

Appendix 2

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Comparison of our recommendations with other recommendations

Preamble

Our recommendations focus on promoting health equity through preventive care. Our guidance aims to improve the health of people experiencing disadvantages. Most of our recommendations apply only to those experiencing disadvantages. By contrast, preventive care guidance provided by other bodies focuses on the general population. These other recommendations usually aim to promote health generally and not for people experiencing disadvantages, although equity considerations are sometimes mentioned.

Like other recommendation developers, we considered the downsides of the recommended interventions including resource implications and harms such as the harms of false positive screens. These downsides of preventive care and screening may apply differently to individuals who tend to have poorer access to care. Preventive care guidance aimed at the general population tends to place more emphasis on the downsides of preventive care, which is understandable given the wider scope and larger resource implications.

Our recommendations are generally based on the same studies of screening effectiveness as other bodies, but are also based on evidence of disparities that might have received less consideration by others who were focused on the general population. It is common for different bodies creating guidance in the same area to make different recommendations. For example, the Canadian Task Force on Preventive Health Care (CTFPHC) and the United States Preventive Services Task Force (USPSTF) have similar mandates but their guidance sometimes differs (and some examples such as colorectal cancer screening are discussed below). Different foci and perspectives can also lead to differences in recommendations; for example, the CTFPHC that focuses on preventive care has a different Hepatitis C screening recommendation than the Canadian Association for the Study of the Liver that provides guidance on the management of Hepatitis C that included a recommendation about screening. Our perspective is that existing disparities in health outcomes could be partially addressed by more equitable access to effective preventive care interventions.

Guideline recommendations are action oriented and gaps in the literature mean that guidance producers need to make judgements about what is reasonable. For example, while certain screening interventions have been proven to be effective based on the results of clinical trials, there may be a lack of trials comparing different screening approaches such as more frequent versus less frequent screening. In these situations, it is natural that guidance will differ based on the same evidence with respect to matters such as how often screening should be done and at what age screening should start and stop.

This appendix should be read in conjunction with the main guideline document and thus the appendix does not repeat the information in the main guideline document including the list of references. The main guideline document and the evidence tables in Appendix 1 explain the rationale for each of our recommendations. The main guideline document also explains our rigorous and multifaceted methods. Table 1 in the main guideline document displays our recommendations beside recommendations from other groups including the CTFPHC and USPSTF. Here, we additionally provide explanations of how specific recommendations differ from those of other bodies. These explanations are intended to help readers make informed decisions about implementing our recommendations. We respect the work

done by other guideline producers and nothing here is intended as a criticism of our colleagues whose work had a different focus and perspective. Table 1 shows that our recommendations mostly accord with the recommendations provided by others and this overall agreement should be kept in mind while examining particular differences.

We welcome feedback on our guidance and we believe that broad engagement is needed to implement our recommendations. Promoting health equity can mean challenging the status quo and equity-focused efforts can elicit extraordinary scrutiny and criticisms. Most guidelines do not include an appendix like this one, where its recommendations are justified in relation to other guidance. We hope that our recommendations will be judged on their merits and not primarily on how well they agree with other recommendations. We also hope other guideline producers will place more emphasis on equity in the future and it will be interesting to see if guidance begins to converge as more serious consideration is given to health equity.

Selected topics and scope

Our guidance covers cancer screening topics: colorectal cancer, cervical cancer, and lung cancer that are also covered by the CTFPHC and the USPSTF. We excluded breast cancer screening and prostate cancer, that are covered by the CTFPHC and the USPSTF, after we considered the effectiveness of screening and the likelihood that equitable preventive care could promote equitable health outcomes and we point to the need for more research. We included a recommendation about HPV vaccination because we thought it was important to emphasize the need for equitable access to immunization, but the CTFPHC and the USPSTF do not provide guidance on vaccination.

Our cardiovascular disease topics including hypertension and diabetes screening are similar in scope to the CTFPHC and the USPSTF.

The CTFPHC provides guidance on Hepatitis C screening but not on HIV screening, while the USPSTF provides guidance on both, as we do. The USPSTF provides guidance on tuberculosis screening, as we do, but the CTFPHC does not.

Both the CTFPHC and the USPSTF provide guidance on tobacco use but only the USPSTF provides guidance on alcohol use and substance use, as we do.

We combined topics that in practice would be addressed at the same time clinically. For example, it makes sense to measure blood pressure at the same time as cardiovascular risk assessment because blood pressure is an important part of cardiovascular risk assessment and the management of elevated blood pressure should be taken into account when addressing cardiovascular risk.

