

BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open

Peer Support Interventions for Women with Cardiovascular Disease: Protocol for Synthesizing the Literature Using an Evidence Map

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2022-067812
Article Type:	Protocol
Date Submitted by the Author:	26-Aug-2022
Complete List of Authors:	<p>Parry, Monica; University of Toronto Lawrence S Bloomberg Faculty of Nursing, Visintini, Sarah; University of Ottawa Heart Institute Berkman Library; University of Ottawa Johnston, Amy; University of Ottawa, School of Epidemiology and Public Health Colella, Tracey; Toronto Rehabilitation Institution, University Health Network, Cardiac Rehabilitation and Prevention Program; University of Toronto, Department of Medicine Kapur, Deeksha; University of Toronto Faculty of Arts & Science Liblik, Kiera; Queen's University Faculty of Health Sciences Gomes, Zoya; Dalhousie Medical School Dancey, Sonia; University of Ottawa Faculty of Medicine Liu, Shuangbo; University of Manitoba Max Rady College of Medicine Goodenough, Catherine; Canadian Women's Heart Health Centre, Woman with Lived Experience Hay, Jacqueline; University of Manitoba, Applied Health Sciences Noble, Meagan; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing; Indigenous Services Canada Adreak, Najah; The University of British Columbia Robert, Helen; Canadian Women's Heart Health Centre, Woman with Lived Experience Tang, Natasha; Queen's University Faculty of Health Sciences O'Hara, Arland; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing Wong, Anice; University of Ottawa Heart Institute Mullen, Kerri-Anne ; University of Ottawa Heart Institute</p>
Keywords:	Heart failure < CARDIOLOGY, Ischaemic heart disease < CARDIOLOGY, Stroke < NEUROLOGY

SCHOLARONE™
Manuscripts

Title: Peer Support Interventions for Women with Cardiovascular Disease: Protocol for Synthesizing the Literature Using an Evidence Map

Authors and Affiliations: Monica Parry,¹ Sarah Visintini,^{2,3} Amy Johnston,^{2,3} Tracey JF Colella,¹ Deeksha Kapur,¹ Kiera Liblik,⁴ Zoya Gomes,⁵ Sonia Dancey,³ Shuangbo Liu,⁶ Catherine Goodenough,⁷ Jacqueline Hay,⁶ Meagan Noble,^{1,8} Najah Adreak,⁹ Helen Robert,⁷ Natasha Tang,⁹ Arland O'Hara,¹ Anice Wong,² Kerri-Anne Mullen²

¹University of Toronto, Toronto, Ontario, Canada

²University of Ottawa Heart Institute, Ottawa, Ontario, Canada

³University of Ottawa, Ottawa, Ontario, Canada

⁴Queen's University, Kingston, Ontario, Canada

⁵Dalhousie University, Halifax, Nova Scotia, Canada

⁶University of Manitoba, Winnipeg, Manitoba, Canada

⁷Woman with Lived Experience, Canadian Women's Heart Health Alliance, Ottawa, Ontario, Canada

⁸Indigenous Services Canada, Government of Canada, Toronto, Ontario, Canada

⁹University of British Columbia, Vancouver, British Columbia, Canada

Corresponding Author: Dr. Monica Parry NP-Adult PhD

Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

155 College Street, Suite 130, Toronto, ON, Canada, M5T 1P8

Phone: 416-946-3561, **Email:** monica.parry@utoronto.ca

Word Count: 2663

Protocol version: 1.0, August 23/2022

ABSTRACT

Introduction The leading cause of death for women is cardiovascular disease (CVD), including ischemic heart disease, stroke, and heart failure. Previous literature has demonstrated that peer support interventions improve self-reported recovery, hope, and empowerment in other patient populations but the evidence for peer support interventions in women with CVD is unknown. The aim of this study is to describe peer support interventions for women with CVD using an evidence map. Specific objectives are to: 1) provide an overview of peer support interventions used in women with ischemic heart disease, stroke, and heart failure, 2) identify gaps in primary studies where new or better studies are needed, and 3) describe knowledge gaps where complete systematic reviews are required.

Methods and analysis Women living with CVD are members of our investigative team and will collaborate in all steps of the review. We are also collaborating with the Canadian Women's Heart Health Alliance and using the Strategy for Patient-Oriented Research (SPOR) Capacity Development Framework, SPOR Patient Engagement Framework, and the Individual and Family Self-Management Theory. We are also building on previous experience and expertise in knowledge synthesis using methods described by the Evidence for Policy and Practice Information (EPPI) and the Coordinating Centre at the Institute of Education. Six steps will be followed: 1) identify the scope, 2) define key variables, 3) establish a broad and systematic search strategy, 4) identify study eligibility criteria, 5) comprehensively retrieve, screen, and classify the evidence, and 6) report findings in an evidence map.

Ethics and Dissemination The University of Toronto's Research Ethics Board granted approval on April 28th, 2022 (Protocol #42608). Bubble plots (i.e., weighted scatter plots), geographic heat/choropleth maps, and infographics will be used to illustrate peer support intervention elements by category of CVD. Knowledge dissemination will include publication, presentation/public forums, and social media.

Keywords Evidence Map, Peer Support, Cardiovascular Disease, Women, Patient-Oriented Research

Registration: Open Science Framework (DOI 10.17605/OSF.IO/E7KQ3)

STRENGTHS AND LIMITATIONS OF THE REVIEW

- This is the first evidence map to critically examine and synthesize the literature on peer support programs utilized for women with ischemic heart disease, stroke, and heart failure.
- Women with lived experience (i.e., patient partners) will collaborate in identifying search terms as there is evidence that this increases the number of citations by 34%.
- Publication bias will be mitigated by including sources of evidence written in both English and French, and by performing targeted searches for relevant grey literature. Women with lived experience will also verify terms used in the literature search strategy.

INTRODUCTION

The leading cause of premature death for women is cardiovascular disease (CVD), responsible for 35% of total deaths in 2019.¹ Ischemic heart disease (IHD), stroke and heart failure are the most common causes of mortality;^{1,2} which vary across the lifespan and are influenced by ethnicity, racism, and gender.^{3,4} Globally, mortality rates have remained stagnant, however in 2017, mortality increased in women in two high income countries: Canada and the United States.¹ Young women are now more likely to die within one year of a myocardial infarction (MI) compared to men,^{5,6} and women who are transgender have a greater than two-fold increase in MI compared to women who are cisgender.⁷ Moreover, most women are unaware of risk factors or symptoms.⁸ Women also have depression,⁹ anxiety,^{9,10} and lower health-related quality of life (HRQoL)¹¹ one year after an MI, and for many women, fear and anxiety about the future and difficulty moving forward in recovery extends beyond five years of having an MI.¹²⁻¹⁴ Stroke is the second most common cause of CVD-mortality in women worldwide.¹⁵ Getahun et al.¹⁶ also demonstrated an increased risk of stroke in transgender women. Women have a higher lifetime stroke risk compared to men,¹ with risk being highest during pregnancy, menopause, and later in life.⁹ Women with heart failure tend to have preserved ejection fraction, peripartum cardiomyopathy, and/or Takotsubo syndrome,^{17,18} and there are few to no treatments for specific heart failure phenotypes in women,¹ causing more depression and impaired HRQoL in women compared to men.^{19,20}

International CVD priorities, led by the World Health Organization's Global Action Plan for the Prevention and Control of Non-Communicable Diseases (2013-2020) and the United Nations Sustainable Development Goals (2015-2030), focus on good health, gender equality, innovation and infrastructure, reduced inequalities, and partnerships.²¹ Good health focuses on ensuring healthy lives and promoting the well-being of all people at all ages, with a focus to reduce premature mortality from non-communicable diseases through prevention and treatment and the promotion of mental health and well-being.²¹ Individuals 43 to 70 years with IHD report worse physical HRQoL (38.9 [95% CI, 36.9-

1
2 41.0]) compared to the general population.²² Similar results are reported in women with obstructive
3
4 (41.9, SD 8.9) and non-obstructive heart disease (43.7, SD 9.4) ($p=0.072$).²³ Moreover, a decline in
5
6 physical versus mental HRQoL is more predictive of hospital readmission²⁴ and mortality in healthy
7
8 middle-aged and older women ($n=40,337$)²⁵ and in men and women with heart disease.²⁴ The World
9
10 Heart Federation has been advocating globally for better CVD outcomes, suggesting advocacy tactics
11
12 and strategies to reduce CVD by 25% by 2025.²¹ This includes addressing behavioral risk factors for
13
14 better prevention and reducing IHD and stroke in women by identifying and aligning with national
15
16 CVD priorities, strategic communications, media engagement, evidence-based research, partnership
17
18 development, and collaborating with key decision-makers.²¹ The Lancet Commission advocates for a
19
20 global imperative to reduce the global burden of CVD in women by 2030.¹
21
22
23
24

25 Social support in the form of relationships with family and friends, as well as peer support from
26
27 other women with CVD, has been identified as an integral component in the recovery process for
28
29 women following a cardiac event.²⁶ Perceived social support has a direct impact on health outcomes;
30
31 individuals with low levels of social support have higher CVD-related²⁷ and all-cause mortality rates.²⁸
32
33 Results from the Variation in Recovery: Role of Gender on Outcomes of Young AMI Patients
34
35 (VIRGO) study suggested lower social support was associated with worse health outcomes and more
36
37 depressive symptoms 12 months after an MI, with one in five individuals less than 55 years of age
38
39 having low social support following an MI.²⁹ Others report that individuals with low social support
40
41 following an MI had more angina (relative risk [RR], 1.27; 95% confidence interval [CI], 1.10, 1.48),
42
43 lower HRQoL (mean difference [β] = -3.33; 95% CI, -5.25, -1.41), lower mental functioning (β = -
44
45 1.72; 95% CI, -2.65, -0.79), and more depressive symptoms (β = 0.94; 95% CI, 0.51, 1.38).³⁰
46
47 Moreover, the association between social support and HRQoL, depression, and physical functioning
48
49 appears to be stronger in women compared to men.³⁰ In the general population, twice as many women
50
51 have depression^{31,32} and anxiety^{33,34} as men, which are known risk factors for CVD. Depressive
52
53 symptoms are associated with atherosclerotic IHD (odds ratio [OR]=1.07, 95% CI, 1.02, 1.13, per one-
54
55
56
57
58
59
60

1 point increase in the Patient Health Questionnaire [PHQ-9] score) and death (adjusted hazard ratio
2 [HR]=1.07, 95% CI, 1.02, 1.14, per one-point increase in the PHQ-9 score) in women younger than 55
3 years, but not in men or in women over 55 years.³⁵ In postmenopausal women, fatal cardiac events are
4 associated with depression.³⁶ Anxiety has also been linked to developing and the worsening IHD and
5 CVD mortality.³⁷

6
7
8
9
10
11
12
13 It has been suggested that social support, specifically from other women who have lived a
14 similar health or recovery experience, may play a key role in women's CVD rehabilitation and
15 recovery.^{8,38,39} Peer support is the provision of assistance and encouragement by an individual that is
16 considered equal⁴⁰; it is a form of social support delivered by a layperson who has received some
17 formal training to share experiential knowledge and emotional assistance. Defining attributes of all peer
18 relationships include emotional, informational, and appraisal support.⁴⁰ Moreover, providing and
19 receiving support benefits both the receiver and the provider of support.⁴¹ Women (n = 387) aged 42 ±
20 6 years who received a peer support intervention reported better cardiovascular risk factor profiles (i.e.,
21 hypertension, exercise, weight, smoking) compared to women randomized to a control group
22 (difference: 0.75; 95% CI, 0.32, 1.18).⁴² In patients and caregivers following a stroke, the value of peer
23 support during the recovery process was derived through information and advice, encouragement and
24 empowerment, awareness, being helpful, and making connections.⁴³ There is some evidence that peer
25 support interventions improve self-reported recovery for individuals with CVD,^{44,45} and hope and
26 empowerment in other patient populations that include those with mental illness, HIV, and women who
27 are breastfeeding.⁴⁶⁻⁴⁸ Women have identified the importance of engagement in several different
28 activities to promote their recovery including behavioural, social, and psychological dimensions.²⁶ As
29 individuals focus on their own recovery in the context of multiple social roles, re-evaluation and re-
30 prioritization of self can be a challenging task. Women face unique challenges in managing their health
31 and modifying their lifestyle during recovery.⁴⁹⁻⁵² Women often prioritize family, household
32 responsibilities, and caregiver tasks, which subsequently place preventive health behaviours and their

1
2 own health status as secondary.⁵³ There is a need to distinctly enhance the nature and level of care
3
4 provided to women living with CVD. Although there is some evidence for the beneficial effects of peer
5
6 support in women with CVD, a more gender-informative and culturally sensitive knowledge synthesis
7
8 across the lifespan is needed.
9

10 11 **OBJECTIVES**

12
13
14 The overall aim of this study is to describe peer support interventions for women with CVD
15
16 (IHD, stroke, heart failure) using an evidence map. Specific objectives are to: 1) provide an overview
17
18 of peer support interventions used in women with ischemic heart disease, stroke, and heart failure, 2)
19
20 identify gaps in primary studies where new or better studies are needed, and 3) describe knowledge
21
22 gaps where complete systematic reviews are required.
23
24

25 26 **METHODS AND ANALYSIS**

27
28 The main purpose of performing a broad map of the literature (i.e., evidence map) is to identify
29
30 the range of research and identify gaps and future research needs.⁵⁴ An evidence map is broad in scope,
31
32 but systematic in its approach to synthesize the evidence.⁵⁴ Evidence mapping is useful in directing
33
34 future research, including systematic reviews.^{55,56} We are collaborating with women with lived
35
36 experience (Goodenough, Robert) and the Canadian Women's Heart Health Alliance (CWHHA) and
37
38 using the Strategy for Patient-Oriented Research (SPOR) Capacity Development Framework,²³ SPOR
39
40 Patient Engagement Framework,²⁴ and the Individual and Family Self-Management Theory^{25,26} to
41
42 describe peer support interventions used for women with CVD (IHD, stroke, heart failure). The
43
44 Individual and Family Self-Management Theory consists of three dimensions: context, process and
45
46 outcomes.¹⁰⁰ We have used this in a previous integrated mixed methods systematic review to guide
47
48 processes related to defining patient-reported outcome variables and variables used for data
49
50 extraction.⁵⁷ This theory depicts self-management within the broader context of people and other
51
52 influences (e.g., ethnicity, racism, healthcare access, institutionalized gender).¹⁰⁸ The Individual and
53
54
55
56
57
58
59
60

