






BMJ Open Current practices and challenges in adaptation of clinical guidelines: a qualitative study based on semistructured interviews

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To cite: Song Y, Ballesteros M, Li J, *et al*. Current practices and challenges in adaptation of clinical guidelines: a qualitative study based on semistructured interviews. *BMJ Open* 2021;**11**:e053587. doi:10.1136/bmjopen-2021-053587

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2021-053587>).

Received 23 May 2021

Accepted 27 October 2021

ABSTRACT

Objective This study aims to better understand the current practice of clinical guideline adaptation and identify challenges raised in this process, given that published adapted clinical guidelines are generally of low quality, poorly reported and not based on published frameworks.

Design A qualitative study based on semistructured interviews. We conducted a framework analysis for the adaptation process, and thematic analysis for participants' views and experiences about adaptation process.

Setting Nine guideline development organisations from seven countries.

Participants Guideline developers who have adapted clinical guidelines within the last 3 years. We identified potential participants through published adapted clinical guidelines, recommendations from experts, and a review of the Guideline International Network Conference attendees' list.

Results We conducted ten interviews and identified nine adaptation methodologies. The reasons for adapting clinical guidelines include developing *de novo* clinical guidelines, implementing source clinical guidelines, and harmonising and updating existing clinical guidelines. We identified the following core steps of the adaptation process (1) selection of scope and source guideline(s), (2) assessment of source materials (guidelines, recommendations and evidence level), (3) decision-making process and (4) external review and follow-up process. Challenges on the adaptation of clinical guidelines include limitations from source clinical guidelines (poor quality or reporting), limitations from adaptation settings (lacking resources or skills), adaptation process intensity and complexity, and implementation barriers. We also described how participants address the complexities and implementation issues of the adaptation process.

Conclusions Adaptation processes have been increasingly used to develop clinical guidelines, with the emergence of different purposes. The identification of core steps and assessment levels could help guideline adaptation developers streamline their processes. More methodological research is needed to develop rigorous international standards for adapting clinical guidelines.

Strengths and limitations of this study

- To ensure participants' representativeness, we invited clinical guideline (CG) adaptation experts through different ways, including adapted CGs, attendees from the Guideline International Network conference and additional strategies or sources.
- To reduce participant's bias, we complemented participants' views and experiences with their adaptation methodology publications.
- The interview format allowed us to explore the challenges of CG adaptation in depth and how the participants address specific issues.
- The challenges highlighted by our study are likely to be universal to experienced CG adaptation developers, since our participants' selection process limits the study samples to experts with sufficiently large experience in the CG adaptation or development field.
- Some specific challenges, such as particular contextualisation issues, might be under-reported in our study due to the small sample size and fewer participants from low-income/middle-income countries.

INTRODUCTION

Clinical guidelines (CGs) adaptation is an efficient methodology to develop contextualised recommendations.^{1 2} CG adaptation tailors existing trustworthy CGs for local, regional or national guidance, by considering local contextual factors, such as language, availability and accessibility of services and resources, the healthcare setting and the relevant stakeholders' cultural and ethical values.³ CG adaptation may lead to changes compared with the original recommendations in (1) the specific population, intervention or comparator, (2) the certainty of the evidence or (3) the strength of recommendations by including additional information regarding the health conditions,



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monitoring, implementation and implications for research.⁴ Besides, CG adaptation could also be used as an alternative method to develop *de novo* CGs, with the expectation of reducing waste of resources and avoiding duplication of efforts. However, this process should follow a similar and systematic approach as that of the source CGs to benefit from their quality.^{3 5 6}

Currently, there is no single standard adaptation methodology.^{7 8} One systematic review identified eight frameworks for CG adaptation¹: Resource Toolkit for Guideline Adaptation—ADAPTE instrument,⁹ Adapted ADAPTE,¹⁰ Alberta Ambassador programme adaptation phase,¹¹ Grades of Recommendations, Assessment, Development and Evaluation (GRADE) Evidence to Decision frameworks for adoption, adaptation and *de novo* development of trustworthy recommendations (GRADE-ADOLPMENT),⁴ Making GRADE the irresistible choice,¹² RAPADAPTE for rapid guideline development,¹³ Royal College of Nursing (RCN)¹⁴ and Systematic Guideline Review.¹⁵ Most of these frameworks are based on the ADAPTE instrument,⁹ while some use the GRADE Evidence to Decision frameworks.^{1 4} The comparison between frameworks showed similarities in the initial and final phases of the process, and notable differences in the ‘adaptation’ phase of the process.¹ Another recent review categorised the frameworks into formal and informal.⁷ However, new methods and experiences of CG adaptation periodically emerge.^{16–18}

Despite this, published adapted CGs seldom used a published adaptation methodology and their quality is still suboptimal.¹⁹ A systematic survey that assessed 72 published adapted CGs found that only 57 reported any details on adaptation methods, and only 23 used a published adaptation methodology. The proportion of published adapted CGs satisfying the steps of ADAPTE ranges from 4% to 100%. In addition, the mean score of adapted CGs assessed using Appraisal of Guidelines for Research & Evaluation II (AGREE II) was 57% for the ‘rigour of development’ domain, and 50% for the ‘applicability’ domain. Similarly, another systematic assessment found that only 30% of adapted WHO CGs reported adaptation process methods.²⁰

Challenges faced by adaptation groups are not well known and are likely to vary across CG organisations. A recent review described several limitations of published adaptation frameworks and showed that the time to adapt CGs using the same framework varies between 18 months and 3 years.⁷ Besides, most adaptation frameworks require methodology expertise; this might be a barrier for many CG adaptation groups, especially those from low-income/middle-income countries (LMICs). Although international collaboration and providing staff training could help, this should be based on a standardised adaptation process. Furthermore, most published adaptation frameworks were developed from adaptation experiences and lacked validation.⁷ No formal evaluation instrument or guidance could help expertise methodologists improve adaptation frameworks.⁷

In addition, fundamental gaps between international recommendations and realistic best practice are being reported due to poorly CG adaptation, which leaves health providers with non-useful guidance.²¹ There is an urgent need to explore the proper adaptation process and share the global adaptation experience. This study aims to better understand the current practice of CG adaptation and identify the challenges raised in this process, thus providing accordance for the improvement of the adaptation process.

METHODS

We applied a qualitative design using semi-structured interviews. This study is part of the RIGHT-Ad@pt project, which aims to develop a reporting checklist for CG adaptation.²² We reported findings using the Consolidated criteria for Reporting Qualitative research checklist.²³

From now on, we will refer to the CGs selected for adaptation as ‘source CGs’, and to the evidence from the source CGs as ‘source evidence’.

Participants

We sampled a group of CG developers, who had been involved in CG adaptation over the past 3 years using a snowball sampling method.²⁴ We identified potential participants from (1) authors lists of 16 published adapted CGs retrieved from a search for adapted CGs via PubMed (from 1992 to December 2019) (online supplemental appendix 01);²⁵ (2) suggestions from the advisory group of the RIGHT-Ad@pt project and (3) attendees of the 2019 Guideline International Network (G-I-N) conference.

We contacted potential participants by email with an invitation letter including (1) an introduction to the RIGHT-Ad@pt project, (2) the eligibility criteria, (3) the purpose of the semistructured interview, (4) the topics to be discussed and (5) the expected contribution from participants. We sent two email reminders within 1 month. After receiving consent for participation and before starting the semi-structured interviews, we circulated a more detailed description of the RIGHT-Ad@pt project, the interview guide, and collected the Conflicts of interest (CoI) form from each participant. We continued to recruit participants and collect data until we reached saturation.

Data collection

We designed an interview guide based on checklists previously developed by our group, and the experience obtained from the development of the RIGHT-Ad@pt checklist.^{22 26 27} The interview guide included four sections (online supplemental appendix 02): (1) characteristics of participants (country, experience in the field of health-related CGs and CG adaptation), (2) characteristics of participants’ CGs developing organisation, (3) participants’ experiences about current practice in the adaptation process and (4) participants’ views and

experiences about challenges in the adaptation process. Participants completed the first two sections before the interview. We also asked participants to provide the published methodology that supported their adaptation processes if applicable. Interviews were conducted face to face or via teleconference and lasted approximately 40 min. We audiorecorded each interview with the participant's permission. One researcher (YS, PhD(c), female, with guideline development and adaptation experience) conducted the semistructured interviews and transcribed them verbatim.

Data analysis

For quantitative variables (characteristics of participants and organisations), we calculated absolute frequencies and proportions.

For qualitative data regarding adaptation processes, we followed a framework deductive analysis.²⁸ First, we generated a priori thematic framework for the main steps of adaptation processes, based on relevant systematic reviews.¹⁷ Second, we sought additional concepts from the methodological evidence provided by participants. Third, we coded semistructured interviews findings against the resulting thematic framework, revised and merged codes into themes as new aspects emerged. Finally, we proposed subthemes under the drafted thematic framework. For participants' views and experiences about challenges, we applied an inductive thematic analysis; we coded the interview transcripts 'line by line', proposed descriptive themes following the coding process; and generated analytical themes by analysing, organising and creating descriptive subthemes.^{29 30} One author (YS) coded and extracted qualitative data, drafted the framework and proposed themes independently. Two authors (MB and JL) double-checked selected codes and the corresponding quotations. A second senior author (PA-C) reviewed the framework and themes. A final structure was confirmed by discussion and approved by consensus. We used NVivo (V.12 for Mac, QSR International) for qualitative analysis.³¹

Patient and public involvement

The patient and public were not involved in the study.