Depression and dental caries are addressed by guidance from the CTFPHC and the USPSTF.

Social risk factors are not addressed by guidance from the CTFPHC or the USPSTF. Intimate partner violence is addressed by guidance from the USPSTF but not the CTFPHC. Primary care access is not addressed by the CTFPHC or the USPSTF.

Colorectal cancer

Our guidance – that applies only to certain groups experiencing disadvantages – recommends screening outreach starting at age 45 years, consistent with screening recommendations from the USPSTF but earlier than the 50 years starting age recommended by the CTFPHC. Based on the disparities in colorectal cancer outcomes and in screening uptake and the effectiveness of screening, we decided it is reasonable to start outreach for colorectal cancer screening at age 45 years on the understanding that there may be a delay between the initiation of screening outreach and the actual start of screening. The USPSTF estimated that starting general population screening at age 45 rather than 50 would save one life for every 1,000 screened based on results of clinical trials. A previous guideline, like our current one, recommended screening starting at age 45 only for Black people. In 2008, the American College of Gastroenterologists recommended colorectal cancer screening starting at age 50 for the general population but at age 45 for Black people for a variety of reasons, including a lower likelihood of screening and diagnostic testing.(1,2) So there is a precedent for starting screening outreach at 45 years for certain groups and at 50 years for the general population.

Cervical cancer

Our guidance – that applies only to certain groups experiencing disadvantages – recommends screening using HPV self-testing rather than Pap smears. Our recommendation is based on diagnostic accuracy studies that indicate HPV self-testing is accurate, disparities in cervical cancer outcomes and screening rates, and studies of the acceptability of self-testing. Based on the evidence, we made a judgment that HPV self-testing could address disparities. It is important to note that recommendations are based on observational studies of cytological testing with Pap smears and not on clinical trials. Indeed, the CTFPHC recommendation is for “screening for cervical cancer” although the supporting text for this recommendation discusses cytological testing. Thus, our recommendation for HPV testing is actually quite consistent with guidance from the CTFPHC in favor of screening. The USPSTF recommends cervical cancer screening with HPV testing (every 5 years), cytology (every 3 years), or a combination of HPV testing and cytology, for individuals aged 30 to 65 years.

Our recommendation is intentionally silent on the age screening should start, as the starting age is not based on comparative studies and varies by jurisdiction. Other recommendations based the starting age for screening on the incidence and mortality of cervical cancer that increase with age. The best frequency of screening has also not been firmly established.

Lung cancer

Our recommendation – that applies only to certain groups experiencing disadvantages – is for enhanced outreach efforts for those eligible for lung cancer screening, as recommended by the CTFPHC and the USPSTF. Our recommended age range, 50 to 80 years, is the same as the USPSTF and slightly different from the CTFPHC (55 to 74 years). The ideal age range for screening has not been established using comparative studies. We judged that starting screening earlier was reasonable for those who may be poorly connected with care.

Cardiovascular disease including hypertension

Our recommendation – that applies only to certain groups experiencing disadvantages – is for prioritized cardiovascular risk assessments including blood pressure measurement every 3 to 5 years. The CTFPHC

and the USPSTF both recommend cardiovascular risk assessments, as we do, but the frequency is left open. The CTFPHC recommends that risk assessment be done at “all appropriate primary care visits”.

People experiencing disadvantages may be less likely to attend clinic visits and to receive “opportunistic” blood pressure checks and cardiovascular risk assessments. Following our recommendation would ensure people experiencing disadvantages are assessed at least every 5 years. The optimal frequency of risk assessment has not been established by comparative trials. Observational studies indicate that blood pressure typically does not change within a few years and thus that blood pressure screening every 3 to 5 years is reasonable. We decided to make a combined recommendation for cardiovascular risk assessment and blood pressure measurement that aligns the frequency.

Diabetes

Our recommendation – that applies only to certain groups experiencing disadvantages – is for prioritized diabetes screening.

Screening for diabetes is based on indirect evidence that treating diabetes is effective and based on the fact that diabetes can be difficult to detect clinically since trials of diabetes screening compared with no screening did not demonstrate a screening benefit. Thus, there is no obvious basis for starting age, frequency, or ending age of screening. The CTFPHC recommends screening based on risk factors while the USPSTF recommends diabetes screening for those who are overweight or obese between 35 and 70 years.

HIV and Hepatitis C

Our recommendation for age-based Hepatitis C screening is the same as the recommendation from the USPSTF, but differs from the CTFPHC recommendation for risk-factor based screening.

