e-Appendix 1: Definitions of levels of evidence and grades of recommendations of the Canadian Task Force on Preventive Health Care

Levels of evidence

Research-design rating

I	Evidence from randomized controlled trial(s)
II-1	Evidence from controlled trial(s) without randomization
II-2	Evidence from cohort or case–control analytic studies, preferably from more than one centre or research group
II-3	Evidence from comparisons between times or places with or without the intervention; dramatic results from uncontrolled studies could be included here
III	Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees

Quality (internal validity) rating[45]

Good	Study meets all design-specific criteria* well
Fair	Study does not meet (or it is not clear that it meets) at least one design-specific criterion* but has no known "fatal flaw"
Poor	Study has at least one design-specific* "fatal flaw" or an accumulation of lesser flaws to the extent that the results of the study are not deemed able to inform recommendations

Grades of recommendations for specific clinical preventive actions†

A	There is **good** evidence to recommend the clinical preventive action
B	There is **fair** evidence to recommend the clinical preventive action
C	The existing evidence is **conflicting** and does not allow making a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
D	There is **fair** evidence to recommend against the clinical preventive action
E	There is **good** evidence to recommend against the clinical preventive action
I	There is **insufficient** evidence (in quantity or quality or both) to make a recommendation; however, other factors may influence decision-making

*General design-specific criteria are outlined by Harris and associates.[45] Inclusion and exclusion criteria are detailed in the Methods section of that article.

†The task force recognizes that, in many cases, patient-specific factors must be considered and discussed, such as the value the patient places on the clinical preventive action, its possible positive and negative outcomes, and the context or personal circumstances of the patient (medical and other). In certain circumstances where the evidence is complex, conflicting or insufficient, a more detailed discussion may be required.