RESULTS

We invited 39 CG adaptation developers to participate. Participants were identified from published adapted CGs (49%; 19/39), suggestions from the Advisory Group of the RIGHT-Ad@pt project (28%; 11/39), attendees of G-I-N conference (2019) (15%; 6/39) and eligible participants' recommendations (7%; 3/39) (See figure 1). Finally, we conducted ten semistructured interviews between November 2019 and January 2020 until data saturation on the reason for CG adaptation and methodology was reached. Data from published methodologies of different participating

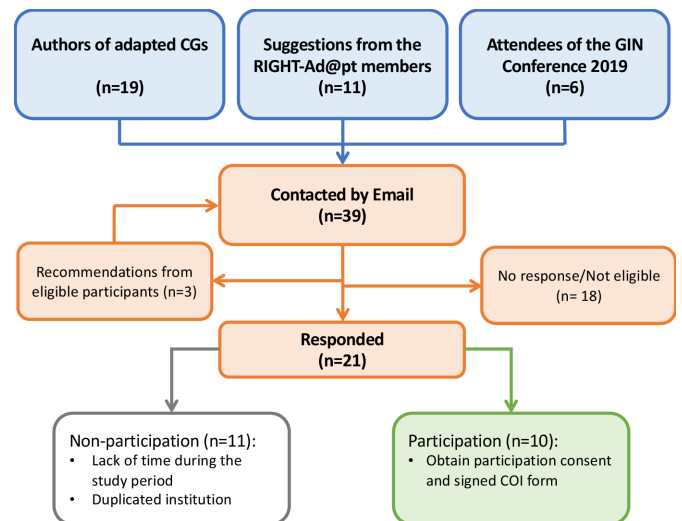


Figure 1 Participant recruitment flow diagram. Relevant conference attendees were identified by screening the list of conference attendees and oral presentation regarding CG adaptation. CGs, clinical guidelines; CoI, conflict of interest; GIN, Guideline International Network.

organisations were included in framework analysis to avoid individual bias. In addition, data from individuals were included in the thematic analysis to reflect participants' views and experiences.

Participants

The main characteristics of participants, as well as their organisations, are summarised in table 1. Participants worked in nine different organisations from seven countries, the majority being from high-income countries (60%; 6/10). Most participants had over 5 years of experience in CG adaptation (70%; 7/10). Most of the included organisations were research/knowledge-producing centres (67%; 6/9), had over 5 years of experience in CG adaptation (78%; 7/9), had a working group size that ranged from 6 to 20 members (78%; 7/9) and spent less than 2 years to complete their adaptation process (78%; 7/9). Most of these organisations had funding sources from government, medical association operation fees, national/international foundations, or the combination of those above (78%; 7/9). Three participants declared a CoI as a coauthor of published adaptation methodology. Other participants have nothing to declare.

Reasons for adapting CGs

We identified four main reasons for CG adaptation (table 2, online supplemental appendix 03): (1) to develop their own CGs; (2) to implement or endorse source CGs; (3) to update an existing CG and (4) to analyse conflicting recommendations from different source CGs. The most common reason to adapt was to develop CGs for their intended setting based on other existing CGs, by first retrieving and adapting existing CGs that could potentially answer their questions, saving resources and time and avoiding duplication of efforts.

Table 1 Characteristics of study sample

Characteristics of interviewees (n=10)	n (%)
Continents (n=10)	
Africa	1 (10)
Asia‡	3 (30)
Europe	2 (20)
North America	4 (40)
Experience in the CG field (n=10)	
Experience in developing CGs*	8 (80)
Experience in adapting CGs*	8 (80)
Methodological experience in developing CGs†	7 (70)
Methodological experience in adapting CGs†	9 (90)
CG user	4 (40)
Years of CG adaptation experience (n=10)	
0–5 years	3 (30)
6–10 years	3 (30)
11–20 years	4 (40)
Characteristics of organisations (n=9)	
Type of organisations (n=9)	
Hospital	1 (11)
Research/knowledge producing organisation	6 (67)
Service provider organisation (community)	1 (11)
University	2 (22)
Professional medical association	2 (22)
Years of CG adaptation practice (n=9)	
0–5 years	2 (22)
6–10 years	3 (33)
11–20 years	3 (33)
>20 years	1 (11)
The average size of CG adaptation working group (n=9)	
0–5	1 (11)
6–10	2 (22)
11–20	5 (56)
>20	1 (11)
Average time for CG adaptation (n=9)	
0–1 year	3 (33)
1–2 years	4 (44)
2–3 years	1 (11)
NR	1 (11)
Funding source (n=9)	
Government funding	2 (22)
Medical association operational fee	2 (22)
National/international foundations	4 (44)
Self-service fee	1 (11)
Pharmacy company	1 (11)

Continued

Table 1 Continued

Characteristics of interviewees (n=10)	n (%)
Multiple funding without industry	3 (33)
Multiple funding including industry	1 (11)

*Participation in a CG development/adaptation group at least once in the past year.

†Participation in a CG technical team at least once in the past year or participation in methodological research.

‡One expert is from Australia but develops CG adaptation in Philippines, we classified the country as Philippines. CG, clinical guideline; NR, not reported.

Some organisations focused on implementing source CGs in the target setting through CG adaptation. Three organisations also updated their own CGs by adapting newly published CGs, while another conducted adaptation processes only when there were discrepancies among different recommendations for the same topic.

Current practice

Six participants reported using their own adaptation methodology.^{8, 32–36} Three of them were based on the ADAPTE instrument and/or the GRADE-ADOLPMENT framework.^{4, 9} One participant used a published adaptation framework⁹ and supplemented it with GRADE to rate the certainty of the evidence.³⁷ Two used a guideline quality assessment tool named German Instrument for Methodological Guideline Appraisal (DELBI) to inform the CG adaptation process in their setting.³⁸ Lastly, one participant reported not using a formal methodology. See online supplemental appendix 04 for detailed new methodologies.

Participants reported using the following nine CG adaptation methodologies (table 3):

1. ADAPTE instrument.⁹
2. Adopt–Contextualise–Adapt framework.³⁶
3. American College of Physicians guidance statement.³⁴
4. American Society of Clinical Oncology CG endorsement/adaptation methodology.³²
5. Cancer Care Ontario's endorsement protocol.³⁵
6. DynaMed editorial methodology.³³
7. DELBI³⁸
8. GRADE-ADOLPMENT framework.⁴
9. Piloted adaptation Framework.⁸

Seven of the nine methodologies were not identified in previous publications. Based on the framework analysis, we identified four main steps in the process of adapting CGs (figure 2 and table 3).

Selection of the scope and source CG(s)

CG adaptation groups defined or identified CG topic, scope and key questions before or after the selection of source CGs. Most organisations reported first predefining the topic, scope and key questions, then searching for existing relevant or implementable CGs.^{9, 32, 33, 35} Some also identified key questions from newly released, well-known

Table 2 Views and experiences of CG adaptation

Themes	No of participants
Reasons for adapting CGs	
Develop their CGs	
As part of de novo CG development process	3
To avoid duplicates and save efforts	1
To save resources and time	3
Implementing/endorsing for target settings	5
Updating existing CGs	3
Solving recommendations' controversy	1
Challenges for adapting CGs	
Poor reporting or the limitations of source CG(s)	2
Limited skills in advanced CG development and adaptation	3
The intensity in terms of resources and time for adaptation	2
Specific steps of adaptation process:	
Addressing context differences between source CG(s) and adapted CG	4
Addressing inconsistency and integrate recommendations from different source CG(s)	3
Updating or supplementing with research evidence	1
Implementation barriers	5
Addressing context differences between source CG(s) and the adapted CG	
Through panel discussion	7
Adapting to the target context (at CG level)	
Prioritising the source CG(s) according to different factors	2
Discarding the source CG(s)	1
Adapting to the target context (at recommendation level)	
Evaluating the reason behind and reconsidering the strength of the recommendations	1
Contextualising by considering different factors	3
Formulating new recommendations for a specific population (eg, subgroups)	1
Adapting to the target context (at evidence level)	
Supplementing new evidence/other considerations	2
Reporting the differences when drafting the recommendation	3
Addressing inconsistencies between recommendations from different source CG(s)	
Through panel discussion	2
Selecting source CG(s) with different criteria (at CG level)	
Good quality/rigorous development of source CG(s)	5
Content relevance/suitability to the target context	2
Most up to date	2
Trustworthy source CG(s)	1
Assessing the reason for inconsistency	

Continued

Table 2 Continued

Themes	No of participants
At recommendation level	4
At evidence level	3
Not applicable when single CG was included	4
Updating source evidence	
Trigger for supplement/update search of source CG(s)	
Source CG(s) do not answer all the questions of interest	3
Source CG(s) are outdated	1
Source CG(s) are consensus-based	2
Experts' suggestions	2
Way of including new evidence	
Literature search (eg, pragmatic search or a full de novo search)	6
Update the search from source CG(s)	3
Experts' suggestions	3
If the source CG(s) are not evidence-based or do not answer the questions	
Start CG de novo development process	3
Discard the recommendation	1
Conduct the consensus process	1
Considering implementation barriers	
Way of obtaining information	
Experts' opinion	4
Literature search	5
Group discussion	5
Decision making after consideration of implementation barriers	
Modifying the practice instead of change recommendations	1
Modifying the recommendations	1
Reporting the differences if needed	4
CGs, clinical guidelines.	

and trustworthy CGs.^{4 35} The screening criteria of source CGs for a further appraisal at this preliminary stage were: (1) stakeholders' preferences of CG topic;^{4 32 35} (2) a good reputation of the CGs developers;^{32 34 35} (3) methodological quality of the source CGs;^{8 9} (4) clinical relevance to the target context³³ and (5) CoIs management and funding independence of the source CGs.³²

Assessment of source materials

CG adaptation groups reviewed and assessed source CGs. We stratified this step into three levels based on participants' reported practice:

- **Guideline level:** The guideline quality, trustworthiness, transparency of the process, value and relevance to clinical practice, resource availability and inclusion of latest evidence (up to date) were assessed.^{9 32-36} To rate the CG quality, most participants applied the AGREE II instrument. To ensure source CGs were up

