

**Supplementary Table S1.** Assessment of quality of spirometric testing

<b>Rating</b>	<b>Criteria</b>
A	At least 3 acceptable trials (for age 6 and under: 2 acceptable) AND the difference between the best two FEV1 and FVC values is equal to or less than 100mL (80mL if FVC < 1.0L; For age 6 and under: 80mL or 8% of FVC or FEV1 whichever is greater)
B	At least 3 acceptable trials (for age 6 and under: 2 acceptable) AND the difference between the best two FEV1 and FVC values is equal to or less than 150mL (100mL if FVC < 1.0L; For age 6 and under: 100mL or 10% of FVC or FEV1 whichever is greater)
C	At least 2 acceptable trials AND the difference between the best two FEV1 and FVC values is equal to or less than 200mL (150mL if FVC < 1.0L; For age 6 and under: 150mL or 15% of FVC or FEV1 whichever is greater)
D	At least 2 acceptable trials but the results are not reproducible according to 'C' OR only one acceptable trial.
F	No acceptable trial available

**Supplementary Table S2.** Operational definitions for chest X-ray interpretation

Chest X-ray finding	Definition and description
Air-space consolidation	<p>The presence of a dense or confluent opacity occupying a portion or whole of a lobe or of the entire lung that may contain one or more of the following features:</p> <ul style="list-style-type: none"> <li>• Air bronchograms</li> <li>• Air-space nodules</li> <li>• Ill-defined or fluffy border</li> <li>• A silhouette sign</li> </ul> <p>The reader should indicate the location of the lesion.</p>
Cardiomegaly	<p>Cardiothoracic ratio &gt; 0.55.</p> <p>The cardiothoracic ratio is calculated using the convention of measuring the thoracic diameter as the distance from the inner margin of the ribs at the level of the dome of the right hemidiaphragm and the cardiac diameter as the horizontal distance between the most rightward and most leftward margins of the cardiac shadow.</p>
Pulmonary venous hypertension	<p>The presence of one or more of the following:</p> <ul style="list-style-type: none"> <li>• Larger upper lobe vessels</li> <li>• Kerley's A or B lines</li> <li>• Increased prominence of “interstitial markings”</li> <li>• Enlargement and indistinctness of hila</li> <li>• Confluent acinar shadows (pulmonary alveolar oedema)</li> <li>• Perihilar alveolar filling</li> <li>• Lower lobe or more generalized alveolar filling</li> </ul> <p>The reader should describe what is seen from the list above.</p>

**Supplementary Table S3.** Comparison between patients who completed the full survey, those who completed the minimal data questionnaire, and those who refused to participate at all healthcare facilities

	<b>Baseline survey</b>	<b>Minimal data collected</b>	<b>Declined to complete minimal data questionnaire</b>
Total	977	169	471
Male (n, %)	638 (65.3)	87 (51.5)	266 (56.5)
Age, years (mean, SD)	55.5 (17.1)	50.2 (20.5)	47.9 (22.7)

**Supplementary Table S4.** Other clinical diagnoses given by treating doctors for patients not meeting any of the predefined syndromes (n=129)

<b>Diagnoses</b>	<b>n (%)</b>
Pleural effusion	6 (4.7)
Lung tumour	4 (3.1)
Old tuberculosis	2 (1.6)
Myocardial infarction	2 (1.6)
Musculoskeletal pain	2 (1.6)
Lung abscess	2 (1.6)
Pneumothorax	1 (0.8)
Laryngeal cancer	1 (0.8)
Anterior mediastinal tumour	1 (0.8)
Subcutaneous emphysema and pneumomediastinum	1 (0.8)
Reported only patient's respiratory symptoms	20 (15.5)
Other non-respiratory diagnosis	59 (45.7)

**Supplementary Table S5.** Treatment provided to patients with a clinical diagnosis of bronchitis given by treating doctors

<b>Diagnosis</b>	<b>n</b>	<b>Systemic corticosteroids</b>	<b>Inhaled corticosteroids</b>	<b>Long-acting bronchodilators</b>	<b>Short-acting beta-agonist</b>	<b>Antibiotics</b>	<b>Diuretics</b>	<b>Anti-tuberculosis</b>
Bronchitis alone	243	80 (32.9)	5 (2.1)	27 (11.1)	1 (0.4)	205 (84.4)	6 (2.5)	0 (0)
COPD + bronchitis	12	8 (66.7)	6 (50)	8 (66.7)	1 (8.3)	9 (75)	1 (8.3)	0 (0)
Asthma + bronchitis	21	11 (52.4)	17 (81)	18 (85.7)	3 (14.3)	19 (90.5)	2 (9.5)	0 (0)

### Supplementary references:

1. Webb WR, Higgins CB. Thoracic Imaging: Pulmonary and Cardiovascular Radiology. Lippincott Williams & Wilkins, Third Edition, 2017.
2. Wortham JM, Gray J, Verani J, Contreras CL, Bernart C, Moscoso F, Moir JC, Reyes Marroquin EL, Castellan R, Arvelo W, Lindblade K, McCracken JP. Using Standardized Interpretation of Chest Radiographs to Identify Adults with Bacterial Pneumonia—Guatemala, 2007–2012. *PloS one* 2015; 10(7): e0133257.
3. Mahomed N, Fancourt N, de Campo J, de Campo M, Akano A, Cherian T, Cohen OG, Greenberg D, Lacey S, Kohli N, Lederman HM, Madhi SA, Manduku V, McCollum ED, Park K, Ribo-Aristizabal JL, Bar-Zeev N, O'Brien KL, Mulholland K. Preliminary report from the World Health Organisation Chest Radiography in Epidemiological Studies project. *Pediatric radiology* 2017; 47(11): 1399-1404.