1
2 Family Self-Management Theory¹⁰⁰ has provided a platform for testing clinical interventions that have
3
4 included the Arthritis Self-Management Program (ASMP)¹⁰⁹ and the Diabetes Self-Management
5
6 Program.¹¹⁰ This model highlights the role of social influence (e.g., peer support) and the value of
7
8 emotional, informational, and appraisal support (*Figure 1*).^{100,111}
9

10
11 -Insert Figure 1-
12

13 We used the Preferred Reporting Items for Systematic reviews and Meta-Analyses for Protocols
14
15 2015 (PRISMA-P 2015) checklist when preparing this manuscript (Supplementary Table 1).⁵⁸
16
17 Additionally, the Guidance for Reporting Involvement of Patients and the Public – Long Form (GRIPP
18
19 2 - LF) was used to document the engagement of women with lived experience (Goodenough, Robert)
20
21 (Supplementary Table 2).⁵⁹ We will also use a patient partner compensation rate structure described in
22
23 the Recommendations on Patient Engagement Compensation – Prepared by the SPOR Networks in
24
25 Chronic Diseases and the PICHI Network⁶⁰: each (Goodenough, Robert) will receive a one-year
26
27 honorarium of \$1000 that will include compensation for 4-hours of training and assistance across all
28
29 other activities of the project (i.e., screening, knowledge translation and exchange [KTE] activities).
30
31
32
33

34 We will not register our evidence map on PROSPERO, the international prospective register of
35
36 systematic reviews, as evidence mapping does not meet the inclusion criteria for this registry.
37
38 However, to manage records and promote transparency, we have registered our project on the Open
39
40 Science Framework (DOI 10.17605/OSF.IO/E7KQ3).⁶¹ Assessment of risk of bias, meta-bias(es), or
41
42 strength of the evidence will not be undertaken. We will follow methods described by the Evidence for
43
44 Policy and Practice Information (EPPI) and the Coordinating Centre at the Institute of Education,^{56,62-65}
45
46 using six steps utilized in performing previous broad maps of the literature⁶⁶: 1) identify the scope of
47
48 the evidence map, 2) define key variables, 3) establish a comprehensive search strategy, 4) identify
49
50 clear eligibility criteria, 5) systematically retrieve, screen and classify the evidence, and 6) report the
51
52 findings in an evidence map.
53
54
55

56 57 **Identify the Scope of the Evidence Map** 58

1
2 The initial scope of the work was defined by the research team to focus on the most common
3
4 causes of CVD mortality in women^{1,3}: IHD, stroke and heart failure. The research question, key
5
6 variables, and eligibility criteria were discussed with women with lived experience (Goodenough,
7
8 Robert). Our overarching review question was established: *What is known about peer support*
9
10 *interventions used for women with CVD (IHD, stroke, and heart failure)?* This question can be
11
12 answered by a broad range of evidence that includes RCTs, cohort and cross-sectional studies, case
13
14 control studies and case series/reports across reported from urban and rural settings across the globe.
15
16

17 **Define Key Variables**

18
19 We used the PICO framework to focus our research question and also to inform our broad
20
21 search of the literature.¹¹⁵ The PICO elements included the population, intervention, comparison and
22
23 outcomes. Keywords and the National Library of Medicine's Medical Subject Headings (MeSH) were
24
25 combined under two of the PICO categories: (P) women with CVD (IHD, stroke and heart failure) and
26
27 (I) peer support. We did not search using a comparator or by outcome so that we could maintain
28
29 breadth and reduce bias in our search strategy. The draft MEDLINE search strategy was informed by
30
31 searches of existing reviews (*Table 1*) and executed by a library scientist.^{116,117} Women with lived
32
33 experience (Goodenough, Robert) collaborated to identify and confirm search terms as there is
34
35 evidence that this may increase the number of citations retrieved by 34%.^{112,118}
36
37
38
39
40

41 **Establish a Comprehensive Search Strategy**

42
43 The literature on peer support interventions used for women with CVD (IHD, stroke, and heart
44
45 failure) will be systematically and comprehensively searched using MeSH headings and keywords in
46
47 accordance with the search criteria in the bibliographic databases. Publications will need to be available
48
49 in English or French. The following five databases will be searched: CINAHL, EMBASE, MEDLINE,
50
51 APA PsychInfo, the Cochrane Database of Systematic Reviews and the Cochrane Central Register of
52
53 Controlled Trials, and Scopus. We will also search Clinicaltrials.gov and the WHO International
54
55 Clinical Trials Registry Platform (ICTRP). Further grey literature will be identified via Proquest
56
57
58
59
60

Dissertations and Theses, handsearching abstracts for specific conferences, and a targeted advanced Google search. Citations will be exported from electronic search interfaces to Covidence¹¹⁹ for duplicate elimination and screening.

Table 1 Draft Medline Search, 1946 - (Database: MEDLINE(R) ALL, Platform: Ovid)

#	Searches
1	*social support/
2	Self-Help Groups/
3	peer group/
4	(peer* adj3 (support* or educat*)).ti,ab,kf.
5	((social adj3 support) and peer*).ti,ab,kf.
6	or/1-5
7	((heart or cardiac) adj2 (disease or surg* or patient?)).ti,ab,kf.
8	exp Myocardial Ischemia/
9	((coronary adj2 (arter* or stenosis* or atherosclerosis* or arteriosclerosis* or syndrome or microvascular)) or (coronary adj5 disease?) or CAD).ti,ab,kf.
10	(small adj2 (arter* or vessel*) adj2 disease*).ti,ab,kf.
11	(angina or stroke? or MINOCA or INOCA or SCAD or Kounis).ti,ab,kf.
12	((heart or myocardial) adj3 infarct*).ti,ab,kf.
13	(isch?emi* adj3 (heart or cardiac or myocardial)).ti,ab,kf.
14	((heart or cardiac or coronary) adj2 (spasm* or vasospasm* or embolism*)).ti,ab,kf.
15	exp Myocardial Revascularization/
16	((aortocoronary or coronary) adj3 bypass*) or CABG).ti,ab,kf.
17	(angioplast* or atherectomy* or endarterectomy* or thrombectomy* or PCI or PTCA or (Percutaneous adj3 (intervent* or revascular*))).ti,ab,kf.
18	exp Stroke/
19	Stroke Rehabilitation/
20	Cardiac Rehabilitation/
21	((brain* or cerebr* or cerebell* or vertebrobasilar or hemispher* or intracran* or intracerebral* or infratentorial* or supratentorial* or anterior circulation or posterior circulation or basal ganglia) adj5 (isch?emi* or infarct* or thrombo* or emboli*)).ti,ab,kf.
22	((brain* or cerebr* or cerebell* or intracerebral or intracran* or parenchymal or intraventricular or infratentorial or supratentorial or basal gangli*) adj5 (h?emorrhage* or h?ematoma* or bleed*)).ti,ab,kf.
23	exp Heart Failure/
24	exp Ventricular Dysfunction, Left/
25	((heart or cardiac) adj2 (failure or resynchroni*)).ti,ab,kf.
26	(cardiomyopath* or Takotsubo or HFrEF or HFpEF).ti,ab,kf.
27	or/7-26
28	6 and 27

Identify Clear Eligibility Criteria

Inclusion and exclusion criteria will be kept broad, and studies will be included if they discuss a peer support intervention and include women, independent of the research design (*Table 2*). Types of participants will include cis and trans women greater than 18 years of age with IHD, stroke, or heart failure. To ensure our search is broad, we will not specifically search by ‘women’. However, we will ensure women are included in the studies during the screening process. We will not specifically define a minimum sample size of women to minimize selection bias. Moreover, this will be an important variable to describe in our evidence map. Outcomes will include health status, HRQoL, and healthcare costs. We will include disease-specific and generic reports and measures of two patient-reported outcomes: health status (i.e., worsening of the condition, etc.) and HRQoL (i.e., perceived wellbeing measured using the Minnesota Living with Heart Failure, Kansas City Cardiomyopathy Questionnaire, SF-12, EuroQoL 5D-3L, etc.).⁶⁷ Estimating direct and indirect costs of peer support using a cost-effectiveness analysis (CEA), incremental cost-effectiveness ratio (ICER), or quality-adjusted life years (QALYs) will be included.⁶⁸

Table 2 Inclusion and Exclusion Criteria.

Include if study involves:	Exclude if study involves:
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Women <ul style="list-style-type: none"> <input type="checkbox"/> Including cis and trans women <input type="checkbox"/> Also include if sex/gender is not specified <input checked="" type="checkbox"/> Adults aged 18 and older <input checked="" type="checkbox"/> One or more of the following diagnoses: <ul style="list-style-type: none"> <input type="checkbox"/> Heart disease <input type="checkbox"/> Ischemic heart disease <input type="checkbox"/> Coronary heart disease <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Acute coronary syndrome <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Unstable angina <input type="checkbox"/> MINOCA (myocardial infarction with non-obstructive coronary arteries) <input type="checkbox"/> Spontaneous Coronary Artery Dissection (SCAD) <input type="checkbox"/> Microvascular coronary disease <input type="checkbox"/> Coronary artery spasm 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Men only <input checked="" type="checkbox"/> Exclusively the following diagnoses (if none of the inclusion diagnoses on the left are also present): <ul style="list-style-type: none"> <input type="checkbox"/> Peripheral arterial disease <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Heart valve diseases <ul style="list-style-type: none"> <input type="checkbox"/> Stenosis <input type="checkbox"/> Regurgitation/leaky valve <input type="checkbox"/> Arrhythmias <ul style="list-style-type: none"> <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Supraventricular tachycardia <input type="checkbox"/> Palpitations <input type="checkbox"/> Hypertension <input type="checkbox"/> Risk factors for cardiovascular disease (e.g., physical inactivity or sedentary lifestyle, smoking, depression), but no diagnosis of a cardiovascular disease

<ul style="list-style-type: none"> ○ Coronary embolism ○ Kounis syndrome ○ Congestive Heart failure <ul style="list-style-type: none"> ▪ Cardiomyopathy ▪ HFrEF (heart failure with reduced ejection fraction) ▪ HFpEF (heart failure with preserved ejection fraction) ▪ Takotsubo syndrome ○ Stroke or Cerebrovascular accident <input checked="" type="checkbox"/> A support intervention led by a peer(s) ○ Could be <ul style="list-style-type: none"> ▪ Individual (1:1) support or group programs ▪ Virtual/online programs ▪ The provision of emotional, appraisal, and/or informational assistance 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Support programs led by health care professionals, and not peers with lived experience <input checked="" type="checkbox"/> Informal social support from family, friends, or caregivers, and not peers with lived experience <input checked="" type="checkbox"/> Systematic reviews and meta-analyses, scoping reviews (these types of studies should be flagged and documented in a group Google doc for reference) <input checked="" type="checkbox"/> Descriptive or qualitative papers presenting general principles, frameworks, conceptual models, or qualities of peer support, but that do not evaluate a peer support intervention(s), specifically (these types of studies might be useful to flag in our Google doc as reference papers)
--	---

Systematically Retrieve, Screen and Classify the Evidence

All team members, including women with lived experience (Goodenough, Robert), will participate in retrieving, screening and classifying the evidence. All team members will receive: 1) one-hour of training on screening titles and abstracts, 2) one-hour of training on screening full-text reviews, and 3) two-hours of training on data extraction (4-hours total). A test batch of studies (n = 24) screened as ‘include, exclude or unsure’ will be compared for inter-rater reliability and discussed between reviewers (including the women with lived experience [Goodenough, Robert]) in a two-hour meeting to establish title and abstract screening accuracy and confirm understanding of the inclusion and exclusion criteria.⁶⁹ Title, abstract, and full-text articles will be screened by two independent reviewers.

Disagreements or conflicts will be resolved by a third reviewer (Parry or Mullen). Data from included studies will be extracted to include article-level data (e.g., author/country, publication year) and study-level data (e.g., sample size, percent women, study design, population (e.g., context), intervention and outcomes. Contextual factors will include participant characteristics as guided by the Individual and Family Self-Management Theory (e.g., sex, gender [roles, relations, identity and institutionalized], ethnicity, racism, age).¹⁰⁰ We will use the Template for Intervention Description and Replication –

TIDieR)¹²⁰ to extract peer support intervention details that will include intervention procedures, peer background and training, modes of delivery (i.e., face-to-face, group), location of delivery (i.e., in-person, virtual), number of times the intervention was delivered over what period of time (i.e., duration, intensity, dose), and intervention fidelity. Social facilitation details including type of support (emotional, informational, and appraisal support) will also be captured in our data extraction. Outcomes will include health status, HRQoL, and healthcare costs. To ensure transparency and rigor, we will describe our methods of locating relevant unpublished and grey literature in a systematic way,^{20,121,122} following processes used in our previous broad map of the literature.⁶⁶

Report Findings in an Evidence Map

The findings of all studies meeting the eligibility criteria will be summarized narratively. This will include a description of the participants, settings, and peer support interventions. The Individual and Family Self-Management Theory will guide specific descriptions by context, process, and outcomes. Bubble plots (i.e., weighted scatter plots), geographic heat/choropleth maps, and infographics will be used to graphically illustrate peer support intervention elements by category of CVD (i.e., IHD, stroke, and heart failure). Analyses will be performed using R, a software environment for statistical computing and graphics.⁷⁰

ETHICS AND DISSEMINATION

Ethics approval has been granted from the University of Toronto (42608, April 28/2022). It is not necessary to obtain informed consent for this review. Knowledge will be disseminated through publication, presentation/public forums, and social media.