The CTFPHC recommendation for risk factor based screening was based on a lack of trials of screening and a modelling study that indicated screening individuals who are *not* at elevated risk would prevent decompensated cirrhosis, hepatocellular carcinoma, and deaths. The recommendations for age-based screening from the USPSTF and the Canadian Association for the Study of the Liver are based on the prevalence of Hepatitis C and the effectiveness of treatment. Recommendations for broader screening criteria are consistent with global efforts to eliminate Hepatitis C.

Other guidance does not prominently mention equity. The CTFPHC Hepatitis C guideline states: “In cases where the balance of cost and benefits is ambiguous, key stakeholders differ about the acceptability or feasibility of the implementation, or the effects on health equity are unclear, they are likely to result in a weak recommendation.”

We made a single recommendation for HIV and Hepatitis C screening. Testing for HIV and Hepatitis C can be discussed at the same time, and testing for HIV based on phlebotomy can be ordered at the same time as testing for Hepatitis C. We aligned the age ranges for HIV and Hepatitis C screening, although the age ranges for HIV screening from the USPSTF is slightly different (15 to 65 years rather than 18 to 79 years).

Tuberculosis

Our recommendation for tuberculosis screening applies only to people with certain risk factors, similar to the USPSTF and a Canadian recommendation related to immigrants and refugees.

We recommend interferon-gamma release assay (IGRA) testing as it is accurate and may be more helpful in individuals who have been vaccinated against tuberculosis. The Canadian Tuberculosis Standards (2022) strongly recommends either IGRA testing or TB skin testing and conditionally recommends IGRA over TB skin testing in certain situations: “An interferon-gamma release assay is the preferred test when: children over two years of age and less than 10 years of age previously received a Bacille Calmette-Guérin (BCG) vaccine against tuberculosis; persons at least 10 years of age received a BCG vaccine after infancy (older than one year of age), or received a BCG vaccine more than once and/or are uncertain about when they received a BCG vaccine; adequate training and quality assessment and control are NOT available for tuberculin skin test administration and/or reading, but personnel and facilities to perform interferon-gamma release assays are available; a person is unable or unlikely to return to have their tuberculin skin test read; or tuberculin skin testing is contraindicated.”

Tobacco use

Our recommendation for tobacco use screening is similar to recommendations from the CTFPHC and the USPSTF.

Alcohol use

Our recommendation for alcohol use screening is similar to the recommendation from the USPSTF.

Other substance use

Our recommendation for substance use screening is similar to the recommendation from the USPSTF.

Depression

Our recommendation for depression screening is similar to recommendations from the USPSTF and the Canadian Network for Mood and Anxiety Treatments, which differ from the CTFPHC recommendation against screening.

Clinical trials of the effects of screening show mixed results; one trial found a substantial benefit but no benefit was seen in other trials with different populations. Positive recommendations are also based on indirect evidence that depression treatments are effective. Canadian patients generally rated the benefits of screening for [post-partum depression](#) as more important than potential harms, and overall believed that the benefits outweighed the harms. In making our positive recommendation, we recognized that a negative recommendation could be reasonable because screening consumes clinical resources and can have other downsides, and because depression is symptomatic when present. The CTFPHC recommendation against screening assumes that there will be routine clinical inquiries about depression, while our equity focused guidance is partly based on the understanding that people experiencing disadvantages may be less likely to receive appropriate routine care such as clinical inquiries about depression. Thus, depression screening could make care more equitable.

Dental caries

Our recommendation for dental caries screening in children is broadly consistent with older (1995) guidance from the CTFPHC that focuses on fluoride treatment but also includes referral for patients with active tooth decay. The USPSTF recommends fluoride treatments and not screening for caries. Our recommendation for screening could improve health equity especially because access to dental care is often publicly funded for children.

Poverty

Our recommendation for social risk screening in families with children is not comparable to guidance from the CTFPHC or the USPSTF.

Intimate partner violence

Our recommendation for intimate partner violence screening is similar to the recommendation from the USPSTF, although that guidance applies only to women of reproductive age. Trials of intimate partner violence screening do not show a benefit, but there are proven effective interventions for intimate partner violence and screening instruments are accurate. We decided that screening made sense for all women, trans people, and nonbinary people, rather than just for women of “reproductive age”.

Primary care access

Our recommendation for primary care connection is not comparable to guidance from the CTFPHC or the USPSTF.