Table 3 Main steps of the adaptation process

	Selection of the scope and source CG(s)		Assessment of source materials	Decision-making process	External review and follow-up
Adaptation methodology/year CG(s)					
ADAPTE 2010 ⁹	<ul style="list-style-type: none"> ▶ Determining the health question ▶ Search for existing CGs/other relevant documents ▶ Source CG(s) screening and selection 	<ul style="list-style-type: none"> ▶ Source CG quality assessment ▶ Source CG currency assessment ▶ Source CG content assessment ▶ Source CG consistency assessment ▶ Acceptability and applicability of recommendations assessment 	<ul style="list-style-type: none"> ▶ Review assessment ▶ Choosing between source CGs and recommendations 	<ul style="list-style-type: none"> ▶ External review and acknowledgement of source CG(s) ▶ Consulting source CG(s) 	
Adopt-Contextualise-Adapt Framework 2016 ³⁶	<ul style="list-style-type: none"> ▶ Redefining CG topics¹ ▶ Search for international existing CGs ▶ Source CG(s) selection by evaluating the implementability of the question to the target setting 	<ul style="list-style-type: none"> ▶ Evaluation of methodological quality of the source CG(s)^a ▶ Content review and recommendations and evidence summary ▶ Identifying recommendations relevant to steps along the patient journey ▶ Dealing with two or more relevant recommendations ▶ Supplementing with local evidence^a 	<ul style="list-style-type: none"> ▶ Developing composite recommendations⁴ ▶ Decision making as adoption, contextualisation/adaptation according to the local context 	<ul style="list-style-type: none"> ▶ Plan Implementation ▶ Focused public consultation ▶ Planning and evaluation of the CG adaptation roll out ▶ Establishing partnerships 	
ACP guidance statement 2019 ³⁴	<ul style="list-style-type: none"> ▶ Choosing topics with recommendation conflicts ▶ Search and selection of national-level source CG(s) within 5 years² 	<ul style="list-style-type: none"> ▶ Assessing quality and process transparency of source CG(s) ▶ Assessing the interpretation of the evidence (benefits, harms, costs, and patient values and preferences) ▶ Source evidence review^b 	<ul style="list-style-type: none"> ▶ Presenting evidence summary and proposing recommendations ▶ Reaching consensus by discussion or voting 	<ul style="list-style-type: none"> ▶ Public panel review ▶ Peer review process ▶ Publication ▶ Financial support ▶ Reporting ▶ Updating 	
ASCO CG endorsement/adaptation methodology 2019 ³²	<ul style="list-style-type: none"> ▶ Based on the ASCO's priority topics ▶ Selection of source CGs matched by criteria³ 	<ul style="list-style-type: none"> ▶ Quality of source CGs appraisal using AGREE II^c ▶ Content review with expert's agreement on recommendations ▶ SRs appraisal using AMSTAR and search for new evidence (eg, when the evidence base is outdated.) 	<ul style="list-style-type: none"> ▶ Evidence synthesis with a matrix containing recommendations and supporting evidence ▶ Independent evidence review by the expert panel ▶ Modification decision (eg, contextualisation, clarification, or new evidence addressing) made by the expert panel ▶ Full committee approval or voting for consensus 	<ul style="list-style-type: none"> ▶ Review by applicant organisations of source CG(s) ▶ Peer review by journal ▶ Publication ▶ Derivative clinical tools/resources ▶ Updating 	

Continued

Table 3 Continued

Selection of the scope and source CG(s)		Assessment of source materials	Decision-making process	External review and follow-up
Adaptation methodology/year	CG(s)			
CCO endorsement protocol 2019 ³⁵	<ul style="list-style-type: none"> Defining key topics based on the release of well-known CGs that meet the interest of CCO or Defining key topics based on CG-related project and identify existing CG addressing CCO's topic 	<ul style="list-style-type: none"> Initial assessment and selection of source CG(s)^d Source recommendations assessment^e Likelihood of new evidence assessment (if so, a de novo development will start) 	<ul style="list-style-type: none"> Review of the draft endorsement document by an expert panel Consensus and approval 	<ul style="list-style-type: none"> Professional Consultation Final Publication Maintenance/Updating
DynaMed editorial methodology 2019 ³³	<ul style="list-style-type: none"> Based on the current existing topics of Dynamed Screening and selection of the best available evidence based on relevance and potential impact on clinical decision-making and patient care 	<ul style="list-style-type: none"> Critically appraisal of source CGs regarding trustworthiness, relevance, and clinical value Rating of the strength of the recommendations (eg, net benefit, cost and burdens, and patients' value)^f Rating of potential source of bias and certainty of the evidence 	<ul style="list-style-type: none"> Evidence reporting and review by clinicians Synthesis of multiple evidence reports^g Based on conclusions of the overviewed evidence with direct links provided 	<ul style="list-style-type: none"> Review by the editorial team, topic/section editors, and EBM experts Updating daily
DELBI 2019 ³⁸	<ul style="list-style-type: none"> Defining key questions before source CG selection⁴ Systematic search for existing CGs Criteria description for source CG selection 	<ul style="list-style-type: none"> Quality review of source CG(s)⁹ Source recommendation review⁹ Systematic update of searches for primary evidence 	<ul style="list-style-type: none"> Describing the modifications of recommendations 	<ul style="list-style-type: none"> External review CG adaptation process*
GRADE-ADOLPMENT 2017 ⁴	<ul style="list-style-type: none"> CG topic and source CG selection⁵ Questions prioritisation by the panel from selected source CGs 	<ul style="list-style-type: none"> Checking Evidence to Decision frameworks availability of source CGs Completing the GRADE Evidence to Decision frameworks Updating systematic reviews of health effects and identifying local data^h 	<ul style="list-style-type: none"> Preparing GRADE Evidence to Decisions frameworks and review by an expert panel Formulating recommendations through consensus or voting 	<ul style="list-style-type: none"> NA
Piloted adaptation framework 2017 ⁸	<ul style="list-style-type: none"> CG topic prioritisation and Ministry of Health approval CG search from National guideline Clearinghouse 	<ul style="list-style-type: none"> Source CG quality assessmentⁱ Identifying relevant recommendations from source CG(s) based on panel expertise and clinical practice settings 	<ul style="list-style-type: none"> Adopted/adapted/new recommendations compilation Expert review 	<ul style="list-style-type: none"> External review Online access for public consultation Updating
Adaptation experience 2019	<ul style="list-style-type: none"> Predefining health questions⁶ Searching for existing CG⁶ 	<ul style="list-style-type: none"> Source CG quality assessment using AGREE II^j Identifying evidence from the most up-to-date CGsⁱ Underlying evidence reviewⁱ 	<ul style="list-style-type: none"> Evidence review from source CG(s) Decision-making by national-level experts with no further details provided^μ 	<ul style="list-style-type: none"> National external review¹

Continued

Table 3 Continued

Adaptation methodology/year CG(s)	Selection of the scope and source	Assessment of source materials	Decision-making process	External review and follow-up
<p>The criteria or clarification for topic/scope/questions selection and source CG screening:</p> <p>1: Quote: 'At that time we have identified the top of the conditions for stroke and low back pain. We look at the literature, even at that time, there were so many CGs published already for those two topics.' (Participant 10)</p> <p>2: Sources were from PubMed and GIN library in the last five years or current practice, and Web of science.</p> <p>3: Criteria are: high-quality CG developers, detailed Col management, and financially independence; or applicant organisations' preferable.</p> <p>4: Quote: 'If the CG adaptation groups plan to develop a new CG, they will search for the existing evidence from published CGs first.' (Participant 06)</p> <p>5: Assessed the relevance to stakeholders, proposed by a professional group or prioritised by stakeholders; in addition, GRADE approach and Evidence to Decision frameworks availability are required.</p> <p>6: Quote: 'A lot of kind of process will be in a national process, and there will be specific health questions and PICO's. Then we will be asked to conduct SRs. We do have in that particular process is that the SR would include first to look at what CGs are out there, and then we will look at what SRs are out there before we conduct our systematic review.' (Participant 09)</p> <p>The considerations or clarifications for the assessment of source materials:</p> <p>a: Quote: 'We quickly appraise source CGs using AGREE II to ensure the source CG you are basing on are good quality; ... To adapt, we update the search and include new evidence. ... It means you take evidence surrounded for instance in the local context settings, there might be a new paper has been published locally, not internationally, but it answers the questions the local context actually asked. Then the recommendation could change.' (Participant 10)</p> <p>b: Quote: 'We will look at the evidence and do the assessment ourselves. If we do the quality assessment, we look at the systematic review, and if the systematic review doesn't make sense, we will look at the primary studies.' (Participant 07)</p> <p>c: Quote: 'We do not have a numeric cut-off for AGREE II.' (Participant 02)</p> <p>d: Criteria: Scope, relevance, and timing, quality and methods, resource availability; acceptability;</p> <p>e: Interpretation and justification, applicability/relevance, qualifications & clarifications.</p> <p>f: Quote: 'If we see many CGs agree, and we know the evidence is high quality, we don't need to go into a lot of greater depth because everything is pointing into the right direction. If we see the CGs are disagreeing, then we may have to evaluate and see why they are disagreeing and that where we checked the currency of the content to help us to understand the disagreement.' (Participant 01)</p> <p>g: Quote: 'We don't have a critical cut off to choose which CG to use, we do prioritise by the quality of the CG. The CG adaptation group will create CG synopses, prefer methodologically sound recommendations. ... The adaptation group should be transparent if they have appropriate changes in the recommendations when the adaptation process and provide the scientific rationale behind the change.' (Participant 03)</p> <p>h: We conducted rapid SRs of patient's value, cost-effectiveness; We considered local data suggested by panel members (patients' value and preference, cost, resource use, population prevalence and incidence).</p> <p>i: Quote: 'We request the adaptation group to assess the quality of the CGs using the AGREE II instrument. We do not have a cut-off of the AGREE score, because sometimes there are few source CGs for the consideration of adaptation. ... If there are no clear answers for several questions in the source CG(s), they looked at existing Cochrane SRs but do not conduct a new one. No cost-effectiveness evidence was searched, but patients' values and preferences, yes.' (Participant 08)</p> <p>j: Quote: 'If there is a CG of good quality, those are the recommendations. So, if I see a CG from NICE, or from European, our society will have both or do an AGREE appraisal. If there are good quality, I transparently put in my review about what the quality it was, and I pooled out the recommendations that could be relevant for that health question. And then I also look at the underlying evidence from those CGs, also the SRs, that independent of pooling out the if possible, a GRADE evidence table, or something that explains the magnitude of the effect and the certainty of evidence.' (Participant 09)</p> <p>The considerations or clarifications for the decision-making process:</p> <p>a: Quote: 'In the most recent CG we published, we extracted the source recommendations from the source CGs, we have developed composite recommendations, which is the new recommendation based on the other CG have said...' (Participant 10)</p> <p>β: 'Current evidence, current CGs, and clinical expertise's recommendations to support clinical decision making'.</p> <p>μ: Quote: 'For people who work in the CG adaptation group they have any Evidence to Decision framework, so they will look at the quality of evidence from source CGs or other SRs.' (Participant 09)</p>				

Continued

Table 3 Continued

Adaptation methodology/year CG(s)	Selection of the scope and source	Assessment of source materials	Decision-making process	External review and follow-up
<p>The considerations or clarifications for the external review process:</p> <p>* Quote: 'Our organisation doesn't do for the CG adaptation group, but they do the external review process by themselves'. (Participant 03)</p> <p>† Quote: 'The national group I am referring to send the adapted CG out for comment, feedback, and input as external review. We don't have a specific small external review team broadly.' (Participant 10)</p> <p>DELBI is a CG assessment tool used by adaptation group to inform CG adaptation.</p> <p>ACR, American College of Physicians; ADAPTE, Resource Toolkit for Guideline Adaptation; AGREE II, Appraisal of Guidelines for Research & Evaluation II; ASCO, American Society of Clinical Oncology; CCO, Cancer Care Ontario; CGs, clinical guidelines; Col, conflict of interest; DELBI, German Instrument for Methodological Guideline Appraisal; GRADE, Grading of Recommendations, Assessment, Development and Evaluations; NA, not applicable; NICE, National Institute for Health and Care Excellence; SR, systematic review.</p>				

to date, some participants conducted a comprehensive search and chose the most recent CG among those with similar quality.