AUTHOR CONTRIBUTIONS

The PI (Parry) and Co-PI (Mullen) conceived the study. Kapur and Parry drafted and revised the manuscript prior to submission. Co-authors (Adreak, Colella, Dancey, Gomes, Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen, Noble, O'Hara, Robert, Tang, Visintini) will contribute to all steps of the review. One co-author (Wong) will be responsible for coordinating administrative aspects of the

1 review. Most authors (Adreak, Colella, Dancey, Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen,
2 Noble, Parry, Robert, Tang, Visintini) are grant holders. Two women with lived experience
3
4 (Goodenough, Robert) from the CWHHA are Co-Is. The CWHHA is a volunteer organization of over
5
6 130 health professionals and women living with CVD. Their mission is to support patients, clinicians,
7
8 scientists, and decision-makers to implement evidence, transform clinical practices, and impact public
9
10 policy related to women's cardiovascular health. CWHHA members, and the 16 patient advocate
11
12 members, voted in the Fall 2020 strategic planning session to pursue a project focused on peer support
13
14 for women with CVD. This evidence map review is direct guidance from women who live with CVD.
15
16 Parry finalized the Research Ethic Board (REB) submission. The Co-PIs (Parry, Mullen) will provide
17
18 day-to-day oversight of the review. Most authors (Adreak, Colella, Dancey, Goodenough, Hay,
19
20 Johnston, Kapur, Liblik, Liu, Mullen, Noble, Parry, Robert, Tang, Visintini) assisted to build and
21
22 approve content for the funding application. All authors (Adreak, Colella, Dancey, Gomes,
23
24 Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen, Noble, O'Hara, Parry, Robert, Tang, Visintini,
25
26 Wong) approved the final manuscript prior to submission. All authors (Adreak, Colella, Dancey,
27
28 Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen, Noble, O'Hara, Parry, Robert, Tang, Visintini,
29
30 Wong) are also accountable for all aspects of ensuring the accuracy and integrity of the work across all
31
32 steps of the review.
33
34
35
36
37
38
39
40

41 **Funding:** This work was supported by the Canadian Institute of Health Research Strategy for Patient-
42
43 Oriented Research (SPOR) Patient-Oriented Research – open pool Priority Announcement (CIHR;
44
45 470800).

46
47
48 **Competing Interest:** None declared.

49
50 **Supplemental Material.** PRISMA-P and GRIPP 2 – LF Checklists, REB Approval Letter, CIHR
51
52 Funding Decision, CIHR Reviews.

53
54
55 **ORCID IDs:**

56
57 Monica Parry: [0000-0002-6941-1380](https://orcid.org/0000-0002-6941-1380)

1 Sarah Visintini: [0000-0001-6966-1753](tel:0000-0001-6966-1753)

2 Amy Johnston: [0000-0003-1934-7867](tel:0000-0003-1934-7867)

3 Tracey JF Colella: [0000-0001-6228-9012](tel:0000-0001-6228-9012)

4 Kiera Liblik: [0000-0003-1385-9298](tel:0000-0003-1385-9298)

5 Zoya Gomes: [0000-0002-6541-5835](tel:0000-0002-6541-5835)

6 Sonia Dancey: [0000-0003-0714-2899](tel:0000-0003-0714-2899)

7 Shuangbo Liu: [0000-0002-8722-0182](tel:0000-0002-8722-0182)

8 Jacqueline Hay: [0000-0002-4284-7141](tel:0000-0002-4284-7141)

9 Meagan Noble: [0000-0002-7665-0558](tel:0000-0002-7665-0558)

10 Najah Adreak: [0000-0002-0731-7110](tel:0000-0002-0731-7110)

11 Natasha Tang: [0000-0001-8825-6219](tel:0000-0001-8825-6219)

12 Helen Robert: [0000-0002-8240-0600](tel:0000-0002-8240-0600)

13 Kerri-Anne Mullen: [0000-0002-4868-4486](tel:0000-0002-4868-4486)

14 **AUTHOR EMAIL ADDRESSES:**

15 Monica Parry: monica.parry@utoronto.ca

16 Sarah Visintini: SVisintini@ottawaheart.ca

17 Amy Johnston: AJohnston@ottawaheart.ca

18 Tracey JF Colella: Tracey.Colella@uhn.ca

19 Deeksha Kapur: deeksha.kapur@mail.utoronto.ca

20 Kiera Liblik: 14k13@queensu.ca

21 Zoya Gomes: zoya.gomes@dal.ca

22 Sonia Dancey: sonia.dancey@gmail.com

23 Shuangbo Liu: sliu@sbgh.mb.ca

24 Catherine Goodenough: pcgoodenough@sympatico.ca

25 Jacqueline Hay: umhayj@myumanitoba.ca

1
2
3 Meagan Noble: meagan.noble@mail.utoronto.ca
4

5 Najah Adreak: najahaldreak@gmail.com
6

7 Helen Robert: hrobertnw@gmail.com
8

9
10 Natasha Tang: ntang@qmed.ca
11

12 Arland O'Hara: arland.ohara@utoronto.ca
13

14 Anice Wong: AniWong@ottawaheart.ca
15

16
17 Kerri-Anne Mullen: KMullen@ottawaheart.ca
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

REFERENCES

1. Vogel B, Acevedo M, Appelman Y, et al. The Lancet women and cardiovascular disease Commission: reducing the global burden by 2030. *The Lancet*. 2021.
2. Norris C, Yip C, Nerenberg K, et al. Introducing the Canadian Women's Heart Health Alliance ATLAS on Epidemiology, Diagnosis, and Management of Cardiovascular Disease in Women. *CJC Open* 2020;2:145-150.
3. Norris C, Yip C, Nerenberg K, et al. State of the Science in Women's Cardiovascular Disease: A Canadian Perspective on the Influence of Sex and Gender. *JAHA*. 2020;9.
4. Bishop N. Race is not a risk factor: Reframing discourse on racial health inequalities in CVD prevention. *American Journal of Preventative Cardiology*. 2021;6.
5. Jaffer S, Foulds H, Grewal J, et al. Canadian Women's Heart Health Alliance Atlas. Chapter 2: The Scope of the Problem. *CJC Open*. 2021;3:1-11.
6. Izadegahdar M, Singer J, Lee M, et al. Do younger women fare worse? Sex differences in acute myocardial infarction hospitalization and early mortality rates over ten years. *J Womens Health*. 2014;23:10-17.
7. Alzahrani T, Nguyen T, Ryan A, et al. Cardiovascular disease risk factors and myocardial infarction in the transgender population. *Circ Cardiovasc Qual Outcomes*. 2019;12.
8. McDonnell L, Pipe A, Wstcott C, et al. Perceived vs actual knowledge and risk of heart disease in women: findings from a Canadian survey on heart health awareness, attitudes, and lifestyle. *Can J Cardiol*. 2014;30:827-834.
9. Norris C, Hegadoren K, Patterson L, Pilote L. Sex differences in prodromal symptoms of patients with acute coronary syndrome: a pilot study. *Prog Cardiovasc Nurs*. 2008;23:27-31.
10. Dixon T, Lim L, Powell H, Fisher J. Psychosocial experiences of cardiac patients in early recovery: a community-based study. *J Adv Nurs*. 2000;31:1368-1375.

11. Lacey E, Walters S. Continuing inequality: gender and social class influences on self perceived health after a heart attack. *J Epidemiol Community Health*. 2003;57:622-627.
12. Sjostrom-Strand A, Ivarsson B, Sjoberg T. Women's experience of a myocardial infarction: 5 years later. *Scandinavian Journal Caring Sci*. 2011;25:459-466.
13. Liblik K, Hu R, Gomes Z, et al. Female risk factors for post-myocardial infarction depression and anxiety (FRIDA): Pilot results. *General Hospital Psychiatry*. 2022.
14. Liblik K, Mulvagh S, Hindmarch C, Alavi N, Johri A. Depression and anxiety following acute myocardial infarction in women. *Trends in Cardiovascular Medicine*. 2022;32(6):341-347.
15. GBD. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2015;385:117-171.
16. Getahun D, Nash R, Flanders W, et al. Cross-sex hormones and acute cardiovascular events in transgender persons. *Ann Intern Med*. 2018;169:205-210.
17. Benjamin E, Virani S, Callaway C, et al. Heart Disease and Stroke Statistics - 2018 Update. A Report from the American Heart Association. *Circulation*. 2018;137:e67-e492.
18. Lam C, Arnott C, Beale A, et al. Sex differences in heart failure. *Eur Heart J*. 2019;40:3859-3868.
19. Rutledge T, Reis V, Linke S, Greenberg B, Mills P. Depression in heart failure: a meta-analytic review of prevalence, intervention effects, and association with clinical outcomes. *J Am Coll Cardiol*. 2006;48:1527-1537.
20. Khariton Y, Nassif M, Thomas L, et al. Health status disparities by sex, race/ethnicity, and socioeconomic status in outpatients with heart failure. *JACC Heart Fail*. 2018;6:465-473.
21. Markbreiter J, Buckley P. *CVD Advocacy Toolkit*. 2016.

- 1
2 22. Prior J, Jordan K, Kadam U. Variations in patient-reported physical health between cardiac and
3 musculoskeletal diseases: systematic review and meta-analysis of population-based studies.
4
5
6 *Health and Quality of Life Outcomes*. 2015;13.
7
- 8
9 23. Rieckmann N, Neumann K, Feger S, et al. Health-related quality of life, angina type and
10 coronary artery disease in patients with stable chest pain. *Health and Quality of Life Outcomes*.
11
12 2020;18.
13
- 14
15 24. Hansen T, Thygesen L, Zwisler A, et al. Self-reported health-related quality of life predicts 5-
16 year mortality and hospital readmissions in patients with ischemic heart disease. *European*
17
18 *Journal of Preventive Cardiology*. 2015;22(7):882-889.
19
- 20
21 25. Kroenke C, Kubzansky L, Adler N, Kawachi I. Prospective change in health-related quality of
22 life and subsequent mortality among middle-aged and older women. *American Journal of*
23
24 *Public Health*. 2008;98(11):2085-2091.
25
- 26
27 26. Colella T, Hardy M, Hart D, et al. The Canadian Women's Heart Health Alliance Atlas on the
28
29 Epidemiology, Diagnosis, and Management of Cardiovascular Disease in Women - Chapter 3:
30
31 Patient Perspectives. *CJC Open*. 2021;3:229-235.
32
- 33
34 27. Barth J, Schneider S, von Kanel R. Lack of social support in the etiology and prognosis of
35
36 coronary heart disease: a systematic review and meta-analysis. *Psychosomatic Medicine*.
37
38 2010;72:229-238.
39
- 40
41 28. Holt-Lunstad J, Smith T, Layton B. Social relationships and mortality: a meta-analysis. *PLoS*
42
43 *Med*. 2010;7.
44
- 45
46 29. Bucholz E, Strait K, Dreyer R, et al. Effect of low perceived social support on health outcomes
47
48 in young patients with acute myocardial infarction: Results from the Variation in Recovery:
49
50 Role of Gender on Outcomes of Young AMI Patients (VIRGO) Study. *JAHA*. 2014;3.
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
30. Leifheit-Limson E, Reid K, Kasl S, et al. The role of social support in health status and depressive symptoms after acute myocardial infarction. *Circulation: Cardiovascular Quality and Outcomes*. 2010;3(2):143-150.
31. Carrero J, de Jager D, Verduijn M, et al. Cardiovascular and noncardiovascular mortality among men and women starting dialysis. *Clin J Am Soc Nephrol*. 2011;6:1722-1730.
32. Albert P. Why is depression more prevalent in women? *J Psychiatry Neurosci*. 2015;40:219-221.
33. Malik S, Spertus J, Reid K, et al. Depressive symptoms after acute myocardial infarction: evidence for highest rates in younger women. *Arch Intern Med*. 2006;166:876-883.
34. Meijer A, Conradi H, Bos E, Thombs B, van Melle J, de Jonge P. Prognostic association of depression following myocardial infarction with mortality and cardiovascular events: a meta-analysis of 25 years of research. *Gen Hosp Psychiatry*. 2011;33:203-216.
35. Shah A, Ghasemzadeh N, Zaragoza-Macias E, et al. Sex and age differences in the association of depression with obstructive coronary artery disease and adverse cardiovascular events. *JAMA*. 2014;3.
36. Vaccarino V, Badimon L, Corti R, et al. Ischaemic heart disease in women: are there sex differences in pathophysiology and risk factors? Position paper from the working group on coronary pathophysiology and microcirculation of the European Society of Cardiology. *Cardiovasc Res*. 2011;90:9-17.
37. Roest A, Martens E, de Jonge P, Denollet J. Anxiety and risk of incident coronary disease: a meta-analysis. *J Am Coll Cardiol*. 2010;56(1):38-46.
38. Arthur H, Wright D, Smith K. Women and heart disease: the treatment may end but the suffering continues. *Can J Nurs Res*. 2001;33(3):17-29.
39. Kristofferzon M, Lofmark R, Carlsson M. Myocardial infarction: gender differences in coping and social support. *J Adv Nurs*. 2003;44(4):360-374.

- 1
2 40. Dennis C. Peer support within a health care context: a concept analysis. *International Journal of*
3
4 *Nursing Studies*. 2003;40:321-332.
5
6 41. Henderson A. Abused women and peer-provided social support: The nature and dynamics of
7
8 reciprocity in a crisis situation. *Issues in Mental Health Nursing*. 16:117-128.
9
10 42. Gómez-Pardo E, Fernández-Alvira J, Vilanova M, et al. A comprehensive lifestyle peer group-
11
12 based intervention on cardiovascular risk factors. *JACC*. 2016;67(5):476-485.
13
14 43. Morris R, Morris P. Participants' experiences of hospital-based peer support groups for stroke
15
16 patients and carers. *Disability and Rehabilitation*. 2011;34(4):347-354.
17
18 44. Clark A, Munday C, McLaughlin D, Catto S, McLaren A, MacIntyre P. Peer support to
19
20 promote physical activity after completion of centre-based cardiac rehabilitation: evaluation of
21
22 access and effects. *European Journal of Cardiovascular Nursing*. 2012;11(4):388-395.
23
24 45. Parry M, Watt-Watson J, Hodnett E, Tranmer J, Dennis C, Brooks D. Cardiac Home Education
25
26 and Support Trial (CHEST): A pilot study. *Can J Cardiol*. 2009;25(12):e393-e398.
27
28 46. Power S, Hegarty J. Facilitated Peer Support in Breast Cancer. *Cancer Nursing*. 2010;33(2).
29
30 47. Arlotti J, Cottrell B, Hughes S, Curtin J. Breastfeeding among low-income women with and
31
32 without peer support. *Journal of Community Health Nursing*. 1998;15(3):163-178.
33
34 48. Mejias N, Gill C, Shpigelman C. Influence of a support group for young women with
35
36 disabilities on sense of belonging *Journal of Counseling Psychology*. 2014;61(2):208-220.
37
38 49. Angus J, King-Shier K, Spaling M, et al. A secondary meta-synthesis of qualitative studies of
39
40 gender and access to cardiac rehabilitation. *Journal of Advanced Nursing*. 2015;71(8):1758-
41
42 1773.
43
44 50. Smith C, Leon M, Mack M, et al. Transcatheter versus surgical aortic-valve replacement in
45
46 high-risk patients. *N Engl J Med*. 2011;364(23):2187-2198.
47
48 51. Wieslander I, Baigi A, Turesson C, Fridlund B. Women's social support and social network
49
50 after their first myocardial infarction; a 4-year follow-up with focus on cardiac rehabilitation.
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
- European Journal of Cardiovascular Nursing: Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*. 2005;4(4):278-285.
52. Hellem E, Bruusgaard K. “When what is taken for granted disappears”: women’s experiences and perceptions after a cardiac event. *Physiotherapy Theory and Practice*. 2018:1-11.
53. Sjostrom-Strand A, Fridlund B. Women's descriptions of symptoms and delay reasons in seeking medical care at the time of a first myocardial infarction: A qualitative study. *International Journal of Nursing Studies*. 2008;45:1003-1010.
54. Miake-Lye I, Hempel S, Shanman R, Shekelle P. What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Syst Rev*. 2016;5(28).
55. Zainuddin Z, Perera CJ, Haruna H, Habiburrahim H. Literacy in the new norm: stay-home game plan for parents. *Information and Learning Sciences*. 2020;121(7/8):645-653.
56. Oliver S, Harden A, Rees R. An emerging framework for including different types of evidence in systematic reviews for public policy. *Evaluation*. 2005;11(4):428-446.
57. Parry M, Bjornnes A, Victor J, et al. Self-management interventions for women with cardiac pain: A systematic review and meta-analysis. *Canadian Journal of Cardiology*. 2018;34:458-467.
58. Moher D, Shamseer L, Clarke M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews*. 2015;4.
59. Staniszewska S, Brett J, Simera I, et al. GRIPP2 reporting checklists: tools to improve reporting of patient and public involvement in research. *BMJ*. 2017;358:1-7.
60. SPOR. *Recommendations on patient engagement compensation*. 2018.
61. Foster E, Deardorff A. Open Science Framework (OSF). *Journal of the Medical Library Association*. 2017;105(2):203-206.