Summary and conclusion

Our recommendations are generally consistent with those from the CTFPHC and the USPSTF where we provide guidance on the same topics. Several of our recommendations relate to measures that could improve adherence to screening recommended by other bodies such as the CTFPHC, and these include our recommendations for cervical cancer screening and lung cancer screening. In the two areas where our guidance differs substantially from the CTFPHC – depression screening and Hepatitis C screening – we present specific justifications for our recommendations that accord with recommendations from other bodies including the USPSTF. In several topics, our guidance differs in relatively minor ways from the guidance provided by the CTFPHC and the USPSTF with respect to starting age, frequency, stopping age, or other factors, and this is because gaps in the literature mean judgements need to be made. Like other developers of recommendations, we used rigorous and transparent methods and we present the data underlying our recommendations, so readers can understand their basis even if they might disagree with them. Our guidance is the first to focus on promoting health equity through preventive care and thus it was designed to complement rather than to perfectly match other guidance.

Implementing recommendations and complementary guidance simultaneously

Our recommendations focused on promoting health equity apply to people experiencing disadvantages and they can be implemented with complementary guidance that is focused on the general population. Here we provide some additional guidance about how to simultaneously implement our recommendations and recommendations from others.

Clinicians should use their judgement in utilizing aspects of the additional guidance provided here that are relevant to their patient populations and practice attributes and context. Actual approaches will depend on factors such as the prevalence of particular patient characteristics, supports available to primary care providers in clinic and external supports available.

Identifying and contacting patients who experience disadvantages

Prioritizing people experiencing disadvantages for preventive care interventions involves identifying patients experiencing certain disadvantages. Primary care providers may already have the information needed to identify patients experiencing disadvantages stored in patient profiles within charts. Where necessary, such as for new patients, providers can use standard questions about characteristics that can be used to populate electronic health records. Asking questions about identity is acceptable to primary care patients: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6693598/>

Primary care providers can both run searches of electronic health records to identify patients due for screening and opportunistically offer recommended preventive care interventions during patient encounters. Outreach to patients can happen by email, text messaging, mail or phone and can be facilitated by team members other than clinicians. Outreach can be done at the same time as outreach for the general patient population.

Outreach for colorectal cancer screening could be done the same way as for the general population starting at age 50 years, but starting at age 45 years for those experiencing disadvantages. The eligibility criteria for cervical cancer screening is the same as for routine practice; the only difference is that our recommendation is for HPV self-testing to be offered to patients experiencing disadvantages. Our lung cancer screening recommendation will identify more people (20 pack-years smoking history, ages 50 to 80 years) than the 2016 recommendation for the general population from the Canadian Task Force on Preventive Health Care (30 pack-years, 55 to 74 years). We recommend diabetes screening starting at age 40 for people experiencing disadvantages, regardless of other risk factors.

For some recommended interventions such as colorectal cancer screening, cervical cancer screening using HPV self-testing, diabetes screening, lung cancer screening, HIV and Hepatitis C screening, and tuberculosis screening using blood testing, patients may not need a clinical encounter to initiate screening assuming patients have been provided with information about the interventions.

Discussing and offering preventive care interventions

Shared decision-making should be implemented for applicable preventive care interventions. This should involve a discussion of the benefits, risks, and relevant alternatives to recommended preventive care interventions. Shared decision-making may not be applicable to interventions that involve asking

patients questions such as screening for substance use, depression, poverty, and intimate partner violence.

Time requirements of implementing recommendations

We considered the time constraints of primary care providers when we made our recommendations. The guideline panel was made up mostly of primary care providers who are cognisant of time constraints in clinical settings.

Some of our recommendations reduce the workload for primary care providers such as HPV self-testing, blood testing for tuberculosis (that avoids the multiple visits required by skin testing), and HIV self-testing. Compared with other guidance, our recommendations could result in less screening. For example, other guidance recommends checking blood pressure at all appropriate visits whereas our guidance recommends that blood pressure testing be done once every 5 years.

We also provide some guidance on how the recommendations could be implemented relatively quickly. For example, depression screening could be done by asking two questions. Other members of the care team could be involved. For example, prioritized outreach for colorectal cancer screening could be done by phone calls from members of the care team who are not clinicians.

In resource constrained settings, certain preventive care interventions could be prioritized. We have provided a table that orders the interventions by the overall burden. Clinicians could review this table in light of the unique characteristics of their patient population, to decide which interventions to prioritize. In many settings, it could make sense to prioritize cardiovascular disease and cancer prevention.

