los ataques cerebrovasculares estaba cubierta en menos directrices que otros componentes de la atención médica, y ninguna recomendaba la vigilancia. Las directrices sobre ataques cerebrovasculares en los países de ingresos bajos y medios no cumplían con los estándares requeridos para el desarrollo de directrices; la amplitud del público objetivo; la cobertura de los cuatro componentes de los servicios de ataques cerebrovasculares; ni la adaptación al contexto socioeconómico. El número de directrices de los países de ingresos bajos y medios que demostraron ser transparentes fue menor que el de los países de ingresos altos. Menos de una cuarta parte de las directrices incluían planes de aplicación detallados y consideraciones socioeconómicas. Las directrices sobre los ataques cerebrovasculares en los países de ingresos bajos y medios deben elaborarse en colaboración con una categoría más amplia de proveedores de servicios sanitarios y partes interesadas, con un espectro completo de intervenciones traducibles y adecuadas al contexto. [illegible] 目的 以在国际层面发现国家级中风护理指南中的差距，并改善这些指南的质量。 我们系统性地检索了医学数据库和医学会网站，并联系了国际组织。 自 2010 年至 2020 年以任何语言发表的针对特定国家的中风护理和控制指南均满足纳入资格。 我们回顾了各个指南所涵盖的中风服务四大关键要素（监测、预防、紧急护理和康复）。 我们还评估了医学研究所八项临床实践指南标准的遵守情况；指南的可实施性；以及指南针对目标受众的广度。 涵盖中风服务的四大要素以及对社会经济环境的适应程度。 与高收入国家的指南相比，低收入和中等收入国家的指南透明度较低。 不到四分之一的指南涵盖详细的实施计划和社会经济学方面的考虑因素。 低收入和中等收入国家的中风指南需要与更广泛的医疗护理提供者以及利益相关者共同制定，并因地制宜地采取一系列可转化的干预调控措施。 Выявить пробелы в национальных рекомендациях по инсульту, которые возможно устранить с целью повышения качества услуг по лечению инсульта в странах с низким и средним уровнем доходов. Авторы систематически проводили поиск в медицинских базах данных и на веб-сайтах медицинских обществ, а также связывались с международными организациями. Национальные рекомендации по лечению и контролю инсульта, опубликованные с 2010 по 2020 г. на любом языке, соответствовали критериям для включения. Авторы изучили каждую включенную рекомендацию в отношении охвата четырьмя ключевыми компонентами услуг по инсульту (эпиднадзор, профилактика, неотложная помощь и реабилитация). Было также оценено соответствие восьми стандартам Института медицины для рекомендаций по клинической практике, простота внедрения рекомендаций и планы по их распространению среди целевых аудиторий. Авторы изучили 108 подходящих рекомендаций из 47 стран, включая четыре страны с низким уровнем доходов, 24 страны со средним уровнем доходов и 19 стран с высоким уровнем доходов. Во всем мире первичная профилактика инсульта охватывала меньшее количество рекомендаций по сравнению с другими компонентами медицинской помощи, и ни один из них не рекомендовал эпиднадзор. Рекомендации по инсульту в странах с низким и средним уровнем доходов не соответствовали требуемым стандартам для разработки рекомендаций, широте целевой аудитории, охвату четырьмя компонентами услуг по инсульту и адаптации к социально-экономическим условиям. Рекомендации, принятые в странах с низким и средним уровнем доходов, в меньшей степени демонстрировали прозрачность, в отличие от рекомендаций для стран с высоким уровнем дохода. Менее четверти рекомендаций включали подробные планы по реализации и социально-экономические соображения. Рекомендации по инсульту в странах с низким и средним уровнем доходов необходимо разрабатывать совместно с более широкой категорией поставщиков медицинских услуг и заинтересованных сторон, с полным спектром реализуемых и соответствующих обстановке вмешательств. Stroke is the second leading cause of death and disability globally, with evidence of an increasing incidence of stroke among young adults.1–3 The burden of stroke is increasing in low- and middle-income countries.4 Studies have shown a 37% increase in the number of deaths among younger adults aged 20–64 years in low- and middle-income countries, from 942 921 to 1 292 347, versus a 20% decline in high-income countries over the period 1990–2013, from 236 566 to 191 359.4 Improvements in the prevention and management of stroke after implementation of evidence-based guidelines in routine medical practice have substantially lowered the incidence and mortality rates of stroke in high-income countries over the past 30 years.1,3,5–8 In contrast, low- and middle-income countries present wide differences in the quality of stroke prevention and care, with gaps identified in the knowledge and skills of health professionals, the resources available within health systems and the components of stroke care available locally.6,9 Addressing these gaps could be aided by guidelines with pragmatic evidence-based recommendations and implementation action plans for individuals and health systems.10 However, successful implementation of guidelines depends on having locally developed content in which region-specific barriers and local sociocultural characteristics are considered.11–13 We conducted a systematic review to compare recent clinical guidelines on stroke in low- and middle-income countries with those of high-income countries. We aimed to characterize specific gaps in guideline development, target audiences and content in relation to the spectrum of stroke care covered14 and the features that promote implementation. Our review was informed by the view that the content of guidelines for low- and middle-income countries should be adapted with solutions that are pragmatic for these countries and perhaps graded according to ease of implementation.15 Periodic review of published stroke guidelines is also important to improve their impact on stroke prevention and outcomes. We pre-registered the proposed methods for this systematic review on the International Prospective Register of Systematic Reviews (CRD42018112620). The review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines16 as well as procedures used by the Global Alliance for Chronic Diseases group for the systematic review of guidelines for hypertension and diabetes mellitus.14,17,18 We searched the following electronic medical databases for published guidelines on management and prevention of stroke: PubMed®, African Journals Online, Directory of Open Access Journals, Google Scholar, SciELO and Excerpta Medica Database (EMBASE). We based our search strategy on the PICO strategy19 of evidence-based models (population: stroke guidelines; intervention: not applicable; comparison: guidelines from high-income countries versus those from low- and middle-income countries; outcome: spectrum of stroke care). We used medical subject headings and titles containing the following search terms: "country name" AND "guideline" OR "consensus" OR "clinical protocols" OR "standards" OR "recommendations" AND "stroke OR cerebrovascular disorder/disease OR intracranial haemorrhage OR cerebrovascular accident". We also used the Google search engine to identify stroke guidelines published on the websites of medical societies. To identify additional guidelines, we contacted country representatives on the Lancet Neurology Commission on Stroke (listed in the authors' data repository),20 members of the World Stroke Organization and the Global Alliance of Health Research Funders.15 Three of the authors independently screened the titles of records from the above-mentioned sources. Three authors independently reviewed the title, year of publication, publication type and author. This information was collated by one author and duplicates and irrelevant records based on the reviewers' decisions were removed. Abstracts of each relevant title were independently reviewed for eligibility by three authors and the relevant publications were obtained for review. Additional publications obtained were screened by one author to determine their eligibility before inclusion. Reviewers with experience in stroke care in each participating country assisted in reviewing guidelines that were not published in English language. We included all country-specific stroke guidelines published from 2010 to 2020 regardless of the language. To avoid duplication, we selected the most recent guidelines where there were two or more guidelines. We excluded guidelines if they were designed exclusively for management of stroke in younger people (age