- 1
2 62. EPPI. EPPI Centre: Evidence for Policy and Practice Information and Coordinating Centre.
3
4 Social Science Research Unit at the UCL Institute of Education. <http://eppi.ioe.ac.uk/cms/>.
5
6 Accessed April 5, 2015.
7
8
9 63. Pope C, Mays N, Popay J. *Synthesizing Qualitative and Quantitative Health Evidence*. New
10
11 York: McGraw Open University Press; 2007.
12
13 64. Harden A, Garcia J, Oliver S, et al. Applying systematic review methods to studies of people's
14
15 views: an example from public health research. *Journal of Epidemiology and Community*
16
17 *Health*. 2004;58:794-800.
18
19
20 65. Thomas J, Harden A, Oakley A, et al. Integrating qualitative research with trials in systematic
21
22 reviews. *BMJ*. 2004;328:1010-1012.
23
24
25 66. Parry M, Bjornnes A, Clarke H, et al. Self-management of cardiac pain in women: an evidence
26
27 map. *BMJ Open*. 2017;7.
28
29
30 67. Masterson Creber R, Spadaccio C, Dimagli A, Myers A, Taylor B, Fremes S. Patient-Reported
31
32 Outcomes in Cardiovascular Trials. *Can J Cardiol*. 2021;37(9):1340-1352.
33
34
35 68. Wagner T, Yoon J, Jacobs J, et al. Estimating costs of an implementation intervention. *Medical*
36
37 *Decision Making*. 2020;40(8):959-967.
38
39
40 69. Polanin J, Pigott T, Espelage D. Best practice guidelines for abstract screening large-evidence
41
42 systematic reviews and meta-analyses. *Res Syn Meth*. 2019;10:330-342.
43
44
45 70. R-Core-Team. R: A language and environment for statistical computing. R Foundation for
46
47 Statistical Computing. <https://www.R-project.org/>. Published 2020. Accessed September 8,
48
49 2021.
50
51
52
53
54
55
56
57
58
59
60

1
2 Figure Legend
3

4 **Figure 1** Individual and Family Self-Management Theory.
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

067812 on 5 October 2022. Downloaded from <http://bmjopen.bmj.com/> on October 28, 2024 by guest. Protected by copyright.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41



Supplementary Table 1 PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol and utilized as a general guidance document for this evidence map protocol*.

Section and topic	Item No	Checklist item	Page
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a review protocol	1
Update	1b	If the protocol is for an update of a previous review, identify as such	N/A
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	2, 8
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1, 15-16
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	13-14
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	1
Support:			
Sources	5a	Indicate sources of financial or other support for the review	14
Sponsor	5b	Provide name for the review funder and/or sponsor	14
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	13-14
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	4-7
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	7, 9
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	11-12, Table 2
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	9-10
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits,	Table 1

		such that it could be repeated	
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	8, 10
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility, and inclusion in evidence map)	11-13
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	12
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	9, Table 1
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	11
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	8
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	13
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2 , Kendall's τ)	13
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	13
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	8
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	8

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1): g7647.

Supplemental Table 2 GRIPP2 Long Form.

Section and topic	Checklist item	Page
Section 1: Abstract of paper		
1a: Aim	Report aims of study	2
1b: Methods	Describe methods used by which patients/public involved	2
1c: Results	Report impacts and outcomes of PPI in study	N/A
1d: Conclusions	Summarize main conclusions of study	N/A
1e: Keywords	Include PPI or alternative terms as keywords	2
Section 2: Background to paper		
2a: Definition	Report definition of PPI used and how it links to comparable studies	6
2b: Theoretical underpinnings	Report theoretical rationale and influences of PPI	7
2c: Concepts and theory development	Report any conceptual models or influences used	7
Section 3: Aims of paper		
3: Aim	Report aims of study	7
Section 4: Methods of paper		
4a: Design	Describe methods by which patients involved	9, 12, 13-14
4b: People involved	Describe patients involved with PPI activity in study	14
4c: Stages of involvement	Report on how PPI used at different stages of study	9, 12, 13-14
4d: Level or nature of involvement	Report level or nature of PPI used at various stages	9, 12, 13-14
Section 5: Capture or measurement of PPI impact		
5a: Qualitative evidence of impact	Report methods to qualitatively explore impact of PPI	N/A
5b: Quantitative evidence of impact	Report methods to quantitatively measure impact of PPI	N/A
5c: Robustness of measure	Report rigour of method used to capture impact of PPI	N/A
Section 6: Economic assessment		
6: Economic assessment	Report method used for economic assessment of PPI	N/A
Section 7: Study results		
7a: Outcomes of PPI	Report results of PPI, including positive and negative outcomes	N/A
7b: Impacts of PPI	Report positive and negative impacts PPI had on research, individuals involved, and wider impacts	N/A
7c: Context of PPI	Report contextual factors the enabled or hindered the process of impact of PPI	N/A
7d: Process of PPI	Report process factors that enabled or hindered PPI	N/A
7e: Theory development	Report any theory development in PPI that emerged	N/A
7eii: Theory development	Report testing of theoretical models, if any	N/A
7f: Measurement	Report instrument development and testing	N/A
7g: Economic assessment	Report costs or benefits of PPI	N/A
Section 8: Discussion and conclusion		
8a: Outcomes	Comment on how PPI influenced overall study	N/A
8b: Impacts	Comment on impacts of PPI and how they contribute to new knowledge	N/A
8c: Definition	Comment on definition of PPI used and report any suggested changes	N/A
8d: Theoretical underpinnings	Comment on study's contribution to theory development of PPI	N/A
8e: Context	Comment on how context factors influenced PPI	N/A
8f: Process	Comment on how process factors influenced PPI	N/A
8g: Measurement/capture of PPI impact	Comment on how well PPI impact was evaluated	N/A
8h: Economic assessment	Discuss economic costs or benefits of PPI	N/A
8i: Reflections/critical perspective	Reflect on what went well and what did not go well	N/A

PPI=patient and public involvement

BMJ Open

Peer support interventions for women with cardiovascular disease: protocol for synthesizing the literature using an evidence map

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2022-067812.R1
Article Type:	Protocol
Date Submitted by the Author:	20-Sep-2022
Complete List of Authors:	<p>Parry, Monica; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing</p> <p>Visintini, Sarah; University of Ottawa Heart Institute Berkman Library; University of Ottawa, Health Sciences Library</p> <p>Johnston, Amy; University of Ottawa, School of Epidemiology and Public Health; University of Ottawa Heart Institute</p> <p>Colella, Tracey; University Health Network, KITE - Toronto Rehabilitation Cardiovascular Prevention & Rehabilitation Program; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing and the Rehabilitation Sciences Institute</p> <p>Kapur, Deeksha; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing (Research Assistant)</p> <p>Liblik, Kiera; Queen's University Faculty of Health Sciences</p> <p>Gomes, Zoya; Dalhousie Medical School</p> <p>Dancey, Sonia; University of Ottawa Faculty of Medicine</p> <p>Liu, Shuangbo; University of Manitoba, Section of Cardiology, Department of Internal Medicine, Rady Faculty of Health Sciences</p> <p>Goodenough, Catherine; University of Ottawa Heart Institute, Canadian Women's Heart Health Alliance</p> <p>Hay, Jacqueline; University of Manitoba, Faculty of Kinesiology and Recreation Management; St Boniface General Hospital, Institute of Cardiovascular Sciences, Albrechtsen Research Centre</p> <p>Noble, Meagan; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing; Indigenous Services Canada</p> <p>Adreak, Najah; The University of British Columbia, Department of Surgery</p> <p>Robert, Helen; University of Ottawa Heart Institute, Canadian Women's Heart Health Alliance</p> <p>Tang, Natasha; Queen's University Faculty of Health Sciences</p> <p>O'Hara, Arland; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing</p> <p>Wong, Anice; University of Ottawa Heart Institute, Canadian Women's Heart Health Centre</p> <p>Mullen, Kerri-Anne ; University of Ottawa Heart Institute, Canadian Women's Heart Health Centre</p>
Primary Subject Heading:	Cardiovascular medicine

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Secondary Subject Heading:	Patient-centred medicine
Keywords:	Heart failure < CARDIOLOGY, Ischaemic heart disease < CARDIOLOGY, Stroke < NEUROLOGY



1
2 **Peer support interventions for women with cardiovascular disease: protocol for synthesizing the**
3
4 **literature using an evidence map**
5
6

7 Monica Parry,¹ Sarah Visintini,^{2,3} Amy Johnston,^{4,5} Tracey JF Colella,^{1,6,7} Deeksha Kapur,¹ Kiera
8 Liblik,⁸ Zoya Gomes,⁹ Sonia Dancey,¹⁰ Shuangbo Liu,¹¹ Catherine Goodenough,¹² Jacqueline L.
9 Hay,^{13,14} Meagan Noble,^{1,15} Najah Adreak,¹⁶ Helen Robert,¹² Natasha Tang,⁸ Arland O'Hara,¹ Anice
10 Wong,¹⁷ Kerri-Anne Mullen¹⁷
11
12
13
14
15
16

17 ¹Lawrence S. Bloomberg Faculty of Nursing, University of Toronto
18
19

20 ²Berkman Library, University of Ottawa Heart Institute
21

22 ³Health Sciences Library, University of Ottawa
23

24 ⁴School of Epidemiology and Public Health, University of Ottawa
25

26 ⁵University of Ottawa Heart Institute
27

28 ⁶Toronto Rehabilitation Cardiovascular Prevention & Rehabilitation Program, KITE - University
29 Health Network
30
31

32 ⁷Rehabilitation Sciences Institute, University of Toronto
33

34 ⁸Faculty of Health Sciences, Queen's University
35

36 ⁹Dalhousie University Medical School
37

38 ¹⁰Faculty of Medicine, University of Ottawa
39

40 ¹¹Section of Cardiology, Department of Internal Medicine, Rady Faculty of Health Sciences, University
41 of Manitoba
42
43

44 ¹²Woman with Lived Experience, Canadian Women's Heart Health Alliance
45

46 ¹³Faculty of Kinesiology and Recreation Management, University of Manitoba
47

48 ¹⁴Institute of Cardiovascular Sciences, St. Boniface General Hospital Albrechtsen Research Centre
49

50 ¹⁵Indigenous Services Canada, Government of Canada
51

52 ¹⁶Department of Surgery, University of British Columbia
53
54
55
56

1
2 ¹⁷Canadian Women's Heart Health Centre, University of Ottawa Heart Institute
3
4
5

6 **Correspondence to:**

7
8 Dr. Monica Parry NP-Adult PhD

9
10 Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

11
12 155 College Street, Suite 130, Toronto, ON, Canada, M5T 1P8

13
14
15 **Email:** monica.parry@utoronto.ca

16
17
18
19 **Word count:** 3048

20
21
22 **Protocol version:** 1.0, August 23/2022
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

ABSTRACT

Introduction The leading cause of death for women is cardiovascular disease (CVD), including ischemic heart disease, stroke, and heart failure. Previous literature suggests peer support interventions improve self-reported recovery, hope, and empowerment in other patient populations but the evidence for peer support interventions in women with CVD is unknown. The aim of this study is to describe peer support interventions for women with CVD using an evidence map. Specific objectives are to: 1) provide an overview of peer support interventions used in women with ischemic heart disease, stroke, and heart failure, 2) identify gaps in primary studies where new or better studies are needed, and 3) describe knowledge gaps where complete systematic reviews are required.

Methods and analysis We are building on previous experience and expertise in knowledge synthesis using methods described by the Evidence for Policy and Practice Information (EPPI) and the Coordinating Centre at the Institute of Education. Seven databases will be searched from inception: CINAHL, Embase, MEDLINE, APA PsychInfo, the Cochrane Database of Systematic Reviews and the Cochrane Central Register of Controlled Trials, and Scopus. We will also conduct grey literature searches for registered clinical trials, dissertations and theses, and conference abstracts. Inclusion and exclusion criteria will be kept broad, and studies will be included if they discuss a peer support intervention and include women, independent of the research design. No date or language limits will be applied to the searches. Qualitative findings will be summarized narratively, and quantitative analyses will be performed using R.

Ethics and dissemination The University of Toronto's Research Ethics Board granted approval on April 28th, 2022 (Protocol #42608). Bubble plots (i.e., weighted scatter plots), geographic heat/choropleth maps, and infographics will be used to illustrate peer support intervention elements by category of CVD. Knowledge dissemination will include publication, presentation/public forums, and social media.