Our recommendations largely accord with other recommendations that also consider feasibility issues including time requirements. Additionally, our focus on equity and the care of people who experience disadvantages means that we placed more weight on ensuring the process of care and health outcomes are equitable. Applying an equity lens to primary care means considering how negative recommendations for preventive care maneuvers might result in disparities in care, since some patients may request and receive interventions that are not recommended. Thus, placing too much emphasis on the care provider's time required to implement the recommendations might exacerbate existing inequities. For example, a negative recommendation about depression screening based in part on inaccurate estimates of the time requirements could lead to disparities in who is offered care related to depression since patients with better access to care will receive more relevant clinical attention in the absence of screening.

Some studies indicate that adhering to preventive care recommendations, and other clinical practice guideline recommendations, would consume a prohibitive amount of primary care provider time. These calculations are based on estimates of the time needed and not measurements of the actual time consumed by implementing the guideline recommendations. Some of these estimates indicate that clinicians would need to spend more time than is available to implement the preventive care recommendations, so clearly these estimates do not reflect what actually happens. These time estimates also do not take into consideration how the recommended interventions could displace clinician time that might be consumed by less important activities. For example, if a patient books a 15 minute appointment slot for an ankle sprain, a clinician who is aware of recommended preventive care interventions may curtail discussions of the ankle sprain in order to make time for effective preventive care that could be life-saving. We support studies of the actual time implications of recommendations and of other implications including effects on health equity.

Our guidance can both promote health equity while reducing time requirements on clinicians.

Values statement

Health inequities are, by definition, avoidable. There are disparities in health outcomes and access to preventive care based on gender, racialization, income, and other factors. Equitable access to preventive care is one facet of promoting health equity.

People experiencing disadvantages should be prioritized for access to beneficial preventive care services. Preventive care should be provided in ways and settings that meet the needs of people experiencing disadvantage.

Information about the benefits and harms of screening, and about disparities in preventive care and health outcomes, should be used to provide guidance that promotes health equity. Our recommendations will build on existing general guidance about preventive care that might mention equity in passing, by focusing squarely on health equity.

Patient values and preferences literature review

Patients experiencing disadvantages prefer care that explicitly addresses health inequities (Keefe 2019). Experiences of equitable care are associated with greater confidence in care and the ability to prevent and manage health problems (Ford-Gibloe, 2018; Prodan-Bhalla, 2019). Patients generally want preventive services such as screening tests and several studies show an enthusiastic desire for screening (Schwartz 2004; Domenighetti 2003; Hudson 2012; Brotons 2012). While studies of patient preferences for screening find that patients overestimate the benefits of screening, the studies also find that patients want to be screened after they have reviewed information about the screening tests. Patients prefer screening more often than clinicians expect, and patients seem to value the accuracy of tests and avoiding pain or unpleasantness related to testing (Marshall 2009).

Many studies indicate that patients experiencing disadvantages want to be offered preventive care services and prefer to play an active role in discussing options, for example, in the modality of colorectal cancer screening (Lee 2018). Racialized patients may be less likely to complete colonoscopies compared with less invasive screening procedures for colorectal cancer (Inadomi, 2012; Wolf 2016; Chablani 2017). Patients generally prefer HPV testing over cytological screening for cervical cancer (Biddell 2020). A qualitative study of 14 Canadian patients generally rated the benefits of screening for [post-partum depression](#) as more important than potential harms and overall believed that the benefits outweighed the harms. Patients are generally open to cardiovascular risk assessment but many require substantial benefits to take preventive treatments (Albarqoun 2017). Patients believe that screening for social risk is important (Byhoff 2019) and 79% believed that it is appropriate (De Marchis, 2019). Patients are open to discussing social risk when there is a trusting care relationship and structures are in place to provide needed supports (O'Loughlin, 2022).

Decisions about screening for prostate cancers, that is not covered by our guidance, is sensitive to patient preferences (Hansen 2019; Vernooij 2018).

References

Keefe SL, Gessesse RM, Lincoln ER, Meerkins K, Evans TR. Prioritizing Health Equity: Patient Perspectives from a Clinic-Based PhotoVoice Qualitative Study. *Health Equity*. 2019 Nov 4;3(1):573-580.

Ford-Gilboe M, Wathen CN, Varcoe C, Herbert C, Jackson BE, Lavoie JG, Pauly BB, Perrin NA, Smye V, Wallace B, Wong ST, Browne AJ. How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy. *Milbank Q*. 2018 Dec;96(4):635-671.

Prodan-Bhalla N, Browne AJ. Exploring women's health care experiences through an equity lens: Findings from a community clinic serving marginalised women. *J Clin Nurs*. 2019 Oct;28(19-20):3459-3469.