- ▶ Recommendation level: The recommendation content, the formulation process of source recommendations (eg, how the net benefit, resources, patients' values and other criteria were considered), as well as the strength of recommendation were reviewed.^{8 9 32–35} Some participants used a CG summary format to display recommendations and facilitate panel discussion.^{8 32 38} Recommendations were modified as needed based on the discussion of the evidence.^{4 33 34}
- ▶ Evidence level: The certainty of the evidence of the source recommendations was reviewed.^{4 6 9 33–35} Some participants assessed the risk of bias of included primary studies and systematic reviews, and the certainty of the source evidence.^{32 33} Besides, updating the original search or supplementing with new evidence was also conducted at this level, if necessary.^{4 6 8 32 33 38} The reasons to update source evidence were: (1) it did not clearly answer all the key questions; (2) it was not adequately searched or appraised; (3) it was considered outdated (eg, more than 3 years since the last search) or (4) when panel experts recommended it (table 2, online supplemental appendix 03).

Decision-making process

CG adaptation groups review the summarised evidence and decide whether to adapt (with modifications) or adopt (without modifications) the source recommendations. To support the decision, some participants presented the summarised evidence using a matrix or direct links containing both recommendations and evidence. Where CG developers of source CGs used GRADE-ADOLOPMENT, the GRADE Evidence to Decision frameworks of source CGs were reviewed or completed by the CG adaptation groups.⁴ Decisions were made mostly through panel discussion or voting.

External review and follow-up

Following the decision-making process, an external review or a peer review process was conducted. Moreover, a follow-up process was scheduled, including the plan for dissemination, monitoring and updating. Those processes were similar to *de novo* CG development processes. However, some organisations also consulted source CG developers on the changes made to source recommendations.^{9 32}

Challenges for adapting CGS

Most participants reported challenges to the adaptation and development of CGs in general (table 2, online supplemental appendix 03). Challenges of the adaptation process were: (1) limitations from source CGs, including poor reporting and quality; (2) limited advanced CG development and adaptation skills of the CG adaptation group; (3) resource and time intensity required for

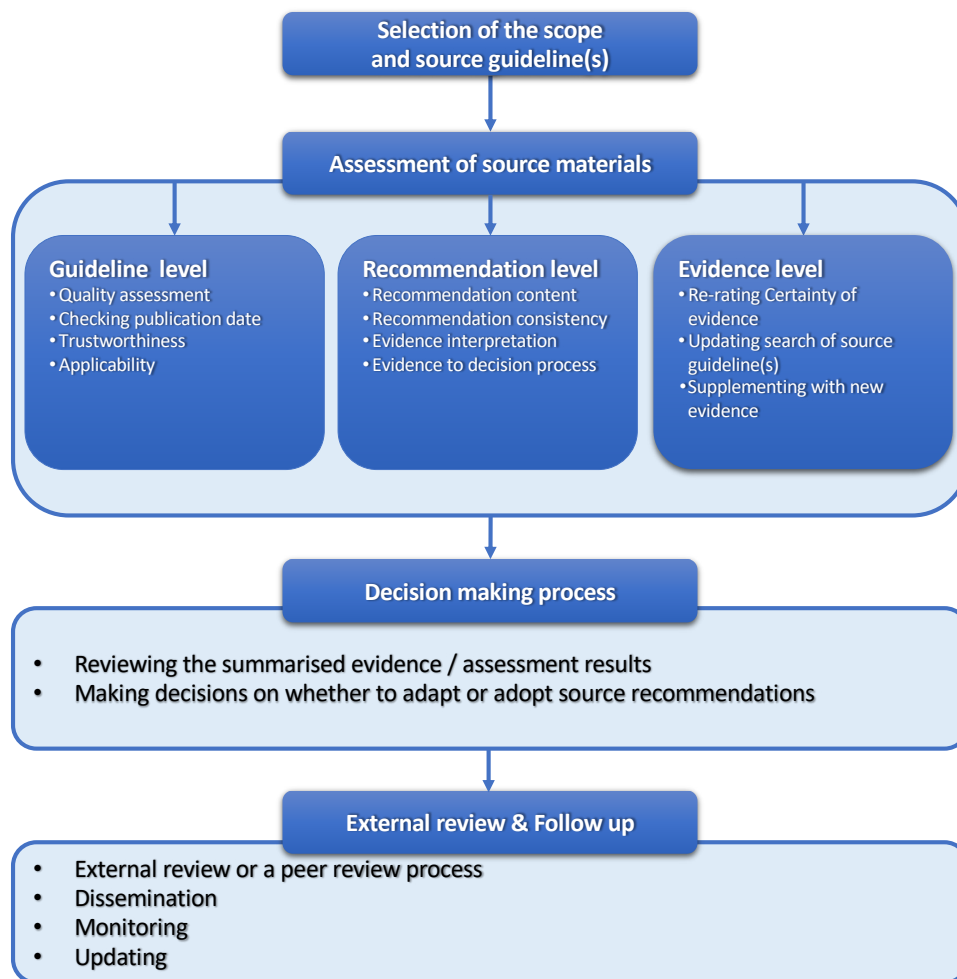


Figure 2 Main steps of the adaptation process. CGs, clinical guidelines.

adaptation; (4) challenges arising from specific adaptation process, including how to address and report context differences between source CGs and adapted CGs; how to address inconsistency and integrate recommendations from different source CGs, and how to update source evidence, including update search and supplement with additional evidence and (5) implementation barriers of CG adaptation.

We identified participants' strategies for dealing with the specific challenges within the adaptation process and implementation issues (table 2, online supplemental appendix 03).

Addressing context differences between source CG(s) and adapted CG

According to participants' views and experiences, the differences in setting or population between source CGs and target context were addressed mainly through panel discussion and experts' opinions. CG adaptation groups could address these differences at multiple levels: (1) at CG level, by prioritising source CGs according to different criteria or discarding the entire source CGs if the difference was large enough; (2) at recommendation level, by modifying the strength of recommendations due

to differences after considering the balance of the benefits and harms, other factors (eg, acceptability or feasibility) or formulating new recommendations (eg, new recommendations for subgroup population) and (3) at evidence level, by supplementing with new evidence (eg, local data). Finally, participants stated that differences and modifications were reported or documented along with the adapted CG.

Addressing inconsistencies between recommendations from different source CG(s)

The inconsistency between recommendations was addressed by prioritising those source CGs that (1) had good quality or rigorous development process, (2) were relevant to the target context, (3) were most up to date and (4) were considered trustworthy. The reasons behind the inconsistency were also assessed on the recommendation and evidence level. At the recommendation level, whether (1) the inconsistency was due to a different target population, (2) the evidence was sufficient or up to date and (3) the evidence was appropriately interpreted. At the evidence level, whether the source evidence was appropriately assessed.

Updating source evidence

CG adaptation groups sometimes used evidence that is more recent or relevant in addition to the source evidence. To identify new evidence, participants relied on literature searches, including full *de novo* search or pragmatic search (eg, PubMed, local databases or Cochrane database), updating the source search or experts' suggestions. However, half of the participants expressed their unwillingness to supplement with new evidence since they generally based on the source CGs, maintaining the merits of adaptation to save resources and time. If the evidence base of the source CGs was unclear or did not answer their questions, participants conducted a *de novo* CG development process, discarded the recommendation or formulated recommendations based on the discussion.

Considering implementation barriers

CG adaptation groups considered different implementation barriers, including medical policy, cost of the intervention or management, equity, applicability or feasibility. The implementation barriers were identified through experts' opinions (eg, policymakers, primary carers or CG adaptation panel) or literature search (eg, local data). Most of the CG adaptation groups held a discussion to address implementation barriers by considering the applicability of their settings. As a result, either the recommendations or the implementation plan were modified to facilitate the CG adaptation. Finally, the differences in implementation considerations with the source CGs and the modifications were reported in the adapted CGs.

DISCUSSION

Our study summarises the current practice of CG adaptation derived from different methodologies used by nine organisations worldwide. We structured adaptation processes into four steps, including three-level source materials assessment (guideline, recommendation and evidence level). We identified the reasons of CG adaptation groups for adaptation, the challenges faced during the process, and their strategies to overcome these. Most of the identified methodologies were not discussed in previous systematic reviews.

Our findings in the context of previous research

We described reasons for conducting adaptation processes, which has not been previously highlighted in the literature.^{1 7} Fervers *et al* defined CG adaptation as an alternative methodology to developing *de novo* CGs or as a systematic method to improve implementation.³⁹ Our findings reflect this definition and suggest that most adaptation groups are conducting adaptation processes as part of their CG *de novo* development. Besides, we identified that adaptation processes could also play a role in updating and harmonising source recommendations.

We identified nine adaptation methodologies that CG adaptation groups have been using, two of which had

been described by previous reviews, while seven had not.^{1 7} Unlike previous reviews, our study—in addition to summarising and comparing published frameworks—describes the used adaptation processes in a novel structured way, including the stratified assessment of source materials. This stratification fits the conceptual progression of CG adaptation; Fervers *et al* considered two levels in this process, the guideline level (quality of source CGs) and recommendation level (coherence between evidence and recommendations, and the applicability of specific recommendations).³⁹ More recently, Wang *et al* described a shift towards an evidence level (evidence of recommendations).⁷

To this day, very few studies have explored the challenges arising from the adaptation process. Only one review has described the limitations of using adaptation frameworks and gaps for adaptation knowledge.⁷ Our study identified that adaptation challenges arise from limitations of source CGs (poor quality or reporting), limitations of adaptation settings (lacking resources or skills), and the complexity of the adaptation process. In addition, we described the strategies used by the participants to address specific steps of the adaptation process, thereby providing new knowledge to inform more streamlined adaptation processes: for contextualisation and reconciliation, adaptation groups could address different issues at three levels of source materials assessment; for updating source evidence, they could add new evidence through a literature search or experts' suggestions; for implementation, adaptation groups could hold a panel discussion, and consider modifying recommendations or the implementation plan if necessary.