Study registration Open Science Framework, DOI:10.17605/OSF.IO/E7KQ3.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Keywords Evidence Map, Peer Support, Cardiovascular Disease, Women, Patient-Oriented Research

For peer review only

STRENGTHS AND LIMITATIONS OF THIS STUDY

- Publication bias will be mitigated by including sources of evidence written in both English and French, and by performing targeted searches for relevant grey literature.
- Inclusion and exclusion criteria will be kept broad and studies will be included if they discuss a peer support intervention and include women (cis and trans) with ischemic heart disease, stroke or heart failure, independent of the research design.
- All team members will receive one-hour of training on screening titles and abstracts, one-hour of training on screening full-text reviews, and two-hours of training on data extraction.
- Bubble plots (i.e., weighted scatter plots), geographic heat/choropleth maps, and infographics will be used to graphically illustrate quantitative results.
- Although the Individual and Family Self-Management Theory will consider the broader context of gender and outcomes, a conceptual theory that foregrounds gender within an intersectional lens may have strengthened study methods and results.

INTRODUCTION

The leading cause of premature death for women is cardiovascular disease (CVD), responsible for 35% of total deaths in 2019.(1) Ischemic heart disease (IHD), stroke and heart failure are the most common causes of mortality,(1, 2) which vary across the lifespan and are influenced by ethnicity, racism, and gender.(3, 4) Globally, mortality rates have remained stagnant; however in 2017, mortality increased in women in two high income countries: Canada and the United States.(1) Young women are now more likely to die within one year of a myocardial infarction (MI) compared to men,(5, 6) and women who are transgender have a greater than two-fold increase in MI compared to women who are cisgender.(7) Moreover, most women are unaware of risk factors or symptoms.(8) Women also have depression,(9) anxiety,(9, 10) and lower health-related quality of life (HRQoL)(11) one year after an MI, and for many women, fear and anxiety about the future and difficulty moving forward in recovery extends beyond five years of having an MI.(12-14) Stroke is the second most common cause of CVD-mortality in women worldwide.(15) Getahun et al.(16) also demonstrated an increased risk of stroke in transgender women. Women have a higher lifetime stroke risk compared to men,(1) with risk being highest during pregnancy, menopause, and later in life.(17) Women with heart failure tend to have preserved ejection fraction, peripartum cardiomyopathy, and/or Takotsubo syndrome,(18, 19) and there are few to no treatments for specific heart failure phenotypes in women,(1) causing more depression and impaired HRQoL in women compared to men.(20, 21)

International CVD priorities, led by the World Health Organization's Global Action Plan for the Prevention and Control of Non-Communicable Diseases (2013-2020) and the United Nations Sustainable Development Goals (2015-2030), focus on good health, gender equality, innovation and infrastructure, reduced inequalities, and partnerships.(22) Good health focuses on ensuring healthy lives and promoting the well-being of all people at all ages, with a focus to reduce premature mortality from non-communicable diseases through prevention and treatment and the promotion of mental health and well-being.(22) Individuals 43 to 70 years with IHD report worse physical HRQoL (38.9 [95% CI,

1
2 36.9-41.0]) compared to the general population.(23) Similar results are reported in women with
3
4 obstructive (41.9, SD 8.9) and non-obstructive heart disease (43.7, SD 9.4) (p=0.072).(24) Moreover, a
5
6 decline in physical versus mental HRQoL is more predictive of hospital readmission(25) and mortality
7
8 in healthy middle-aged and older women (n=40,337)(26) and in men and women with heart
9
10 disease.(25) The World Heart Federation has been advocating globally for better CVD outcomes,
11
12 suggesting advocacy tactics and strategies to reduce CVD by 25% by 2025.(22) This includes
13
14 addressing behavioral risk factors for better prevention and reducing IHD and stroke in women by
15
16 identifying and aligning with national CVD priorities, strategic communications, media engagement,
17
18 evidence-based research, partnership development, and collaborating with key decision-makers.(22)
19
20 The Lancet Commission advocates for a global imperative to reduce the global burden of CVD in
21
22 women by 2030.(1)

23
24
25
26
27 Social support in the form of relationships with family and friends, as well as peer support from
28
29 other women with CVD, has been identified as an integral component in the recovery process for
30
31 women following a cardiac event.(27) Perceived social support has a direct impact on health outcomes;
32
33 individuals with low levels of social support have higher CVD-related(28) and all-cause mortality
34
35 rates.(29) Results from the Variation in Recovery: Role of Gender on Outcomes of Young AMI
36
37 Patients (VIRGO) study suggested lower social support was associated with worse health outcomes and
38
39 more depressive symptoms 12 months after an MI, with one in five individuals less than 55 years of
40
41 age having low social support following an MI.(30) Others report that individuals with low social
42
43 support following an MI had more angina (relative risk [RR], 1.27; 95% confidence interval [CI], 1.10,
44
45 1.48), lower HRQoL (mean difference [β] = -3.33; 95% CI, -5.25, -1.41), lower mental functioning (β
46
47 = -1.72; 95% CI, -2.65, -0.79), and more depressive symptoms (β = 0.94; 95% CI, 0.51, 1.38).(31)
48
49 Moreover, the association between social support and HRQoL, depression, and physical functioning
50
51 appears to be stronger in women compared to men.(31) In the general population, twice as many
52
53 women have depression(32, 33) and anxiety(34, 35) as men, which are known risk factors for CVD.
54
55
56
57
58
59

1
2 Depressive symptoms are associated with atherosclerotic IHD (odds ratio [OR]=1.07, 95% CI, 1.02,
3 1.13, per one-point increase in the Patient Health Questionnaire [PHQ-9] score) and death (adjusted
4 hazard ratio [HR]=1.07, 95% CI, 1.02, 1.14, per one-point increase in the PHQ-9 score) in women
5
6 younger than 55 years, but not in men or in women over 55 years.(36) In postmenopausal women, fatal
7
8 cardiac events are associated with depression.(37) Anxiety has also been linked to developing and the
9
10 worsening IHD and CVD mortality.(38)

11
12
13
14
15
16 It has been suggested that social support, specifically from other women who have lived a
17
18 similar health or recovery experience, may play a key role in women's CVD rehabilitation and
19
20 recovery.(8, 39, 40) Peer support is the provision of assistance and encouragement by an individual that
21
22 is considered equal(41); it is a form of social support delivered by a layperson who has received some
23
24 formal training to share experiential knowledge and emotional assistance. Defining attributes of all peer
25
26 relationships include emotional, informational, and appraisal support.(41) Moreover, providing and
27
28 receiving support benefits both the receiver and the provider of support.(42) Women (n = 387) aged 42
29
30 \pm 6 years who received a peer support intervention reported better cardiovascular risk factor profiles
31
32 (i.e., hypertension, exercise, weight, smoking) compared to women randomized to a control group
33
34 (difference: 0.75; 95% CI, 0.32, 1.18).(43) In patients and caregivers following a stroke, the value of
35
36 peer support during the recovery process was derived through information and advice, encouragement
37
38 and empowerment, awareness, being helpful, and making connections.(44) There is some evidence that
39
40 peer support interventions improve self-reported recovery for individuals with CVD,(45, 46) and hope
41
42 and empowerment in other patient populations that include those with mental illness, HIV, and women
43
44 who are breastfeeding.(47-49) Women have identified the importance of engagement in several
45
46 different activities to promote their recovery including behavioural, social, and psychological
47
48 dimensions.(27) As individuals focus on their own recovery in the context of multiple social roles, re-
49
50 evaluation and re-prioritization of self can be a challenging task. Women face unique challenges in
51
52 managing their health and modifying their lifestyle during recovery.(50-53) Women often prioritize
53
54
55
56
57
58
59

1 family, household responsibilities, and caregiver tasks, which subsequently place preventive health
2 behaviours and their own health status as secondary.(54) There is a need to distinctly enhance the
3
4 nature and level of care provided to women living with CVD. Although there is some evidence for the
5
6 beneficial effects of peer support in women with CVD, a more gender-informative and culturally
7
8 sensitive knowledge synthesis across the lifespan is needed.
9
10
11
12

13 **Objectives**

14
15
16 The overall aim of this study is to describe peer support interventions for women with CVD (IHD,
17 stroke, heart failure) using an evidence map. Specific objectives are to: 1) provide an overview of peer
18 support interventions used in women with ischemic heart disease, stroke, and heart failure, 2) identify
19 gaps in primary studies where new or better studies are needed, and 3) describe knowledge gaps where
20 complete systematic reviews are required.
21
22
23
24
25
26
27
28
29

30 **METHODS AND ANALYSIS**

31
32 The main purpose of performing a broad map of the literature (i.e., evidence map) is to identify the
33 range of research and identify gaps and future research needs.(55) An evidence map is broad in scope,
34 but systematic in its approach to synthesize the evidence.(55) Evidence mapping is useful in directing
35 future research, including systematic reviews.(56, 57) We are collaborating with women with lived
36 experience (Goodenough, Robert) and the Canadian Women's Heart Health Alliance (CWHHA) and
37 using the Strategy for Patient-Oriented Research (SPOR) Capacity Development Framework,(58)
38 SPOR Patient Engagement Framework,(59) and the Individual and Family Self-Management
39 Theory(60, 61) to describe peer support interventions used for women with CVD (IHD, stroke, heart
40 failure). The Individual and Family Self-Management Theory(62) consists of three dimensions:
41 context, process, and outcomes. We have used this in a previous integrated mixed methods systematic
42 review to guide processes related to defining patient-reported outcome variables and variables used for
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2 data extraction.(63) This theory depicts self-management within the broader context of people and
3
4 other influences (e.g., ethnicity, racism, healthcare access, institutionalized gender).(64) The Individual
5
6 and Family Self-Management Theory(62) has provided a platform for testing clinical interventions that
7
8 have included the Arthritis Self-Management Program (ASMP)(65) and the Diabetes Self-Management
9
10 Program.(66) This model highlights the role of social influence (e.g., peer support) and the value of
11
12 emotional, informational, and appraisal support (*Figure 1*).(62, 67)
13
14

15
16 -Insert Figure 1-
17

18 We used the Preferred Reporting Items for Systematic reviews and Meta-Analyses for Protocols
19
20 2015 (PRISMA-P 2015) checklist when preparing this manuscript (Supplementary Table 1).(68)
21
22 Additionally, the Guidance for Reporting Involvement of Patients and the Public – Long Form (GRIPP
23
24 2 - LF) was used to document the engagement of women with lived experience (Supplementary Table
25
26 2).(69) We will also use a patient partner compensation rate structure described in the
27
28 Recommendations on Patient Engagement Compensation – Prepared by the SPOR Networks in
29
30 Chronic Diseases and the PICHI Network(70): each woman with lived experience will receive a one-
31
32 year honorarium of \$1000 that will include compensation for 4-hours of training and assistance across
33
34 all other activities of the project (i.e., screening, knowledge translation and exchange [KTE] activities).
35
36
37

38 We will not register our evidence map on PROSPERO, the international prospective register of
39
40 systematic reviews, as evidence mapping does not meet the inclusion criteria for this registry.
41
42

43 However, to manage records and promote transparency, we have registered our project on the Open
44
45 Science Framework (DOI 10.17605/OSF.IO/E7KQ3).(71) Assessment of risk of bias, meta-bias(es), or
46
47 strength of the evidence will not be undertaken. We will follow methods described by the Evidence for
48
49 Policy and Practice Information (EPPI) and the Coordinating Centre at the Institute of Education,(57,
50
51 72-75) using six steps utilized in performing previous broad maps of the literature(76): 1) identify the
52
53 scope of the evidence map, 2) define key variables, 3) establish a comprehensive search strategy, 4)
54
55
56
57
58
59
60

1
2 identify clear eligibility criteria, 5) systematically retrieve, screen and classify the evidence, and 6)
3
4 report the findings in an evidence map.
5

6 **Identify the scope of the evidence map**

7
8
9 The initial scope of the work was defined by the research team to focus on the most common causes of
10
11 CVD mortality in women(1, 2): IHD, stroke and heart failure. The research question, key variables, and
12
13 eligibility criteria were discussed with women with lived experience (Goodenough, Robert). Our
14
15 overarching review question was established: *What is known about peer support interventions used for*
16
17 *women with CVD (IHD, stroke, and heart failure)?* This question can be answered by a broad range of
18
19 evidence that includes RCTs, cohort and cross-sectional studies, case control studies and case
20
21 series/reports across reported from urban and rural settings across the globe.
22
23
24

25 **Define key variables**

26
27 We used the PICO framework to focus our research question and also to inform our broad search of the
28
29 literature.(77) The PICO elements included the population, intervention, comparison and outcomes.
30
31 Keywords and the National Library of Medicine's Medical Subject Headings (MeSH) were combined
32
33 under two of the PICO categories: (P) women with CVD (IHD, stroke and heart failure) and (I) peer
34
35 support. We did not search using a comparator or by outcome so that we could maintain breadth and
36
37 reduce bias in our search strategy. Women with lived experience (Goodenough, Robert) collaborated to
38
39 identify and confirm search terms as there is evidence that this may increase the number of citations
40
41 retrieved by 34%.(55, 78) The draft MEDLINE search strategy (*Table 1*) was also informed by
42
43 searches of existing reviews(79, 80) and executed by a library scientist (Visintini).
44
45
46
47

48 **Establish a comprehensive search strategy**

49
50 The literature on peer support interventions used for women with CVD (IHD, stroke, and heart failure)
51
52 will be systematically and comprehensively searched using subject headings and keywords in
53
54 accordance with the search syntaxes in each bibliographic databases. As noted, the search was drafted
55
56 in MEDLINE via Ovid (*Table 1*) by a library scientist. Prior to finalization and execution, the draft
57
58
59
60

MEDLINE search strategy will be peer reviewed by another librarian(81). It will then be translated and run from inception in the remaining databases: CINAHL (EBSCO), EMBASE (Ovid), APA PsychInfo (Ovid), the Cochrane Database of Systematic Reviews (Ovid) and the Cochrane Central Register of Controlled Trials (Ovid), and Scopus (www.scopus.com). We will also search Clinicaltrials.gov and the WHO International Clinical Trials Registry Platform (ICTRP). Further grey literature will be identified via Proquest Dissertations and Theses, handsearching abstracts for specific conferences, and a targeted advanced Google search. No date or language limits will be applied to the searches. Citations will be exported from electronic search interfaces to Covidence(82) for duplicate elimination and screening.