Schwartz LM, Woloshin S, Fowler FJ Jr, Welch HG. Enthusiasm for cancer screening in the United States. *JAMA*. 2004 Jan 7;291(1):71-8. doi: 10.1001/jama.291.1.71. PMID: 14709578.

Domenighetti G, D'Avanzo B, Egger M, Berrino F, Perneger T, Mosconi P, Zwahlen M. Women's perception of the benefits of mammography screening: population-based survey in four countries. *Int J Epidemiol*. 2003 Oct;32(5):816-21. doi: 10.1093/ije/dyg257. PMID: 14559757.

Hudson B, Zarifeh A, Young L, Wells JE. Patients' expectations of screening and preventive treatments. *Ann Fam Med*. 2012 Nov-Dec;10(6):495-502.

Brotans C, Bulc M, Sammut MR, Sheehan M, Manuel da Silva Martins C, Björkelund C, Drenthen AJ, Duhot D, Görpelioglu S, Jurgova E, Keinanen-Kiukkaniemi S, Kotányi P, Markou V, Moral I, Mortsiefer A, Pas L, Pichler I, Sghedoni D, Tataradze R, Thireos E, Valius L, Vuchak J, Collins C, Cornelis E, Ciurana R, Kloppe P, Mierzecki A, Nadaraia K, Godycki-Cwirko M. Attitudes toward preventive services and lifestyle: the views of primary care patients in Europe. the EUROPREVIEW patient study. *Fam Pract*. 2012 Apr;29 Suppl 1:i168-i176. doi: 10.1093/fampra/cmr102. PMID: 22399549.

Marshall DA, Johnson FR, Kulin NA, Ozdemir S, Walsh JM, Marshall JK, Van Bebber S, Phillips KA. How do physician assessments of patient preferences for colorectal cancer screening tests differ from actual preferences? A comparison in Canada and the United States using a stated-choice survey. *Health Econ*. 2009 Dec;18(12):1420-39. doi: 10.1002/hec.1437. PMID: 19191268; PMCID: PMC3964796.

Lee SJ, O'Leary MC, Umble KE, Wheeler SB. Eliciting vulnerable patients' preferences regarding colorectal cancer screening: a systematic review. *Patient Prefer Adherence*. 2018 Oct 31;12:2267-2282.

Chablani SV, Cohen N, White D, Itzkowitz SH, DuHamel K, Jandorf L. Colorectal Cancer Screening Preferences among Black and Latino Primary Care Patients. *J Immigr Minor Health*. 2017 Oct;19(5):1100-1108.

Wolf RL, Basch CE, Zybert P, Basch CH, Ullman R, Shmukler C, King F, Neugut AI. Patient Test Preference for Colorectal Cancer Screening and Screening Uptake in an Insured Urban Minority Population. *J Community Health*. 2016 Jun;41(3):502-8. doi: 10.1007/s10900-015-0123-0. PMID: 26585609.

Inadomi JM, Vijan S, Janz NK, Fagerlin A, Thomas JP, Lin YV, Muñoz R, Lau C, Somsouk M, El-Nachef N, Hayward RA. Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. *Arch Intern Med*. 2012 Apr 9;172(7):575-82. doi: 10.1001/archinternmed.2012.332. PMID: 22493463; PMCID: PMC3360917.

Biddell CB, O'Leary MC, Wheeler SB, Spees LP. Variation in Cervical Cancer Screening Preferences among Medically Underserved Individuals in the United States: A Systematic Review. *Cancer Epidemiol Biomarkers Prev*. 2020 Aug;29(8):1535-1548.

https://canadiantaskforce.ca/wp-content/uploads/2022/05/CTFPHC_PP_Pregnant-Postpartum-Depression_Data-Summary_Phase-2_190719_FINAL.pdf

Byhoff E, De Marchis EH, Hessler D, Fichtenberg C, Adler N, Cohen AJ, Doran KM, Ettinger de Cuba S, Fleegler EW, Gavin N, Huebschmann AG, Lindau ST, Tung EL, Raven M, Jepson S, Johnson W, Olson AL, Sandel M, Sheward RS, Gottlieb LM. Part II: A Qualitative Study of Social Risk Screening Acceptability in Patients and Caregivers. *Am J Prev Med*. 2019 Dec;57(6 Suppl 1):S38-S46.