Limitations and strengths

Our study has some limitations. We only conducted ten interviews and hence could have missed additional adaptation methods from other countries. In addition, we recruited participants from published adapted guidelines and G-I-N attendees, limiting the study samples to experts with sufficiently large experience in CG adaptation or development field. Besides, we did not interview non-English-speakers, which may bias the study results. Finally, we did not conduct data analysis based on country income due to the small sample size and fewer participants from LMICs that lack resources and technical/methodological experts.²¹ The challenges highlighted by our study are likely to be universal within experienced guideline adaptation developers (eg, intensity and complexity of adaptation process, limitations of source CGs, and implementation barriers). However, some specific challenges, such as specific contextualisation issues, would be under-reported in our study.

Our study also has some strengths. We invited CG adaptation experts from identified adapted CGs, attendees from the G-I-N conference, and other additional strategies or sources to ensure representativeness. To reduce participant's bias, we complemented participants' views and experiences with their adaptation methodology



publications. The interview format allowed us to explore the challenges of CG adaptation in depth and how the participants address specific issues. Moreover, we conducted a framework analysis based on published adaptation frameworks, ensuring our findings' comprehensiveness. Finally, we presented the results in a user-friendly format, including tables and figures.

Implication for practice

CG adaptation has been increasingly used in the guideline arena with diverse initiatives emerging and can be used as a pragmatic methodology to develop recommendations. In 2020, an international WHO collaboration project developed a living map of the latest evidence-based recommendations for the prevention and treatment of COVID-19.⁴⁰ This project makes the source materials available online and allows CG developers to adopt or adapt relevant recommendations for their questions of interest. CG developers could therefore avoid duplication of efforts and focus on how to implement scientific guidance to tackle this public health crisis.

Adaptation processes should be conducted rigorously. The identified core steps of the adaptation process and assessment levels could help CG adaptation groups streamline their future initiatives. CG adaptation groups could predefine the level of source materials to evaluate, simplifying the adaptation process while remaining rigorous. The adaptation process overlaps with the CG *de novo* process when assessing source materials at the recommendation level and the evidence level. At the recommendation level, CG adaptation groups need to review the factors considered to formulate source recommendations. This process uses an approach similar to that applied by the source panels and requires explicit and transparent reporting on the formulation of source recommendations to achieve feasibility. For example, if source CGs followed the GRADE Evidence to Decision frameworks, the adaptation groups need to review the interpretation of evidence regarding each factor considered under the Evidence to Decision frameworks. Not all robust source CGs use the GRADE Evidence to Decision frameworks, but yet, describe in detail how they make recommendations. Similarly, at the evidence level, the boundary between the CG adaptation process and the *de novo* process blurs. The notable difference could be that a *de novo* process conducts a full *de novo* search while the adaptation process updates the source search or supplements it with local evidence. Although the structured adaptation process could be used as a framework, its usability should be further formally assessed and validated.

Implication for future research

There is still room for improving adaptation methodology, especially the efficiency of adaptation processes and the quality as well as credibility of CG adaptation. Besides, there is no framework to guide CG adaptation groups to make judgements on whether to adapt, adopt or develop *de novo* recommendations based on the assessment of source materials. Although the GRADE-ADOLOPMENT is available, it requires the Evidence to

Decisions frameworks from source CGs. A standardised and pragmatic adaptation methodology, including guidance on how to make judgements, should be developed. Furthermore, there is still a need of a validated quality assessment tool and comprehensive reporting guidance to improve the rigorous CG adaptation. The structured adaptation process could be considered as a critical aspect of the quality assessment.

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Funding YS is funded by China Scholarship Council (No 201707040103).

Competing interests EAA has intellectual Cols related to his contribution to the development of methods of guideline adaptation, the RIGHT statement and methodological studies in the field.

Patient consent for publication Not applicable.

Ethics approval The protocol obtained a waiver approval (did not involve patients, biological samples or clinical data) from the Clinical Research Ethics Committee at the Hospital de la Santa Creu i Sant Pau (Barcelona, Spain).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as online supplemental information.

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Appendices

Appendix 01. Identification of published adapted CGs

One author (YS) screened and selected adapted CGs based on pre-established eligibility criteria: “adapted guidelines”, “reported at least one recommendation”, “described the adaptation process”, and “published in English”. Another author (RV) double-checked the findings. We contacted the first author of adapted CGs for participation. If the first author did not respond, we contacted the corresponding author. If they could not participate, we requested they recommended another potential participant. We finally identified 472 records from the pragmatic search, after removing the duplicates and screening title and abstract, we reviewed 41 full texts and 16 adapted CGs to extract contact information.

The pragmatic search strategy of published adapted clinical guidelines and included studies

Search strategy (PubMed from 1992 December to 2019 September)	
#1	“Practice Guidelines as Topic”[Major]
#2	Practice guideline*[tiab]
#3	Clinical guideline*[tiab]
#4	Evidence based guideline*[tiab]
#5	Guideline*[ti]
#6	Recommendation*[ti]
#7	Adopt*[ti]
#8	Adapt*[ti]
#9	Adaptation[tiab]
#10	#1 OR #2 OR #3 OR #4 OR #5 OR #6
#11	#7 OR #8 OR #9
#12	#10 AND #11
Included studies	
1	Nishiyama H. Asia Consensus Statement on NCCN Clinical Practice Guideline for bladder cancer. <i>Jpn J Clin Oncol.</i> 2018;48(1):3-6.
2	Guideline Adaptation Committee. <i>Clinical Practice Guidelines and Principles of Care for People with Dementia.</i> Sydney. Guideline Adaptation Committee; 2016.
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Appendix 02. Interview Open-ended questions

Section 1: Characteristics of participants	
Questions	Probes/Answers
Country	
Organisation	
Please choose the option that best describes your organisation	<input type="checkbox"/> Hospital <input type="checkbox"/> Primary care / General practice <input type="checkbox"/> Research / Knowledge production organisation <input type="checkbox"/> Service provider organisation (community) <input type="checkbox"/> University <input type="checkbox"/> Other
If OTHER, please specify	
How many years of experience in guideline adaptation do you have?	
Please choose the option that best describes your current experience in the health-related guidelines field (please select all that apply)	<input type="checkbox"/> Experience in developing clinical guidelines (participation in a guideline development group at least once in the past year). <input type="checkbox"/> Experience in adaptation clinical guidelines (participation in a guideline adaptation group at least once in the past year). <input type="checkbox"/> Methodological experience in developing clinical guidelines (participation in a guideline technical team at least once in the past year and/or participation in methodological research). <input type="checkbox"/> Methodological experience in adaptation clinical guidelines (participation in a guideline technical team at least once in the past year and/or participation in methodological research). <input type="checkbox"/> Clinical guidelines user (use of clinical guidelines on a daily basis). <input type="checkbox"/> Other: ()
Section 2. Characteristics of health-related guideline developing organisation	
Questions	Probes/Answers
Does your organisation develop health-related guidelines (HRGs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
How many HRGs has your organisation published?	
How many years has your organisation been developing HRGs?	
What is the average size of your HRG development group?	
Does your organisation adapt HRGs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
How many adapted HRGs has your organisation published in the last 3 years?	
How many years has your organisation been adapting HRGs?	
What is the average size of your adaptation group?	
What is the average time for your organisation to develop an adapted guideline?	<input type="checkbox"/> 0 – 1 year <input type="checkbox"/> 1 – 2 years

	<input type="checkbox"/> 2 – 3 years <input type="checkbox"/> ≥ 3 years
Which role does your guideline adaptation group include?	1. Clinicians 2. Patients 3. Methodologists 4. Policy makers 5. Other roles If other, please specify
Section 3. Current practices regarding guideline adaptation in your organisation	
Questions	Probes/Answers
1. What is the trigger for your organisation to adapt source guideline(s)?	<input type="checkbox"/> Implementing the source guideline in your setting <input type="checkbox"/> Developing a <i>de novo</i> guideline <input type="checkbox"/> Others <input type="checkbox"/> Do not know
If others, please specify:	
2. Could you please describe the adaptation process or which framework or methods your organisation used for guideline adaptation?	<input type="checkbox"/> ADAPTE 2010 based <input type="checkbox"/> GRADE based (MAGIC, GRADE-ADOLOPMENT) <input type="checkbox"/> Others
If others, please describe and provide citations (if applicable):	
3. Does your organisation assess the quality, currency, or content of the included source guideline(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how does your organisation assess those aspects? Please specify	
4. Does your organisation consider the difference between source guideline(s) and target context? Like the population, the setting/health systems, or practice variation/target users?	<input type="checkbox"/> Yes <input type="checkbox"/> No
According to your experience, how does your organisation solve the differences? Please specify	
5. Does your organisation assess the consistency of the included source guideline(s)? (Only when ≥ 1 source guideline included)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Only one source guideline included, not applicable
According to your experience, how does your organisation solve the inconsistency? Please specify	
6. Does your organisation consider other systematic reviews/new evidence that might not be included in the source guideline(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
According to your experience, how does your organisation consider other systematic reviews or new evidence?	<input type="checkbox"/> Incentive of starting <input type="checkbox"/> Literature search <input type="checkbox"/> Experts' groups <input type="checkbox"/> Others
If using other methods, please describe:	
7. Does your organisation typically consider constrains/barriers like legislation, policies, or healthcare-setting resources that might impact the implementation when adapting?	<input type="checkbox"/> Yes <input type="checkbox"/> No

According to your experience, how does your organization consider implementation barriers?	
8. Does your organisation externally review the guidelines you adapt prior to publication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
9. What is the funding source for guideline adaptation in your organisation?	
Section 4. Challenges during guideline adaptation process	
Questions	Probes/Answers
1. According to your experience, which part is the most challenging for your organisation when adapting guidelines?	<input type="checkbox"/> Choosing the health question <input type="checkbox"/> Searching for evidence (source guidelines or systematic reviews) <input type="checkbox"/> Evaluating the evidence (source guidelines or systematic reviews) <input type="checkbox"/> Making recommendations from evidence <input type="checkbox"/> Implementation
If others, please describe the identification process:	