Table 1. Draft MEDLINE search, 1946 - (database: MEDLINE(R) ALL, Platform: Ovid)

#	Searches
1	*social support/
2	Self-Help Groups/
3	peer group/
4	(peer* adj3 (support* or educat*)).ti,ab,kf.
5	((social adj3 support) and peer*).ti,ab,kf.
6	or/1-5
7	((heart or cardiac) adj2 (disease or surg* or patient?)).ti,ab,kf.
8	exp Myocardial Ischemia/
9	((coronary adj2 (arter* or stenosis* or atherosclerosis* or arteriosclerosis* or syndrome or microvascular)) or (coronary adj5 disease?) or CAD).ti,ab,kf.
10	(small adj2 (arter* or vessel*) adj2 disease*).ti,ab,kf.
11	(angina or stroke? or MINOCA or INOCA or SCAD or Kounis).ti,ab,kf.
12	((heart or myocardial) adj3 infarct*).ti,ab,kf.
13	(isch?emi* adj3 (heart or cardiac or myocardial)).ti,ab,kf.
14	((heart or cardiac or coronary) adj2 (spasm* or vasospasm* or embolism*)).ti,ab,kf.
15	exp Myocardial Revascularization/
16	((aortocoronary or coronary) adj3 bypass*) or CABG).ti,ab,kf.
17	(angioplast* or atherectomy* or endarterectomy* or thrombectomy* or PCI or PTCA or (Percutaneous adj3 (intervent* or revascular*))).ti,ab,kf.
18	exp Stroke/
19	Stroke Rehabilitation/
20	Cardiac Rehabilitation/
21	((brain* or cerebr* or cerebell* or vertebrobasilar or hemispher* or intracran* or intracerebral* or infratentorial* or supratentorial* or anterior circulation or posterior circulation or basal ganglia) adj5 (isch?emi* or infarct* or thrombo* or emboli*)).ti,ab,kf.

22	((brain* or cerebr* or cerebell* or intracerebral or intracran* or parenchymal or intraventricular or infratentorial or supratentorial or basal gangli*) adj5 (h?emorrhage* or h?ematoma* or bleed*)).ti,ab,kf.
23	exp Heart Failure/
24	exp Ventricular Dysfunction, Left/
25	((heart or cardiac) adj2 (failure or resynchroni*)).ti,ab,kf.
26	(cardiomyopath* or Takotsubo or HFrEF or HFpEF).ti,ab,kf.
27	or/7-26
28	6 and 27

Identify clear eligibility criteria

Inclusion and exclusion criteria will be kept broad, and studies will be included if they discuss a peer support intervention and include women, independent of the research design (*Table 2*). Types of participants will include cis and trans women greater than 18 years of age with IHD, stroke, or heart failure. To ensure our search is broad, we will not specifically search by ‘women’. However, we will ensure women are included in the studies during the screening process. We will not specifically define a minimum sample size of women to minimize selection bias. Moreover, this will be an important variable to describe in our evidence map. Outcomes will include health status, HRQoL, and healthcare costs. We will include disease-specific and generic reports and measures of two patient-reported outcomes: health status (i.e., worsening of the condition, etc.) and HRQoL (i.e., perceived wellbeing measured using the Minnesota Living with Heart Failure, Kansas City Cardiomyopathy Questionnaire, SF-12, EuroQoL 5D-3L, etc.).(83) Estimating direct and indirect costs of peer support using a cost-effectiveness analysis (CEA), incremental cost-effectiveness ratio (ICER), or quality-adjusted life years (QALYs) will be included.(84)

Table 2. Inclusion and exclusion criteria

Include if study involves:	Exclude if study involves:
<input checked="" type="checkbox"/> Women <ul style="list-style-type: none"> <input type="checkbox"/> Including cis and trans women <input type="checkbox"/> Also include if sex/gender is not specified <input checked="" type="checkbox"/> Adults aged 18 and older <input checked="" type="checkbox"/> One or more of the following diagnoses:	<input checked="" type="checkbox"/> Men only <input checked="" type="checkbox"/> Exclusively the following diagnoses (if none of the inclusion diagnoses on the left are also present): <ul style="list-style-type: none"> <input type="checkbox"/> Peripheral arterial disease <input type="checkbox"/> Peripheral vascular disease

<ul style="list-style-type: none"> ○ Heart disease ○ Ischemic heart disease ○ Coronary heart disease ○ Coronary artery disease ○ Acute coronary syndrome ○ Myocardial infarction ○ Unstable angina ○ MINOCA (myocardial infarction with non-obstructive coronary arteries) ○ Spontaneous Coronary Artery Dissection (SCAD) ○ Microvascular coronary disease ○ Coronary artery spasm ○ Coronary embolism ○ Kounis syndrome ○ Congestive Heart failure <ul style="list-style-type: none"> ▪ Cardiomyopathy ▪ HFrEF (heart failure with reduced ejection fraction) ▪ HFpEF (heart failure with preserved ejection fraction) ▪ Takotsubo syndrome ○ Stroke or Cerebrovascular accident <input checked="" type="checkbox"/> A support intervention led by a peer(s) ○ Could be <ul style="list-style-type: none"> ▪ Individual (1:1) support or group programs ▪ Virtual/online programs ▪ The provision of emotional, appraisal, and/or informational assistance 	<ul style="list-style-type: none"> ○ Heart valve diseases <ul style="list-style-type: none"> ▪ Stenosis ▪ Regurgitation/leaky valve ○ Arrhythmias <ul style="list-style-type: none"> ▪ Atrial Fibrillation ▪ Atrial Flutter ▪ Supraventricular tachycardia ▪ Palpitations ○ Hypertension ○ Risk factors for cardiovascular disease (e.g., physical inactivity or sedentary lifestyle, smoking, depression), but no diagnosis of a cardiovascular disease <input checked="" type="checkbox"/> Support programs led by health care professionals, and not peers with lived experience <input checked="" type="checkbox"/> Informal social support from family, friends, or caregivers, and not peers with lived experience <input checked="" type="checkbox"/> Systematic reviews and meta-analyses, scoping reviews (these types of studies should be flagged and documented in a group Google doc for reference) <input checked="" type="checkbox"/> Descriptive or qualitative papers presenting general principles, frameworks, conceptual models, or qualities of peer support, but that do not evaluate a peer support intervention(s), specifically (these types of studies might be useful to flag in our Google doc as reference papers)
--	---

Systematically retrieve, screen and classify the evidence

All team members, including women with lived experience, will participate in retrieving, screening and classifying the evidence. All team members will receive: 1) one-hour of training on screening titles and abstracts, 2) one-hour of training on screening full-text reviews, and 3) two-hours of training on data extraction (4-hours total). A test batch of studies (n = 24) screened as 'include, exclude or unsure' will be compared for inter-rater reliability and discussed between reviewers (including the women with lived experience [Goodenough, Robert]) in a two-hour meeting to establish title and abstract screening accuracy and confirm understanding of the inclusion and exclusion criteria.(85) Title, abstract, and full-

1
2 text articles will be screened by two independent reviewers. Disagreements or conflicts will be resolved
3
4 by a third reviewer (Parry or Mullen). Data from included studies will be extracted to include article-
5
6 level data (e.g., author/country, publication year) and study-level data (e.g., sample size, percent
7
8 women, study design, population [e.g., context], intervention and outcomes). Contextual factors will
9
10 include participant characteristics as guided by the Individual and Family Self-Management Theory
11
12 (e.g., sex, gender [roles, relations, identity and institutionalized], ethnicity, racism, age).(62) We will
13
14 use the Template for Intervention Description and Replication –TIDieR)(86) to extract peer support
15
16 intervention details that will include intervention procedures, peer background and training, modes of
17
18 delivery (i.e., face-to-face, group), location of delivery (i.e., in-person, virtual), number of times the
19
20 intervention was delivered over what period of time (i.e., duration, intensity, dose), and intervention
21
22 fidelity. Social facilitation details including type of support (emotional, informational, and appraisal
23
24 support) will also be captured in our data extraction. Outcomes will include health status, HRQoL, and
25
26 healthcare costs. To ensure transparency and rigor, we will describe our methods of locating relevant
27
28 unpublished and grey literature in a systematic way,(73, 87, 88) following processes used in our
29
30 previous broad map of the literature.(76)
31
32
33
34
35

36 **Report findings in an evidence map**

37
38 The findings of all studies meeting the eligibility criteria will summarized narratively. This will include
39
40 a description of the participants, settings, and peer support interventions. The Individual and Family
41
42 Self-Management Theory will guide specific descriptions by context, process, and outcomes. Bubble
43
44 plots (i.e., weighted scatter plots), geographic heat/choropleth maps, and infographics will be used to
45
46 graphically illustrate peer support intervention elements by category of CVD (i.e., IHD, stroke, and
47
48 heart failure). Analyses will be performed using R, a software environment for statistical computing
49
50 and graphics.(89)
51
52
53

54 **Patient and public involvement**

1
2 Two women living with CVD (Goodenough, Robert) are members of our investigative team and
3
4 members of the CWHHA, a volunteer organization of over 130 health professionals and women living
5
6 with CVD. The mission of the CWHHA is to support patients, clinicians, scientists, and decision-
7
8 makers to implement evidence, transform clinical practices, and impact public policy related to
9
10 women's cardiovascular health. CWHHA members, and the 16 patient advocate members, voted in the
11
12 Fall 2020 strategic planning session to pursue a project focused on peer support for women with CVD.
13
14 This evidence map review is direct guidance from women who live with CVD. We are using the SPOR
15
16 Capacity Development Framework(58) and the SPOR Patient Engagement Framework(59) to ensure
17
18 the perspectives of women living with CVD are integrated into all steps of this broad map of the
19
20 literature, including developing the research question/objectives, key variables, and eligibility criteria,
21
22 defining search terms, screening titles/abstracts and full text papers, evaluating results, and
23
24 disseminating findings. The GRIPP 2 - LF(69) has been utilized to document patient engagement
25
26 activities and we have used the patient partner compensation rate structure described in the
27
28 Recommendations on Patient Engagement Compensation – Prepared by the SPOR Networks in
29
30 Chronic Diseases and the PICHI Network.(70) The guiding principles of co-build, inclusiveness,
31
32 support, and mutual respect underpin all patient engagement activities in this study.(59)
33
34
35
36
37
38
39
40

41 ETHICS AND DISSEMINATION

42
43 Ethics approval has been granted from the University of Toronto (42608, April 28/2022). It is not
44
45 necessary to obtain informed consent for this review. Knowledge will be disseminated through
46
47 publication, presentation/public forums, and social media.
48
49
50
51

52 **Contributors:** The PI (Parry) and Co-PI (Mullen) conceived the study. Kapur and Parry drafted and
53
54 revised the manuscript prior to submission. Co-authors (Adreak, Colella, Dancey, Gomes, Goodenough,
55
56 Hay, Johnston, Kapur, Liblik, Liu, Mullen, Noble, O'Hara, Robert, Tang, Visintini) will contribute to all
57
58
59

1 steps of the review. One co-author (Wong) will be responsible for coordinating administrative aspects
2 of the review. Most authors (Adreak, Colella, Dancey, Goodenough, Hay, Johnston, Kapur, Liblik, Liu,
3
4 of the review. Most authors (Adreak, Colella, Dancey, Goodenough, Hay, Johnston, Kapur, Liblik, Liu,
5
6 Mullen, Noble, Parry, Robert, Tang, Visintini) are grant holders. We thank the two women with lived
7
8 experience (Goodenough, Robert) from the CWHHA who are Co-Is. Parry finalized the Research Ethic
9
10 Board (REB) submission. The Co-PIs (Parry, Mullen) will provide day-to-day oversight of the review.
11
12 Most authors (Adreak, Colella, Dancey, Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen, Noble,
13
14 Parry, Robert, Tang, Visintini) assisted to build and approve content for the funding application. All
15
16 authors (Adreak, Colella, Dancey, Gomes, Goodenough, Hay, Johnston, Kapur, Liblik, Liu, Mullen,
17
18 Noble, O'Hara, Parry, Robert, Tang, Visintini, Wong) approved the final manuscript prior to
19
20 submission. All authors (Adreak, Colella, Dancey, Goodenough, Hay, Johnston, Kapur, Liblik, Liu,
21
22 Mullen, Noble, O'Hara, Parry, Robert, Tang, Visintini, Wong) are also accountable for all aspects of
23
24 ensuring the accuracy and integrity of the work across all steps of the review.
25
26
27
28

29 **Funding:** This work was supported by the Canadian Institute of Health Research Strategy for Patient-
30
31 Oriented Research (SPOR) Patient-Oriented Research – open pool Priority Announcement (CIHR;
32
33 470800).
34
35