De Marchis EH, Hessler D, Fichtenberg C, Adler N, Byhoff E, Cohen AJ, Doran KM, Ettinger de Cuba S, Fleegler EW, Lewis CC, Lindau ST, Tung EL, Huebschmann AG, Prather AA, Raven M, Gavin N, Jepson S, Johnson W, Ochoa E Jr, Olson AL, Sandel M, Sheward RS, Gottlieb LM. Part I: A Quantitative Study of Social Risk Screening Acceptability in Patients and Caregivers. *Am J Prev Med.* 2019 Dec;57(6 Suppl 1):S25-S37.

O'Loughlin K, Shadowen HM, Haley AD, Gilbert J, Lail Kashiri P, Webel B, Huebschmann AG, Krist AH. Patient Preferences for Discussing and Acting on Health-Related Needs in Primary Care. *J Prim Care Community Health.* 2022 Jan-Dec;13:21501319221115946.

Vernooij RWM, Lytvyn L, Pardo-Hernandez H, Albarqouni L, Canelo-Aybar C, Campbell K, Agoritsas T. Values and preferences of men for undergoing prostate-specific antigen screening for prostate cancer: a systematic review. *BMJ Open.* 2018 Sep 5;8(9):e025470.

Hansen TB, Lindholt JS, Diederichsen ACP, Bliemer MCJ, Lambrechtsen J, Steffensen FH, Sjøgaard R. Individual preferences on the balancing of good and harm of cardiovascular disease screening. *Heart.* 2019 May;105(10):761-767.

Albarqouni L, Doust J, Glasziou P. Patient preferences for cardiovascular preventive medication: a systematic review. *Heart.* 2017 Oct;103(20):1578-1586. doi: 10.1136/heartjnl-2017-311244. Epub 2017 May 13. PMID: 28501795.

Search strategies

Topic	PubMed search terms
Colorectal cancer screening	<p>#1 Search (colorectal[ti] OR colon[ti] OR colonic[ti] OR rectal[ti] OR rectum[ti] OR rectosigmoid*[ti] OR adenoma*[ti]) AND (cancer*[ti] OR carcinoma*[ti] OR adenocarcinoma*[ti] OR malignan*[ti] OR tumor[ti] OR tumors[ti] OR tumour[ti] OR tumours[ti] OR neoplas*[ti] OR polyp[ti] OR polyps[ti] OR polyposis[ti])</p> <p>#2 Search (screen*[ti] OR detect*[ti] OR surveillance[ti])</p> <p>#3 Search #1 AND #2</p> <p>#4 Search (colonoscop*[ti] OR colonograph*[ti] OR sigmoidoscop*[ti])</p> <p>#5 Search capsule[ti] AND endoscop*[ti]</p> <p>#6 Search "pill cam"[ti] OR pillcam[ti]</p> <p>#7 Search (fecal[ti] OR faecal[ti] OR stool[ti]) AND (DNA[ti] OR "deoxyribonucleic acid"[ti])</p> <p>#8 Search (fecal[ti] OR faecal[ti] OR stool[ti]) AND (molecular[ti] OR genetic[ti] OR genetics[ti])</p> <p>#9 Search (fdna[ti] OR f-dna[ti] OR sdna[ti] OR s-dna[ti])</p> <p>#10 Search (fecal[ti] OR faecal[ti] OR stool[ti]) AND (immunochemical[ti] OR immunoassay[ti])</p> <p>#11 Search ("fecal occult"[ti] OR "faecal occult"[ti] OR "stool occult"[ti] OR "occult blood"[ti] OR FOBT[ti] OR IFOBT[ti])</p> <p>#12 Search ("septin 9"[ti] OR septin9[ti] OR sept9[ti])</p> <p>#13 Search #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12</p>
Cervical cancer screening	<p>Search: ((cervical cancer[Title]) OR (cervical precancer[Title]) OR (cervical carcinoma[Title]) OR (cervix[Title]) OR (human papillomavirus[Title]) OR (HPV[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (self-test*[Title]) OR (self-sampl*[Title]) OR (self test*[Title]) OR (self sampl*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Review, Systematic Review, in the last 5 years</p> <p>Search: ((cervical cancer[Title]) OR (cervical precancer[Title]) OR (cervical carcinoma[Title]) OR (cervix[Title]) OR (human papillomavirus[Title]) OR (HPV[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (self-test*[Title]) OR (self-sampl*[Title]) OR (self test*[Title]) OR (self sampl*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>
Lung cancer screening	<p>Search: (lung cancer[Title]) AND ((screen*[Title]) OR (test*[Title]) OR (prevent*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p> <p>Search: (lung cancer[Title]) AND ((screen*[Title]) OR (test*[Title]) OR (prevent*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>