Appendix 03. Views and experiences on guideline adaptation

Themes	Quotations
Question: What is the trigger for your organisation to adapt source guideline(s)?	
Developing their guidelines (7 Participants)	<p>✓ As part of de novo guideline development process (3 participants): <i>“The trigger will be for developing a de novo guideline. We adapt multiple guidelines at a time. The multiple guidelines are usually developed in countries like the UK, Canada, the US etc. Then we adapt those for those resources constrain setting.” – (Participant 02)</i></p> <p><i>“For developing de novo guideline. Basically, we are based on the evidence from existing evidence and then may search for new evidence” – (Participant 04)</i></p> <p><i>“Generally, we develop our research question and search for evidence/source guidelines to answer our question. If we find a guideline that answered our question, that is the trigger for us to adapt the guideline potentially.” – (Participant 05)</i></p>
	<p>✓ Avoiding duplicates and saving efforts (1 participant) <i>“Basically, the trigger is to avoid the duplication of the guideline development efforts. Especially the searching and appraising the primary evidence. We advise them to use aggregate evidence before they do their own research. This is one hand, and for another hand will pause to do systematic reviews” (Participant 03)</i></p>
	<p>✓ Saving resources and time (3 participants) <i>“If the guideline group plan to develop a new guideline, they will search for the existing evidence first. However, in the process of adaptation, they always realise that they could not only implement a source guideline because there is some difference between the target settings. If there is already evidence-based up to date guidelines, groups want to use them for their own guideline to avoid or minimise efforts of systematic searches.” (Participant 06)</i></p> <p><i>“First, to say primarily, the first we don’t want to spend resources on developing de novo. Ideally, we would adapt the source guideline(s). The first trigger for adaptation is that we want to limit the cost and to save resources.” (Participant 09)</i></p> <p><i>“We needed to develop in a short period, and we did not have enough money and people to be involved.” (Participant 10)</i></p>
Implementing/Endorsing for target settings (5 participants)	<p>✓ Implementing (3 participants) <i>“Given time and resource constraints, the task force discounted developing new guidelines and opted to adaptation. We use a pragmatic method by which evidence-based guidelines could be adapted to suit our context. New review questions were recommended only for areas not covered by existing guidelines.” (Participant 08)</i></p> <p><i>“Government support to adapt for implementation: To be realistic, sometimes the policies or others suggest there is a need to adapt.” (Participant 09)</i></p>

	<p><i>"We were consulted to assist in developing guidelines that were relevant and implementable in a resource-limited setting."</i> (Participant 10)</p> <p>✓ Endorsing (2 participants)</p> <p><i>"We also do guideline endorsement; sometimes, other organisations come to ASCO to ask us to endorse their guidelines. This could be the single source guidelines. We ask our panel to not change anything of the source guideline(s). In minority times, they made some modifications based on other processes of our own. It's a similar process with what we called adaptation."</i> (Participant 02)</p> <p><i>"We will not search for new evidence when endorsement or adaptation if the source guideline did not answer all of our questions, we will conduct the new systematic review for the rest questions".</i> (Participant 05)</p>
<p>Updating existing guidelines (3 participants)</p>	<p><i>"We will update our guideline when a new guideline comes out by considering whether the new guideline will change our guideline or not, if so, we will adapt/adopt to our topic"</i> (Participant 01)</p> <p><i>"When updating an existed guideline, the group will want to adapt a good guideline when updating. We will first look at the existing guideline if you could make a single recommendation, so in some updated guidelines they choose to adapt two of the recommendations, they made also search for systematic reviews, so another five recommendations are based on systematic reviews, and other recommendations are based on primary studies. Other recommendations are based on experts' consensus."</i> (Participant 06)</p> <p><i>"The other trigger for adaptation could also be when new evidence showing up, and if new primary evidence changes the recommendations/practice, we will choose adapted the recommendation, to be realistic."</i> (Participant 09)</p>
<p>Controversial existing guidelines(1 participant)</p>	<p><i>"We do adaptation only when guidelines are controversial, and we intend to harmonise the guidelines."</i> (Participant 07)</p>
<p>Question: According to your experience, which part is the most challenging for your organisation when adapting guidelines?</p>	
<p>Poor reporting or limitations of source guideline(s) (2 participants)</p>	<p><i>"The most challenging is the guidelines often do a very poor reporting of how they make their decision exactly what was based on, what value they were considering, what methodology is, what is the evidence. So sometimes you get the recommendations, but you don't get the why, and you don't get what evidence they considered, and how they rate it and understand it. So poor reporting would be the biggest challenging part for adaptation."</i> (Participant 01)</p> <p><i>"This is most challenging because as a methodologist I have not read all the evidence, I haven't searched for it all, so I don't know it well. If there are all guidelines and they all consistency, and they all have the same kind of evidence, and then I feel more confident. Sometimes I do a quick search to see if something is outside the source guideline, but really I rely on my experts' panel in this field if they can endorse these recommendations pretty much as it is and if they think the new evidence is going to change the recommendations."</i> (Participant 05)</p>

<p>Limited skills in advanced guideline development and adaptation (3 participants)</p>	<p><i>"I would say evaluating the evidence (source guideline or systematic reviews) is the most challenging part. We don't look at the methods the source guideline(s) used for the evidence appraisal. We reevaluated the quality and certainty of the evidence from source guidelines by ourselves." (participant 07)</i></p> <p><i>"I want to say all of these are challenging. Because I think health questions are difficult for people to phrase, people don't have technical skill for searching evidence, we have limited skill to appraisal and identify guidelines that we are using, and there have very few groups that have specific methods to move evidence to a decision." (Participant 09)</i></p> <p><i>"Framing the health question: sometimes the experts even could not draft the health question correct; Choosing the health question; Searching for evidence (source guideline or systematic reviews) and making recommendations from evidence" (Participant 10)</i></p>
<p>The intensity in terms of resources and time for adaptation (2 participants)</p>	<p><i>"They have to go down to two-level to see the basis of adaptation. But we don't want them to spend a lot of time to see the weeds of primary evidence. We want them to kind of be able to go from the recommendation level directly." (Participant 02)</i></p> <p><i>"For the guideline development groups, the greatest challenging is very time-consuming. Also, the resource intense. Or do I need to do an extra evaluation of the source guideline is not good enough?" - (Participant 03)</i></p>
<p>Challenges arising from specific steps of adaptation process</p>	<p>✓ Addressing context differences between source CGs and adapted CG (including reporting the differences) (4 participants)</p> <p><i>"Sometimes, they also are struggling with translating the evidence to recommendations, because the evidence just not fit to the target population. It is a typical problem of indirectness or imprecision of these things." (Participant 03)</i></p> <p><i>"I think choosing the health questions and also making the recommendations from the evidence-based on our characteristic. Not all the clinical questions are the same for our region because the character is different" (Participant 04)"</i></p> <p><i>"We suggested guideline adaptation group to justify the deviations from source guidelines, but regularly they do not include the reason (reporting). When we ask to clarify the deviations, they said it is too difficult for them to report the reason for deviations. I think it is really too difficult for them to explain. I think this is the real challenging for them because this issue was really discussed in a consensus conference, but nobody really reports the augments (reporting)." (Participant 06)</i></p> <p><i>"The real challenge when you put guidelines together is that you would probably know different guideline groups do their methods differently." (participant 10)</i></p> <p>✓ Addressing inconsistency and integrating recommendations from different source CGs (3 participants)</p> <p><i>"I would say it related to the "making evidence to recommendations". From our adaptation experience, you know you have the extra layer, the source guideline, the SR that described and to inform the recommendations, and the basic primary studies; then we come into the adaptation, they have to go down to two-level to see the basis of adaptation. But we don't want them to spend a lot of time to see the weeds of primary evidence. We want them to kind of be able to go from the recommendation level directly.</i></p>

	<p><i>For solving the inconsistency of recommendations is also a challenging part</i>” (Participant 02)</p> <p><i>“I would say making recommendations from Evidence. If there are evidence that may change the recommendation; is the guideline suitable for our setting? Because it is the link between evidence and recommendations. For adaptation for us is the same with endorsement. If we need to make major change of the recommendation, we will need to develop our own recommendations.”</i> (Participant 05)</p> <p><i>“There wasn’t enough guidance for how to adapt a guideline and even now. There was very limited to no evidence in how recommendations from multiple sources can be put together. Because most of the adapted guideline in practice they only chose one guideline.”</i> (Participant 10)</p> <p>✓ Updating or supplementing additional research evidence (1 participant)</p> <p><i>“The evidence base of the source guidelines was complemented by systematic update searches of primary evidence.” is a challenge for guideline adaptation group.</i> (Participant 06)</p>
<p>Implementation barriers (5 participants)</p>	<p><i>“The very most challenging is stratifying the recommendations, decided them into different practice settings”</i> (Participant 02)</p> <p><i>“Also, I do believe that like many organisations, implementation is also a great challenge. We do our best to develop our guidelines, but implementation still is a hot topic.”</i> (Participant 03)</p> <p><i>“And implementation is a whole separate thing and also challenging”.</i> (Participant 09)</p> <p><i>“Required the resources which might not apply in the target setting. For example, diabetic foot, the evidence and recommendations suggested to conduct yearly foot assessment, however, in practice, none of the clinicians knows how to do a foot examination; Also adherence to the guideline recommendation in the culture of Indian would also be challenging.”</i> (Participant 08)</p> <p><i>“For example: for our setting, who is the best health professional you should contact or deliver the care, and that is a very local context field. Because in some setting maybe they only have a nurse.”</i> (Participant 10)</p>
<p>Question: According to your experience, how does your organisation consider the difference between source guideline(s) and target context? Like the population, the setting/health systems, or practice variation/target users?</p>	
<p>Experts’ opinions and panel discussion (7 participants)</p>	<p><i>“In general, we address the differences according to the feedback from international panel experts/clinicians.”</i> (Participant 02)</p> <p><i>“Mostly addressed in group discussions, when it comes to reviewing the source guidelines. Then decide if they adopt them or they check if they are adoptable for the national systems. So mostly it’s experts’ opinions that come in.”</i> (Participant 03)</p> <p><i>“We made a group discussion; all the participants of my study attend to a seminar and discuss their opinion about the differences.”</i> (Participant 04)</p>