36 **Competing interests:** None declared.
37

38 **Supplemental material:** PRISMA-P and GRIPP 2 – LF checklists.
39

40 **ORCID IDs:**

41 Monica Parry: [0000-0002-6941-1380](https://orcid.org/0000-0002-6941-1380)
42

43 Sarah Visintini: [0000-0001-6966-1753](https://orcid.org/0000-0001-6966-1753)
44

45 Amy Johnston: [0000-0003-1934-7867](https://orcid.org/0000-0003-1934-7867)
46

47 Tracey JF Colella: [0000-0001-6228-9012](https://orcid.org/0000-0001-6228-9012)
48

49 Kiera Liblik: [0000-0003-1385-9298](https://orcid.org/0000-0003-1385-9298)
50

51 Zoya Gomes: [0000-0002-6541-5835](https://orcid.org/0000-0002-6541-5835)
52

53 Sonia Dancey: [0000-0003-0714-2899](https://orcid.org/0000-0003-0714-2899)
54
55
56
57
58
59

1
2
3 Shuangbo Liu: [0000-0002-8722-0182](tel:0000-0002-8722-0182)
4

5 Jacqueline L. Hay: [0000-0002-4284-7141](tel:0000-0002-4284-7141)
6

7 Meagan Noble: [0000-0002-7665-0558](tel:0000-0002-7665-0558)
8

9
10 Najah Adreak: [0000-0002-0731-7110](tel:0000-0002-0731-7110)
11

12 Natasha Tang: [0000-0001-8825-6219](tel:0000-0001-8825-6219)
13

14 Helen Robert: [0000-0002-8240-0600](tel:0000-0002-8240-0600)
15

16 Kerri-Anne Mullen: [0000-0002-4868-4486](tel:0000-0002-4868-4486)
17

18
19 **AUTHOR EMAIL ADDRESSES:**
20

21 Monica Parry: monica.parry@utoronto.ca
22

23 Sarah Visintini: SVisintini@ottawaheart.ca
24

25 Amy Johnston: AJohnston@ottawaheart.ca
26

27 Tracey JF Colella: Tracey.Colella@uhn.ca
28

29 Deeksha Kapur: deeksha.kapur@mail.utoronto.ca
30

31 Kiera Liblik: 14k13@queensu.ca
32

33 Zoya Gomes: zoya.gomes@dal.ca
34

35 Sonia Dancey: sonia.dancey@gmail.com
36

37 Shuangbo Liu: sliu@sbgh.mb.ca
38

39 Catherine Goodenough: pcgoodenough@sympatico.ca
40

41 Jacqueline L. Hay: umhayj@myumanitoba.ca
42

43 Meagan Noble: meagan.noble@mail.utoronto.ca
44

45 Najah Adreak: najahaldreak@gmail.com
46

47 Helen Robert: hrobertnw@gmail.com
48

49 Natasha Tang: ntang@qmed.ca
50

51 Arland O'Hara: arland.ohara@utoronto.ca
52
53
54
55
56
57
58
59
60

1
2 Anice Wong: AniWong@ottawaheart.ca
3

4 Kerri-Anne Mullen: KMullen@ottawaheart.ca
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

REFERENCES

1. Vogel B, Acevedo M, Appelman Y, Bairey Merz C, Chieffo A, Figtree G, et al. The Lancet women and cardiovascular disease Commission: reducing the global burden by 2030. *The Lancet*. 2021.
2. Norris C, Yip C, Nerenberg K, Jaffer S, Grewal J, ALE. L, et al. Introducing the Canadian Women's Heart Health Alliance ATLAS on Epidemiology, Diagnosis, and Management of Cardiovascular Disease in Women. *CJC Open* 2020;2:145-50.
3. Norris C, Yip C, Nerenberg K, Clavel M, Pacheco C, Foulds H, et al. State of the Science in Women's Cardiovascular Disease: A Canadian Perspective on the Influence of Sex and Gender. *JAHA*. 2020;9.
4. Bishop N. Race is not a risk factor: Reframing discourse on racial health inequalities in CVD prevention. *American Journal of Preventative Cardiology*. 2021;6.
5. Jaffer S, Foulds H, Grewal J, Pacheco C, Gonsalves C, Parry M, et al. Canadian Women's Heart Health Alliance Atlas. Chapter 2: The Scope of the Problem. *CJC Open*. 2021;3:1-11.
6. Izadegahdar M, Singer J, Lee M, Gao M, Thompson C, Kopec J, et al. Do younger women fare worse? Sex differences in acute myocardial infarction hospitalization and early mortality rates over ten years. *J Womens Health*. 2014;23:10-7.
7. Alzahrani T, Nguyen T, Ryan A, Dwairy A, McCaffrey J, Yunus R, et al. Cardiovascular disease risk factors and myocardial infarction in the transgender population. *Circ Cardiovasc Qual Outcomes*. 2019;12.
8. McDonnell L, Pipe A, Wstcott C, Perron S, Younger-Lewis D, Elias N, et al. Perceived vs actually knowledge and risk of heart disease in women: findings from a Canadian survey on heart health awareness, attitudes, and lifestyle. *Can J Cardiol*. 2014;30:827-34.
9. Norris C, Hegadoren K, Patterson L, Pilote L. Sex differences in prodromal symptoms of patients with acute coronary syndrome: a pilot study. *Prog Cardiovasc Nurs*. 2008;23:27-31.

10. Dixon T, Lim L, Powell H, Fisher J. Psychosocial experiences of cardiac patients in early recovery: a community-based study. *J Adv Nurs*. 2000;31:1368-75.
11. Lacey E, Walters S. Continuing inequality: gender and social class influences on self perceived health after a heart attack. *J Epidemiol Community Health*. 2003;57:622-7.
12. Sjostrom-Strand A, Ivarsson B, Sjoberg T. Women's experience of a myocardial infarction: 5 years later. *Scandinavian Journal Caring Sci*. 2011;25:459-66.
13. Liblik K, Hu R, Gomes Z, Foldes-Busque G, Mensour E, Sedlak T, et al. Female risk factors for post-myocardial infarction depression and anxiety (FRIDA): Pilot results. *General Hospital Psychiatry*. 2022.
14. Liblik K, Mulvagh S, Hindmarch C, Alavi N, Johri A. Depression and anxiety following acute myocardial infarction in women. *Trends in Cardiovascular Medicine*. 2022;32(6):341-7.
15. GBD. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2015;385:117-71.
16. Getahun D, Nash R, Flanders W, Baird T, Becerra-Culqui T, Cromwell L, et al. Cross-sex hormones and acute cardiovascular events in transgender persons. *Ann Intern Med*. 2018;169:205-10.
17. Cordonnier C, Sprigg N, Sandset E, Pavlovic A, Sunnerhagen K, Caso V, et al. Stroke in women - from evidence to inequalities. *Nature Reviews Neurology*. 2017;13(9):521-32.
18. Benjamin E, Virani S, Callaway C, Chamberlain A, Chang A, Cheng S, et al. Heart Disease and Stroke Statistics - 2018 Update. A Report from the American Heart Association. *Circulation*. 2018;137:e67-e492.
19. Lam C, Arnott C, Beale A, Chandramouli C, Hilfiker-Kleiner D, Kaye D, et al. Sex differences in heart failure. *Eur Heart J*. 2019;40:3859-68.

- 1
2 20. Rutledge T, Reis V, Linke S, Greenberg B, Mills P. Depression in heart failure: a meta-analytic
3
4 review of prevalence, intervention effects, and association with clinical outcomes. *J Am Coll Cardiol*.
5
6 2006;48:1527-37.
7
8
9 21. Khariton Y, Nassif M, Thomas L, Fonarow G, Mi X, DeVore A, et al. Health status disparities
10
11 by sex, race/ethnicity, and socioeconomic status in outpatients with heart failure. *JACC Heart Fail*.
12
13 2018;6:465-73.
14
15
16 22. Markbreiter J, Buckley P. CVD Advocacy Toolkit. 2016.
17
18 23. Prior J, Jordan K, Kadam U. Variations in patient-reported physical health between cardiac and
19
20 musculoskeletal diseases: systematic review and meta-analysis of population-based studies. *Health and*
21
22 *Quality of Life Outcomes*. 2015;13.
23
24
25 24. Rieckmann N, Neumann K, Feger S, Ibes P, Napp A, Preuß D, et al. Health-related quality of
26
27 life, angina type and coronary artery disease in patients with stable chest pain. *Health and Quality of*
28
29 *Life Outcomes*. 2020;18.
30
31
32 25. Hansen T, Thygesen L, Zwisler A, Helmark L, Hoogwegt M, Versteeg H, et al. Self-reported
33
34 health-related quality of life predicts 5-year mortality and hospital readmissions in patients with
35
36 ischemic heart disease. *European Journal of Preventive Cardiology*. 2015;22(7):882-9.
37
38
39 26. Kroenke C, Kubzansky L, Adler N, Kawachi I. Prospective change in health-related quality of
40
41 life and subsequent mortality among middle-aged and older women. *American Journal of Public*
42
43 *Health*. 2008;98(11):2085-91.
44
45
46 27. Colella T, Hardy M, Hart D, Price J, Sarfi H, Mullen K, et al. The Canadian Women's Heart
47
48 Health Alliance Atlas on the Epidemiology, Diagnosis, and Management of Cardiovascular Disease in
49
50 Women - Chapter 3: Patient Perspectives. *CJC Open*. 2021;3:229-35.
51
52
53 28. Barth J, Schneider S, von Kanel R. Lack of social support in the etiology and prognosis of
54
55 coronary heart disease: a systematic review and meta-analysis. *Psychosomatic Medicine*. 2010;72:229-
56
57 38.
58
59
60

- 1
2 29. Holt-Lunstad J, Smith T, Layton B. Social relationships and mortality: a meta-analysis. *PLoS*
3
4 *Med.* 2010;7.
5
6 30. Bucholz E, Strait K, Dreyer R, Geda M, Spatz E, Bueno H, et al. Effect of low perceived social
7
8 support on health outcomes in young patients with acute myocardial infarction: Results from the
9
10 Variation in Recovery: Role of Gender on Outcomes of Young AMI Patients (VIRGO) Study. *JAHA.*
11
12 2014;3.
13
14 31. Leifheit-Limson E, Reid K, Kasl S, Lin H, Jones P, Buchanan D, et al. The role of social
15
16 support in health status and depressive symptoms after acute myocardial infarction. *Circulation:*
17
18 *Cardiovascular Quality and Outcomes.* 2010;3(2):143-50.
19
20 32. Carrero J, de Jager D, Verduijn M, Ravani P, De Meester J, Heaf J, et al. Cardiovascular and
21
22 noncardiovascular mortality among men and women starting dialysis. *Clin J Am Soc Nephrol.*
23
24 2011;6:1722-30.
25
26 33. Albert P. Why is depression more prevalent in women? *J Psychiatry Neurosci.* 2015;40:219-21.
27
28 34. Malik S, Spertus J, Reid K, Krumholz H, Rumsfeld J, Weintraub W, et al. Depressive
29
30 symptoms after acute myocardial infarction: evidence for highest rates in younger women. *Arch Intern*
31
32 *Med.* 2006;166:876-83.
33
34 35. Meijer A, Conradi H, Bos E, Thombs B, van Melle J, de Jonge P. Prognostic association of
35
36 depression following myocardial infarction with mortality and cardiovascular events: a meta-analysis
37
38 of 25 years of research. *Gen Hosp Psychiatry.* 2011;33:203-16.
39
40 36. Shah A, Ghasemzadeh N, Zaragoza-Macias E, Patel R, Eapen D, Neeland I, et al. Sex and age
41
42 differences in the association of depression with obstructive coronary artery disease and adverse
43
44 cardiovascular events. *JAHA.* 2014;3.
45
46 37. Vaccarino V, Badimon L, Corti R, de Wit C, Dorobantu M, Hall A, et al. Ischaemic heart
47
48 disease in women: are there sex differences in pathophysiology and risk factors? Position paper from
49
50
51
52
53
54
55
56
57
58
59
60

- 1
2 the working group on coronary pathophysiology and microcirculation of the European Society of
3
4 Cardiology. *Cardiovasc Res*. 2011;90:9-17.
5
6 38. Roest A, Martens E, de Jonge P, Denollet J. Anxiety and risk of incident coronary disease: a
7
8 meta-analysis. *J Am Coll Cardiol*. 2010;56(1):38-46.
9
10 39. Arthur H, Wright D, Smith K. Women and heart disease: the treatment may end but the
11
12 suffering continues. *Can J Nurs Res*. 2001;33(3):17-29.
13
14 40. Kristofferzon M, Lofmark R, Carlsson M. Myocardial infarction: gender differences in coping
15
16 and social support. *J Adv Nurs*. 2003;44(4):360-74.
17
18 41. Dennis C. Peer support within a health care context: a concept analysis. *International Journal of*
19
20 *Nursing Studies*. 2003;40:321-32.
21
22 42. Henderson A. Abused women and peer-provided social support: The nature and dynamics of
23
24 reciprocity in a crisis situation. *Issues in Mental Health Nursing*. 16:117-28.
25
26 43. Gómez-Pardo E, Fernández-Alvira J, Vilanova M, Haro D, Martínez R, Carvajal I, et al. A
27
28 comprehensive lifestyle peer group-based intervention on cardiovascular risk factors. *JACC*.
29
30 2016;67(5):476-85.
31
32 44. Morris R, Morris P. Participants' experiences of hospital-based peer support groups for stroke
33
34 patients and carers. *Disability and Rehabilitation*. 2011;34(4):347-54.
35
36 45. Clark A, Munday C, McLaughlin D, Catto S, McLaren A, MacIntyre P. Peer support to
37
38 promote physical activity after completion of centre-based cardiac rehabilitation: evaluation of access
39
40 and effects. *European Journal of Cardiovascular Nursing*. 2012;11(4):388-95.
41
42 46. Parry M, Watt-Watson J, Hodnett E, Tranmer J, Dennis C, Brooks D. Cardiac Home Education
43
44 and Support Trial (CHEST): A pilot study. *Can J Cardiol*. 2009;25(12):e393-e8.
45
46 47. Power S, Hegarty J. Facilitated Peer Support in Breast Cancer. *Cancer Nursing*. 2010;33(2).
47
48 48. Arlotti J, Cottrell B, Hughes S, Curtin J. Breastfeeding among low-income women with and
49
50 without peer support. *Journal of Community Health Nursing*. 1998;15(3):163-78.
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
49. Mejias N, Gill C, Shpigelman C. Influence of a support group for young women with disabilities on sense of belonging *Journal of Counseling Psychology*. 2014;61(2):208-20.
50. Angus J, King-Shier K, Spaling M, Duncan A, Jaglal S, Stone J, et al. A secondary meta-synthesis of qualitative studies of gender and access to cardiac rehabilitation. *Journal of Advanced Nursing*. 2015;71(8):1758-73.
51. Smith C, Leon M, Mack M, Miller D, Moses J, Svensson L, et al. Transcatheter versus surgical aortic-valve replacement in high-risk patients. *N Engl J Med*. 2011;364(23):2187-98.
52. Wieslander I, Baigi A, Turesson C, Fridlund B. Women's social support and social network after their first myocardial infarction; a 4-year follow-up with focus on cardiac rehabilitation. *European Journal of Cardiovascular Nursing: Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*. 2005;4(4):278-85.
53. Hellem E, Bruusgaard K. "When what is taken for granted disappears": women's experiences and perceptions after a cardiac event. *Physiotherapy Theory and Practice*. 2018:1-11.
54. Sjostrom-Strand A, Fridlund B. Women's descriptions of symptoms and delay reasons in seeking medical care at the time of a first myocardial infarction: A qualitative study. *International Journal of Nursing Studies*. 2008;45:1003-10.
55. Miake-Lye I, Hempel S, Shanman R, Shekelle P. What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Syst Rev*. 2016;5(28).
56. Zainuddin Z, Perera CJ, Haruna H, Habiburrahim H. Literacy in the new norm: stay-home game plan for parents. *Information and Learning Sciences*. 2020;121(7/8):645-53.
57. Oliver S, Harden A, Rees R. An emerging framework for including different types of evidence in systematic reviews for public policy. *Evaluation*. 2005;11(4):428-46.
58. CIHR. Strategy for Patient-Oriented Research Capacity Development Framework: Canadian Institutes of Health Research; 2015 [Available from: <http://www.cihr-irsc.gc.ca/e/49307.html>].