<p>Cardiovascular disease including hypertension</p>	<p>Search: ((cardiovascular disease[Title]) OR (cardiovascular disease risk[Title]) OR (cardiovascular disease risk assessment[Title]) OR (cardiovascular risk[Title]) OR (cardiovascular risk assessment[Title]) OR (cardiovascular assessment[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (manage*[Title]) OR (treat*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p> <p>Search: ((cardiovascular disease[Title]) OR (cardiovascular disease risk[Title]) OR (cardiovascular disease risk assessment[Title]) OR (cardiovascular risk[Title]) OR (cardiovascular risk assessment[Title]) OR (cardiovascular assessment[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (manage*[Title]) OR (treat*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: Meta-Analysis, Systematic Review</p>
<p>HIV and Hepatitis C screening</p>	<p>Search: ((human immunodeficiency virus[Title]) OR (HIV[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p> <p>Search: ((human immunodeficiency virus[Title]) OR (HIV[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 10 years</p> <p>Search: ((hepatitis C[Title]) OR (hep C[Title]) OR (hepatitis C virus[Title]) OR (hcv[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p> <p>Search: ((hepatitis C[Title]) OR (hep C[Title]) OR (hepatitis C virus[Title]) OR (hcv[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 10 years</p>
<p>Diabetes screening</p>	<p>Search: ((diabetes[Title]) OR (type 2 diabetes[Title]) OR (prediabetes[Title]) OR (pre-diabetes[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p>
<p>Tuberculosis screening</p>	<p>Search: ((tuberculosis[Title]) OR (tb[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p> <p>Search: ((tuberculosis[Title]) OR (tb[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (burden[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 10 years</p>
<p>Tobacco use screening</p>	<p>Search: ((tobacco[Title]) OR (smoking[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title]) OR (cessation[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p>

Appendix 2, as supplied by the authors. Appendix to: Persaud N, Sabir A, Woods H, et al. Preventive care recommendations to promote health equity. *CMAJ* 2023. doi: 10.1503/cmaj.230237. Copyright © 2023 The Author(s) or their employer(s). To receive this resource in an accessible format, please contact us at cmajgroup@cmaj.ca.

	<p>Search: ((tobacco[Title]) OR (smoking[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title]) OR (cessation[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title]))</p>
Alcohol use screening	<p>Search: ((alcohol*[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title]) OR (cessation[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p> <p>Search: ((alcohol*[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title]) OR (cessation[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>
Substance use screening	<p>Search: ((substance*[Title]) OR (drug*[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p> <p>Search: ((substance*[Title]) OR (drug*[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (abstinence[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>
Depression screening	<p>Search: ((depression[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 10 years</p>
Dental caries screening	<p>Search: ((dental caries[Title]) OR (dental care[Title]) OR (oral health[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (utiliz*[Title]) OR (use[Title])) Filters: in the last 5 years</p> <p>Search: ((dental caries[Title]) OR (dental care[Title]) OR (oral health[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (utiliz*[Title]) OR (use[Title]) OR (care[Title]) OR (health[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>
Poverty screening	<p>Search: (poverty[Title]) OR (social needs[Title]) AND ((screen*[Title]) OR (test*[Title]) OR (prevent*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p> <p>Search: (poverty[Title]) OR (social needs[Title]) AND ((screen*[Title]) OR (test*[Title]) OR (prevent*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title])) Filters: in the last 5 years</p>
Intimate partner violence screening	<p>Search: ((intimate partner violence[Title]) OR (ipv[Title]) OR (partner violence[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title])) Filters: Meta-Analysis, Systematic Review, in the last 5 years</p>

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	Search: ((intimate partner violence[Title]) OR (ipv[Title]) OR (partner violence[Title])) AND ((screen*[Title]) OR (test*[Title]) OR (assess*[Title]) OR (treat*[Title]) OR (intervent*[Title]) OR (hospital*[Title]) OR (emergency department*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title]))
Primary care access	<p>Search: (primary care[Title]) AND ((access*[Title]) OR (contribution*[Title]) OR (experience*[Title]) OR (utiliz*[Title])) Filters: Meta-Analysis, Review, Systematic Review</p> <p>Search: (primary care[Title]) AND ((access*[Title]) OR (contribution*[Title]) OR (experience*[Title]) OR (utiliz*[Title]) OR (referral*[Title])) AND ((disparit*[Title]) OR (inequit*[Title]) OR (equit*[Title]) OR (differen*[Title]))</p> <p>Search: (primary care[Title]) AND ((access*[Title]) OR (attach*[Title]) OR (unattach*[Title]))</p>