	<p><i>“We are looking for the similar guidelines. If there are differences, we discuss through our panel and decide to use it or not.” (Participant 05)</i></p> <p><i>“Some group solve differences by discussion or consensus.” (Participant 06)</i></p> <p><i>“By discussion within the development group and acknowledge the difference in a document.” (Participant 08)</i></p> <p><i>“They solve the differences by discussion in the panel, and they may come to a consensus.” (Participant 09)</i></p>
<p>Modifying for the target context</p>	<p>At the guideline level:</p> <p>✓ Prioritising the source guideline according to different factors (3 participants)</p> <p><i>“We do prioritise according to language because we are working in English. First, by prioritisation according to the quality of guideline development organisation, published in English, and sometimes for the global population, which means, common users of our guidelines.” (Participant 01)</i></p> <p><i>“You have to look at each guideline methodologically and to see which one is regularly doing and try to lean towards that but also really on AGREE ii instrument evaluation as well and use that to filter which is a good guideline and which is not. The methodological rigorous is important, but on top of that is the interpretation of the evidence and do recommendations. And often look at the evidence directly as well.” (Participant 07)</i></p> <p>✓ Discarding source guideline (1 participant)</p> <p><i>“We develop our own research question. If the source guideline did not answer our question, we will not consider using them. For example, we are looking for the similar guidelines. If there are differences, we discuss through our panel and decide to use it or not.” (Participant 05)</i></p> <p>At the recommendation level:</p> <p>✓ Modifying strength of the recommendations (1 participant)</p> <p><i>“If there is not certain difference between population, but different considerations or opinions, we will rate down certainty due to inconsistency; If the guidelines are from different regions, we may give weak recommendation with documented justifications.” (Participant 01)</i></p> <p>✓ Contextualizing by considering different factors (3 participants)</p> <p><i>“The working group judge whether to adapt according to the context/new balanced benefits and harms and decide through discussion.” (Participant 06)</i></p>

	<p><i>“The recommendation could be changed due to the difference of health settings/target users/population; we request the guideline development group to provide those modifications as well as the justifications.” (Participant 08)</i></p> <p><i>“I think this was most helpful about the Evidence to decision framework. Because even if the recommendations were come from other setting, you will go through the acceptability, feasibility. In feasibility, if a drug is not available in your country or you need a different formulation, or the price is inaccessible, then it will influence the recommendations. After the decision was made by the guideline panel, the recommendations will go to another level of group for considering whether it is justified and feasible. So, this is a kind of internal quality insurance.” (Participant 09)</i></p> <p>✓ Making a recommendation for subgroup population (1 participant) <i>“If there is a certain difference between population, we do a subgroup population and mark clearly which population suits which context.” (Participant 01)</i></p> <p>At the evidence level: ✓ Supplementing new evidence/other considerations (2 participants) <i>“Also, we do check the existing policies that need to be addressed. It is not systematically searchable, but it is addressed by group discussion.” (Participant 03)</i></p> <p><i>Even at the start, the questions can be contextualised. Which question and which guideline should we practice? Sometimes we did not find any answers. Hence, for some recommendations, we consider some source of information from the local context.” (Participant 10)</i></p>
<p>Reporting the differences when drafting the recommendation (3 participants)</p>	<p><i>“If there is a certain difference between population, we do a subgroup population and mark clearly which population suits which context; If the guidelines are from different regions, we may give weak recommendation with documented justifications.” (Participant 01)</i></p> <p><i>“By discussion within the development group and acknowledge the difference in a document. We request the guideline development group to provide those modifications as well as the justifications.” (Participant 08)</i></p> <p><i>“We did not put them together but will report in the appendix.” (Participant 10)</i></p>
<p>Question: According to your experience, how does your organisation solve inconsistency of recommendations from different source CGs?</p>	
<p>Panel discussion (2 participants)</p>	<p><i>“We deal it more by discussion. There is not a table or formula to tell you how to deal with inconsistency; you have to figure out the reasons for the inconsistency.” (Participant 01)</i></p> <p><i>“I would say that is a challenging part. We do a discussion about the inconsistency and then we do rerate the strength of the recommendation based on published criteria.” (Participant 02)</i></p>
<p>Selection criteria (At the guideline level)</p>	<p>✓ Good quality and rigorously developed (1 participant):</p>

	<p><i>“We use matrixes/tables to map the differences. Sometime if they have a good guideline, they will stop to search another guideline. We Used AGREE II to identify the methodological quality of the guidelines and prioritised by methodology sound recommendations.” (Participant 03)</i></p> <p>✓ Good quality (3 participants): <i>“We don’t have a critical cut off to choose which guideline to use, we do prioritise by quality of the guideline. Some group solve differences by discussion or consensus.” (Participant 06)</i></p> <p><i>“We do not have a cut-off of the AGREE score, because sometimes there are few source guidelines for the consideration of adaptation. By considering guideline quality:1) from the NGC; or 2) consider the results with AGREE II assessment.” (Participant 08)</i></p> <p><i>“So, if it is coming from a higher-level study, and if it’s of good quality, and if it’s pointing the same direction.” (Participant 10)</i></p> <p>✓ Trustworthiness, good quality, and mostly up-to-date (1 participant): <i>“We do not have a numeric cut-off for AGREE ii. We don’t use a qualitative cut-off with the results of AGREE ii, but we do consider the highest quality are guidelines from well-known guideline development organisation that has used systematic reviewed based guideline development methods and has fully describe their methods. And we also can only adapt guidelines that were not funded by industry. The decision to adapt a specific guideline or guidelines, is based on: o the results of the content review and the level of agreement with the recommendations o A quality appraisal of available guideline(s) o the time since completion of the best available guideline(s)” (ASCO guideline development manual)” (Participant 02)</i></p> <p>✓ Up-to-date (1 participant): <i>“We don’t go simply from recommendation to recommendation, we identify the evidence from the most up to date high quality guidelines, also panel will want to look at the primary studies.” (Participant 09)</i></p> <p>✓ Relevant to the target context (2 participant): <i>“We did our plan to evaluate the inconsistency and solve it by considering whether it suits our context.” (Participant 04) “Through panel discussion to make the decision whether this guideline is suitable for Ontario context or not.” (Participant 05)</i></p>
<p>Assessing the reason for inconsistency: (At the recommendations and evidence level)</p>	<p>✓ Assessing at recommendation level (4 participants) <i>“We gonna look into what is the recommendation. If the recommendation is different in different guidelines, then we have to figure out do we think one is right and one is wrong and explain it. Or we just say there is a reason for differences of opinion, and we give a weak recommendation overall, because they disagree. Maybe if you look carefully, the guidelines were actually focusing on different population, and there are not truly inconsistent or giving newer on the strong recommendations, in which case you may agree with both guidelines, and then present it more clearly.” (Participant 01)</i></p>

	<p><i>"We ask them to really compare the guideline and see where the inconsistency comes from on the level of individual recommendations." (Participant 03)</i></p> <p><i>"In another case, more than one guideline was used, some groups consider the consistency by using synopsis of each recommendation and checking the inconsistency but some not." (Participant 06)</i></p> <p><i>"We have to look at the inconsistency, uninformative thoughts, the strength of recommendations that will be based on the quality of your evidence and the level of evidence." (Participant 10)</i></p> <p>✓ Assessing at evidence level (3 participants) <i>Or maybe one guideline has more evidence or more currency than the other, you may ignore the guideline that wasn't aware all the evidence when they made the recommendations. But until you understand why there is inconsistency, you can determine what to do. We don't have a comment table to work through how to do it, the team uses their judgment to explore this and use their experience." (Participant 01)</i></p> <p><i>"If there is consistency, we will only consider the SRs they are using, using other persons SR, or conduct the SR by our-selves." (Participant 05)</i></p> <p><i>"By looking at the evidence interpretation (the appraisal of the evidence, if they are not good, would go into the individual studies and reassess the quality of the evidence) the quality and rigorous of development (assessed by AGREE ii score)." (Participant 07)</i></p>
<p>One single guideline was included (4 participants)</p>	<p><i>"I have in the past looked at whether guidelines have recommended the same treatment. However, recently we have been selecting only one guideline to endorse/adapt." (Participant 05)</i></p> <p><i>"In one case, the group only pick up one good guideline and use it." (Participant 06)</i></p> <p><i>"We did not meet one situation of more than one guideline were included and I do not know how to solve." (Participant 09)</i></p> <p><i>"What people have done is that they chose one guideline one and adapt this guideline for their setting." (Participant 10)</i></p>
<p>Question: According to your experience, how does your organisation consider other systematic reviews or new evidence?</p>	
<p>Triggers for complementing / updating the search for source guideline(s)</p>	<p>✓ Source guideline did not answer all the questions of the adapted guideline (3 participants): <i>"If the source guideline did not answer all of our questions, we will conduct the new systematic review for the rest questions." (Participant 05)</i></p>

	<p><i>“If they find there is no clear answers for their question in the source guidelines, they looked at existing Cochrane SRs but do not conduct a new one.” (Participant 08)</i></p> <p><i>“No guideline answers your question, we do consensus process. If the source guideline has limited evidence for specific questions, we will make a consensus process.” (Participant 10)</i></p> <p>✓ Source guideline(s) were outdated(1 participant): <i>“If it is a great guideline but it’s 3 years old, and since then there are new primary studies come out, they will want to look at that.” (Participant 09)</i></p> <p>✓ Source guideline(s) were consensus based (2 participants): <i>“Resource stratified guidelines means based on the source guidelines and considering resource use. For the source guidelines we did not do the updated;” (Participant 02)</i></p> <p><i>“For experts’ consensus from source guidelines, expert panel decide sometimes in addition to do a systematic search for other aggregate sources of evidence, like Cochrane reviews, and sometimes they decide to have a full de novo search for primary evidence to answer the question.” (Participant 03)</i></p> <p>✓ Expert-panel recommended it (2 participants): <i>“For the other guidelines if we adapt them, yes. In general, we may need to update the literature search if the expert panel think there are new evidence published outside the systematic reviews that particular relevant.” (Participant 02)</i></p> <p><i>“We made national wide guidelines launched by the ministry of health. There are more experts connected with us to make more comprehensive guideline, and they do have other source of evidence. Our group starting by searching the databases like PubMed, etc.” (Participant 04)</i></p>
<p>If the source guideline(s) were not evidence based</p>	<p>✓ Discarded the recommendation, (1 participant): <i>“For consensus recommendations from source guidelines, sometimes the group decides to maybe discard specific recommendations from source guidelines but rather than have a consensus-based recommendation in Germany.” (Participant 03)</i></p> <p>✓ Conducted consensus process, (1 participant): <i>“No guideline answers your question, we do consensus process. If the source guideline has limited evidence for specific questions, we will make a consensus process.” (Participant 10)</i></p> <p>✓ Started guideline de novo process (3 participants): <i>Start guideline de novo process: “We will not search for new evidence when endorsement or adaptation, if the source guideline did not answer all of our questions, we will conduct the new systematic review for the rest questions. We conduct our own SRs if the source guideline did not answer our research questions. We do that only when the source guideline did not address the specific research questions in the case that we are doing multiple questions. Like if we have 5 research questions and the source guideline(s) only</i></p>