- 1
2 59. CIHR. Strategy for Patient-Oriented Research Patient Engagement Framework: Canadian
3
4 Institutes of Health Research; 2015 [Available from: <http://www.cihr-irsc.gc.ca/e/48413.html>.
5
6
7 60. Fawcett J, Watson J, Neuman B, Walker PH, Fitzpatrick JJ. On Nursing Theories and Evidence
8
9 Journal of Nursing Scholarship. 2001;33(2):115-9.
10
11 61. Ryan P, Sawin KJ. The Individual and Family Self-Management Theory: Background and
12
13 Perspectives on Context, Process, and Outcomes. Nurs Outlook. 2009;57(4):217-25.
14
15
16 62. Ryan P, Sawin K. The Individual and Family Self-Management Theory: Background and
17
18 perspectives on context, process, and outcomes. Nursing Outlook. 2009;57(4):217-25.
19
20
21 63. Parry M, Bjornnes A, Victor J, Ayala A, Lenton E, Clarke H, et al. Self-management
22
23 interventions for women with cardiac pain: A systematic review and meta-analysis. Canadian Journal
24
25 of Cardiology. 2018;34:458-67.
26
27
28 64. Gallant M. The influence of social support on chronic illness self-management: a review and
29
30 directions for research. Health Educ Behav. 2003;30(2):170-95.
31
32
33 65. Lorig K, Mazonson P, Holman H. Evidence suggesting that health education for self-
34
35 management in patients with chronic arthritis has sustained health benefits while reducing health care
36
37 costs. Arthritis Rheum. 1993;36(4):439-46.
38
39
40 66. Zubatsky M, Berg-Weger M, Morley J. Using Telehealth Groups to Combat Loneliness in
41
42 Older Adults Through COVID-19. J Am Geriatr Soc. 2020.
43
44
45 67. Grady P, Gough L. Self-Management: A Comprehensive Approach to Management of Chronic
46
47 Conditions. Am J Public Health. 2014;104(8):e25-e31.
48
49
50 68. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting
51
52 items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic
53
54
55
56
57
58
59
60

- 1
2 69. Staniszewska S, Brett J, Simera I, Seers K, Mockford C, Goodland S, et al. GRIPP2 reporting
3
4 checklists: tools to improve reporting of patient and public involvement in research. *BMJ*. 2017;358:1-
5
6 7.
7
8
9 70. SPOR. Recommendations on patient engagement compensation. 2018.
10
11 71. Foster E, Deardorff A. Open Science Framework (OSF). *Journal of the Medical Library*
12
13 Association. 2017;105(2):203-6.
14
15 72. EPPI. EPPI Centre: Evidence for Policy and Practice Information and Coordinating Centre
16
17 London: Social Science Research Unit at the UCL Institute of Education; [Available from:
18
19 <http://eppi.ioe.ac.uk/cms/>.
20
21
22 73. Pope C, Mays N, Popay J. *Synthesizing Qualitative and Quantitative Health Evidence*. New
23
24 York: McGraw Open University Press; 2007.
25
26 74. Harden A, Garcia J, Oliver S, Rees R, Shepherd J, Brunton G, et al. Applying systematic review
27
28 methods to studies of people's views: an example from public health research. *Journal of Epidemiology*
29
30 and Community Health. 2004;58:794-800.
31
32 75. Thomas J, Harden A, Oakley A, Oliver S, Sutcliffe K, Rees R, et al. Integrating qualitative
33
34 research with trials in systematic reviews. *BMJ*. 2004;328:1010-2.
35
36 76. Parry M, Bjornnes A, Clarke H, Cooper L, Gordon A, Harvey P, et al. Self-management of
37
38 cardiac pain in women: an evidence map. *BMJ Open*. 2017;7.
39
40 77. Schardt C, Adams M, Owens T. Utilization of the PICO framework to improve searching
41
42 PubMed for clinical questions. *BMC Med Inform Decis Mak*. 2007;7.
43
44 78. Wang D, Shams-White M, Bright O, Parrott J, Chung M. Creating a literature database of low
45
46 calorie sweeteners and health studies: evidence mapping. *BMC Med Res Methodol*. 2016;16:1-11.
47
48 79. Langhorne P, Ramachandra S. Organised inpatient (stroke unit) care for stroke: network meta-
49
50 analysis. *Cochrane Database Syst Rev*. 2020(4).
51
52
53
54
55
56
57
58
59
60

- 1
2 80. Safi S, Sethi N, Nielsen E, Feinberg J, Gluud C, Jakobsen J. Beta-blockers for suspected or
3
4 diagnosed acute myocardial infarction. *Cochrane Database Syst Rev.* 2019(12).
5
- 6 81. McGowan J, Sampson M, Salzwedel D, Cogo E, Foerster V, Lefebvre C. PRESS Peer Review
7
8 of Electronic Search Strategies: 2015 Guideline Statement. *Journal of Clinical Epidemiology.*
9
10 2016;75:40-6.
11
- 12 82. Covidence. Covidence systematic review software. Melbourne, Australia: Veritas Health
13
14 Innovation.
15
- 16 83. Masterson Creber R, Spadaccio C, Dimagli A, Myers A, Taylor B, Fremes S. Patient-Reported
17
18 Outcomes in Cardiovascular Trials. *Can J Cardiol.* 2021;37(9):1340-52.
19
- 20 84. Wagner T, Yoon J, Jacobs J, So A, Kilbourne A, Yu W, et al. Estimating costs of an
21
22 implementation intervention. *Medical Decision Making.* 2020;40(8):959-67.
23
- 24 85. Polanin J, Pigott T, Espelage D. Best practice guidelines for abstract screening large-evidence
25
26 systematic reviews and meta-analyses. *Res Syn Meth.* 2019;10:330-42.
27
- 28 86. Hoffmann T, Glasziou P, Boutron I, Milne R, Perera R, Moher D, et al. Better reporting of
29
30 interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ.*
31
32 2014;348.
33
- 34 87. Petticrew M, Anderson L, Elder R, Grimshaw J, Hopkins D, Hahn R, et al. Complex
35
36 interventions and their implications for systematic reviews: A pragmatic approach. *International*
37
38 *Journal of Nursing Studies.* 2015.
39
- 40 88. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O, Peacock R. Storylines of
41
42 research in diffusion of innovation: a meta-narrative approach to systematic review. *Social Science &*
43
44 *Medicine.* 2005;61:417-30.
45
- 46 89. R-Core-Team. R: A language and environment for statistical computing Vienna, Austria: R
47
48 Foundation for Statistical Computing; 2020 [Available from: <https://www.R-project.org/>.]
49
50
51
52
53
54
55
56
57
58
59
60

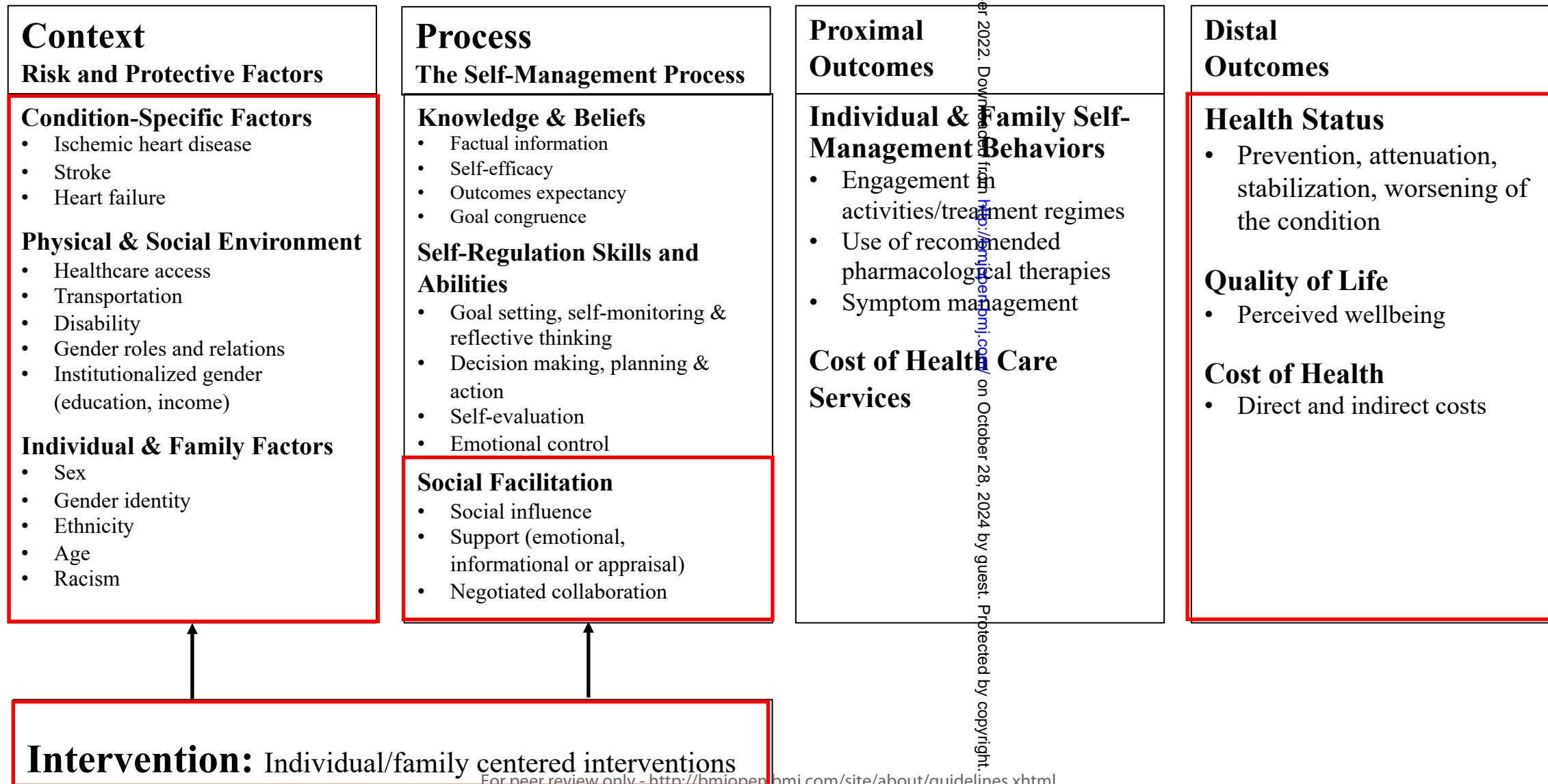
1
2
3 **FIGURE TITLE**

4
5
6 **Figure 1. Individual and Family Self-Management Theory model**
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

067812 on 5 October 2022. Downloaded from <http://bmjopen.bmj.com/> on October 28, 2024 by guest. Protected by copyright.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41



Supplementary Table 1 PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol and utilized as a general guidance document for this evidence map protocol*.

Section and topic	Item No	Checklist item	Section
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a review protocol	Title Page
Update	1b	If the protocol is for an update of a previous review, identify as such	N/A
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	Abstract, Methods and Analysis
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	Authors and Affiliations
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	Contributors
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	N/A
Support:			
Sources	5a	Indicate sources of financial or other support for the review	Funding
Sponsor	5b	Provide name for the review funder and/or sponsor	Funding
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	N/A
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	Introduction
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	Objectives
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	Identify Clear Eligibility Criteria, Table 2
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	Establish a Comprehensive Search Strategy, Table 1

Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	Table 1
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	Establish a Comprehensive Search Strategy
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility, and inclusion in evidence map)	Systematically Retrieve, Screen and Classify the Evidence
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	Systematically Retrieve, Screen and Classify the Evidence
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	Define Key Variables, Table 1
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	Identify Clear Eligibility Criteria
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	Methods and Analysis
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	Report Findings in an Evidence Map
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2 , Kendall's τ)	Report Findings in an Evidence Map
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	Report Findings in an Evidence Map
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	Methods and Analysis
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	Methods and Analysis

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1): g7647.

Supplemental Table 2 GRIPP2 Long Form.

Section and topic	Checklist item	Included
Section 1: Abstract of paper		
1a: Aim	Report aims of study	
1b: Methods	Describe methods used by which patients/public involved	Yes
1c: Results	Report impacts and outcomes of PPI in study	N/A
1d: Conclusions	Summarize main conclusions of study	N/A
1e: Keywords	Include PPI or alternative terms as keywords	Yes
Section 2: Background to paper		
2a: Definition	Report definition of PPI used and how it links to comparable studies	Yes
2b: Theoretical underpinnings	Report theoretical rationale and influences of PPI	Yes
2c: Concepts and theory development	Report any conceptual models or influences used	Yes
Section 3: Aims of paper		
3: Aim	Report aims of study	Yes
Section 4: Methods of paper		
4a: Design	Describe methods by which patients involved	Yes
4b: People involved	Describe patients involved with PPI activity in study	Yes
4c: Stages of involvement	Report on how PPI used at different stages of study	Yes
4d: Level or nature of involvement	Report level or nature of PPI used at various stages	Yes
Section 5: Capture or measurement of PPI impact		
5a: Qualitative evidence of impact	Report methods to qualitatively explore impact of PPI	N/A
5b: Quantitative evidence of impact	Report methods to quantitatively measure impact of PPI	N/A
5c: Robustness of measure	Report rigour of method used to capture impact of PPI	N/A
Section 6: Economic assessment		
6: Economic assessment	Report method used for economic assessment of PPI	N/A
Section 7: Study results		
7a: Outcomes of PPI	Report results of PPI, including positive and negative outcomes	N/A
7b: Impacts of PPI	Report positive and negative impacts PPI had on research, individuals involved, and wider impacts	N/A
7c: Context of PPI	Report contextual factors the enabled or hindered the process of impact of PPI	N/A
7d: Process of PPI	Report process factors that enabled or hindered PPI	N/A
7e: Theory development	Report any theory development in PPI that emerged	N/A
7eii: Theory development	Report testing of theoretical models, if any	N/A
7f: Measurement	Report instrument development and testing	N/A
7g: Economic assessment	Report costs or benefits of PPI	N/A
Section 8: Discussion and conclusion		
8a: Outcomes	Comment on how PPI influenced overall study	N/A
8b: Impacts	Comment on impacts of PPI and how they contribute to new knowledge	N/A
8c: Definition	Comment on definition of PPI used and report any suggested changes	N/A
8d: Theoretical underpinnings	Comment on study's contribution to theory development of PPI	N/A
8e: Context	Comment on how context factors influenced PPI	N/A
8f: Process	Comment on how process factors influenced PPI	N/A
8g: Measurement/capture of PPI impact	Comment on how well PPI impact was evaluated	N/A
8h: Economic assessment	Discuss economic costs or benefits of PPI	N/A
8i: Reflections/critical perspective	Reflect on what went well and what did not go well	N/A

PPI=patient and public involvement