	<p><i>addressed 3 of them, then we need to conduct our own SRs to address the other 2. If we have to look for new evidence, we do the literature search. But for us the adaptation doesn't means we have to search new evidence, if we have to do it, then it is a de novo process." (Participant 05)</i></p> <p><i>"We only limited the evidence of the source guideline; we do not do the supplement evidence otherwise the process will be very complicate. The critical difference of the guideline adaptation and guideline de novo process is you limited the evidence within the source guidelines. You are not looking at the additional information. We don't call them recommendations; recommendations only come out of guidelines that you do yourself." (Participant 07)</i></p> <p><i>"We do not conduct new systematic reviews due to the time limitation. In the case of good guideline absence, we would consider a guideline de novo process rather than an adaptation." (Participant 08)</i></p>
<p>Way of including new evidence</p>	<p>✓ Conducting literature search for complement evidence (6 participants):</p> <p>Pragmatic search (5 participants) <i>"Our group starting by searching the databases like PubMed, etc." (Participant 04)</i></p> <p><i>"Our guideline group will make a search for SRs." (Participant 06)</i></p> <p><i>"They did refer to the Cochrane database. If they find there is no clear answer for their question in the source guidelines, they looked at existing Cochrane SRs but do not conduct a new one. No cost effectiveness evidence was searched, but patients' values and preferences yes." (Participant 08)</i></p> <p><i>"The guideline group link with organisations like the Cochrane centre, and all discuss very nicely to provide evidence." (Participant 09)</i></p> <p><i>"We do everything to ensure the search is comprehensive. We search for guideline has been published everywhere. For some questions we adapted, we take the new evidence around, for instance in the local context setting there might be a new paper that has been published locally, if the evidence answered the question of the local context." (Participant 10)</i></p> <p>Full de novo search (1 participants):</p> <p><i>"For experts' consensus from source guidelines, expert panel decide sometimes in addition to do a systematic search for other aggregate sources of evidence, like Cochrane reviews, and sometimes they decide to have a full de novo search for primary evidence to answer the question." (Participant 03)</i></p> <p>✓ Updating the search from source guideline(s) (3 participants): <i>"Like I said before, we conducted continuously monitoring of new evidence that relevant." (Participant 01)"</i></p>

"In general, we may need to update the literature search if the expert panel think there are new evidence published outside the systematic reviews that particular relevant." (Participant 02)

"If it is a great guideline but its 3 years old, and since then there are new primary studies come out, they will want to look at that. If there is more up to date SR that includes additional studies, they will want to look at that." (Participant 09)

✓ Experts' suggestions (3 participants)

"There are more experts connected with us to make more comprehensive guideline, and they do have other source of evidence. Our group starting by searching the databases like PubMed, etc. And also, experts will recommend new studies if they have one." (Participant 04)

"Experts from our group could recommend recently RCTs apart from SRs identified from the search. But we make the process transparently reported." (Participant 06)

"There is a committee from the national government to find some of the prestigious policy questions. We haven't been involved in any guideline for professional society or private group, we haven't been charged much for conduction reviews. The primary research we don't do. Experts will ask for relevant evidence and we will conduct the synthesis and provide to them if needed to explain or facilitate the decision making." (Participant 09)

Question: According to your experience, how does your organisation consider implementation barriers?

Ways to obtain the information and address it by group discussion (7 participants)

✓ Experts opinion, literature search, group discussion (1 participant)

"For the resource stratified guidelines, yes; I would say most by discussion. For example, we would include panel members who are in primary practice outside the academic medical settings, their experiences can inform what are the constrains and barriers that may impact on the implementation of recommendations. For the resource stratified guideline, we do also discussion and non-systematic environmental scan of the cost-effectiveness analysis literature. To see if the literature can influence the applicability of the implementation." (participant 02)

✓ Experts opinion, literature search, group discussion (1 participant)

"Yes; For example, if one intervention was labelled in the US but off labelled in Germany, we asked the experts panel to assess if the evidence is really sound enough to do a such recommendation. Also, we do check the existing policies that need to be addressed. It is not systematically searchable, but it is addressed by group discussion." (participant 03)

✓ Experts opinion, literature search (1 participant):

"Usually from the government people, they have other field angle to see how we treat disease, this is different with the way of think a clinician. But I think they based on a good tele data to make the problem understandable and solve the problem." (participant 04)

✓ Experts opinion, group discussion (1 participant):

	<p><i>"We ask our panel about the feasibility of implementing a treatment and discussed within our working group by considering the context of our settings." (participant 05)</i></p> <p>✓ Search, (1 participant): <i>"We only look at the cost of the intervention and look at the information available by PubMed." (Participant 07)</i></p> <p>✓ Group discussion, (1 participant): <i>"They do discuss the recommendations and to see if the recommendation is appropriate in their setting, what kind of challenging they will have when implementing the recommendations that adapted. By discussion within the guideline development group. And provide the documented acknowledge." (participant 08)</i></p> <p>✓ Literature search, Group discussion, (1 participant): <i>"We only look at the cost of the intervention and look at the information available by PubMed. Our group will consider at least the feasibility, and within that there will be issue of regulatory issues, ethical issues, and access issues. So, feasibility, equity and cost will be considered." (participant 09)</i></p>
<p>Decision made after considering (2 participants)</p>	<p>✓ Modified the practice instead of changing recommendations: <i>"The source recommendations will not be change, however the practice way maybe tailored for the local context to make it applicable." (Participant 10)</i></p> <p>✓ Modified the recommendations: <i>"At least for medications, we see evidence on the use of medications, check if it's authorised to use. If it's not approved to use for any country, we won't make a recommendation to use even if there are some evidence." (Participant 01)</i></p>
<p>Reporting the difference (4 participants)</p>	<p><i>"We will make the notation in the summary of medication to highlight the difference." – (Participant 01)</i></p> <p><i>"If yes, advice the guideline users this is off-label in Germany and should take this into account when they inform the use for patients." – (Participant 03)</i></p> <p><i>"We described difference constrains when published the guideline, like if the medical insurance did not cover the new intervention, we will mention it." - (Participant 06)</i></p> <p><i>"And provide the documented acknowledge." – (Participant 08)</i></p>

Appendix 04. Identified adaptation methodologies

Question: Could you please describe the adaptation process or which framework or methods your organisation used for guideline adaptation?	
Adaptation Frameworks	Quotes
ADAPTE 2010	<i>"We used ADAPTE 2010 and supplement with GRADE system for assessing the level of evidence." (Participant 04)</i>
ASCO endorsement/adaptation methodology	<i>"We used a mixed method, some of them from ADAPTE methodology. We have published a paper on our methods and I'll be happy to provide that, I think it may explain better than I do." (Participant 02)</i>
DynaMed methodology	<i>"We are using Dynamed methodology which is GRADE-based, you could find it in Dynamed website." (Participant 01)</i>
CCO endorsement protocol	<i>"We used to use more ADAPTE before, and now we are slowly covering to GRADE. For our group we do have an overarching CCO endorsement protocol, but I also use GRADE-ADOLPMENT as it has more details" (Participant 05)</i>
GRADE-ADOLPMENT	
ACP guideline development methods	<i>"We use others methodology of adaptation, which is call ACP guideline development methodology, you could find the information published." (Participant 07)</i>
Pilot adaptation Framework	<i>"The BMJ paper described the framework developed at that time by NICE and piloted it in our setting". (Participant 08)</i>
ACA framework	<i>"We have highlighted the methods in South Africa, and published this resource, and I could give you the references to this methodology. In some cases, questions could either be adopting" (Participant 10)</i>
DELBI	<i>"We do have a national version of the AGREE II instrument, which called DELBI, that is complemented with four specific questions to consider when it comes to guideline adaptation. Most group of our country did not use the whole ADAPTE instrument, but rather consequently used the four questions in DELBI." (Participate 03)</i> <i>"We use the DELBI to assess the guideline methodology quality. But when group adapting, they use question 30-34 to inform their process." (Participate 06)</i>
Adaptation Experience	<i>"I am trying to think the process. They don't have a standardised guideline development or adaptation protocol in the country. A lot of kinds of process will be in a national process and there will be a specific health questions and PICO. Then we will be asked to conduct SR, and then what we do have in that particular process is that the SR would including first to look at what guidelines are out there, and then we will look at what SRs are out there before we conduct our systematic review. If there is a guideline of good quality, those are the recommendations" (Participant 09)</i>

Details of newly identified methodology and organisations:

1. DynaMed editorial methodology ^[3]: DynaMed is a clinician-focused tool designed to facilitate efficient and evidence-based patient care. They review the medical literature daily and updates their CGs. However, Dynamed also adapts CGs when those retrieved reflect relevant differences with the original one.
2. American Society of Clinical Oncology (ASCO) CG endorsement/adaptation methodology ^[4]: ASCO is a scientific society that provides CG endorsement and adaptation for those resource constrained settings.
3. American College of Physicians (ACP) guidance statement ^[5]: ACP is a medical-specialty society that develops CG statements when CGs are controversial and finally achieve the adoption or adaptation.
4. Cancer Care Ontario's (CCO) endorsement protocol ^[6]: The CG development program of the CCO provides CG endorsement/adaptation of high-quality CGs from other authorized institutions.
5. German Instrument for Methodological Guideline Appraisal (DELBI) ^[7]: The Association of the Scientific Medical Societies in Germany (AWMF) developed DELBI to provide CGs as well as adaptation approval and registration in Germany. Guideline adaptation groups (GAGs) in Germany also use DELBI to inform their adaptation process.
6. Piloted adaptation Framework ^[8]: The Indian Ministry of Health and Family Welfare raised a call for adaptation process and piloted the adaptation framework developed by NICE in India context.
7. Adopt-Contextualise-Adapt (ACA) framework ^[9]: Based on a long-term partnership with the International Centre for Allied Health Evidence (iCAHE), one health centre in Philippines developed the ACA framework for practising CGs adaptation with adopt (no modifications from source CGs), contextualized (tailored for target context), and adapt (modified the evidence and recommendations) components.

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