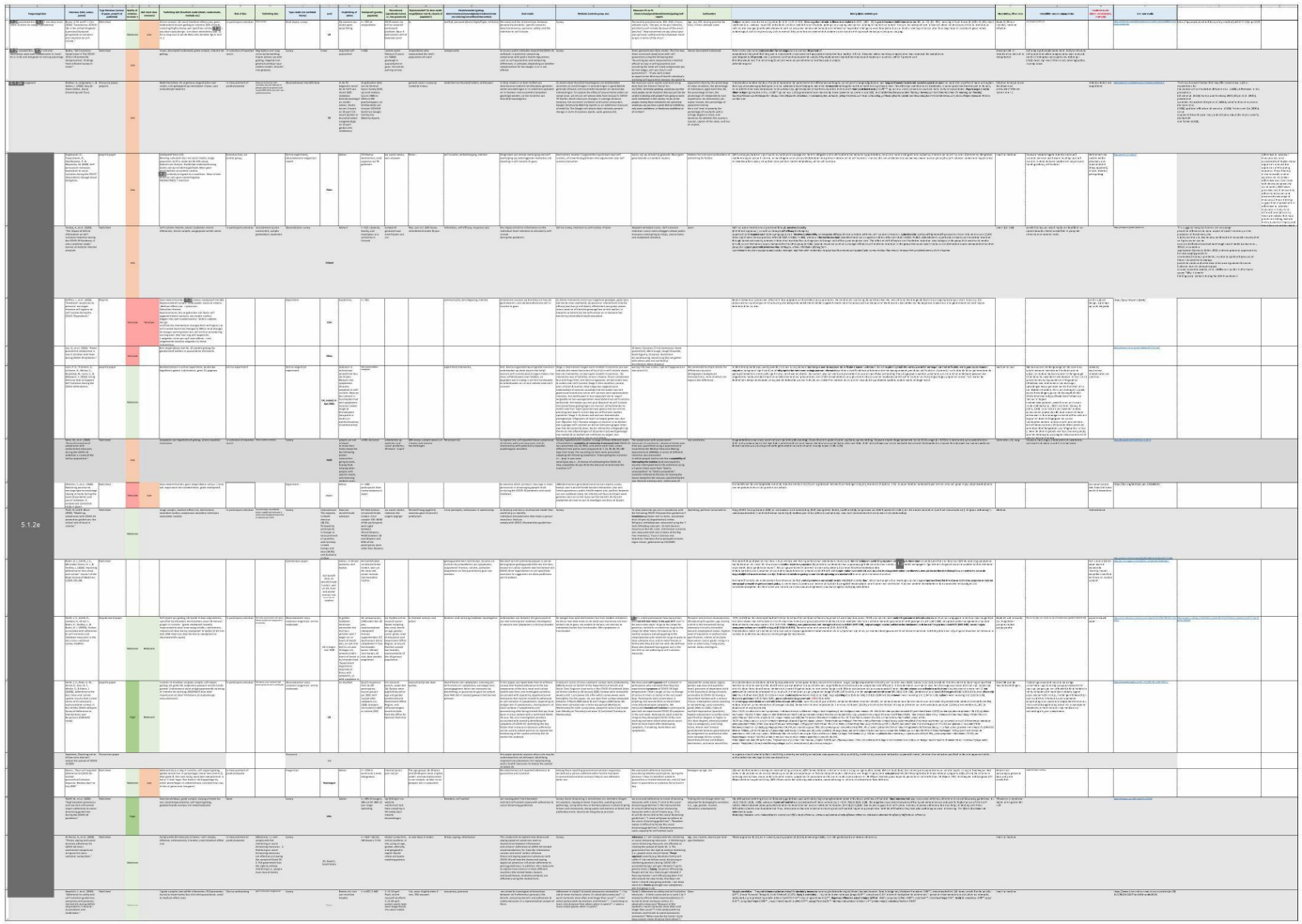
Studies leeg

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Toegevoegd door**	**Literatuur (titel, auteur, jaartal)**	**Type literatuur (review of paper, preprint of published)**	**Quality of evidence**	**QoE check**	**Toelichting QoE (RoB, indirectness, inconsistency, indirectness, imprecision, effect size, right confounders, dose response)**	**Risk of bias (study limitations: design, inclusion and sample info, measurement, confounding, follow-up)**	**Toelichting bias**	**Type studie (zie werkblad hierna)**	**Land**	**Verplichting of advies**	**Steekproef (grootte, populatie)**	**Recruitment (opvallende in/excl cr., hoe geworven)**	**Representatief? (is deze studie vergelijkbaar met NL situatie of populatie?)**
2	11.1.24	5.1.2e Patient reminder and recall interventions to improve immunization rates. Cochrane Database of Systematic Reviews 2018, Issue 1. Art. No.: CD003941. DOI: 10.1002/14651858.CD003941.pub3.	Cochrane review	High		Bijna alles volgens de hoogste standaard gereviewd volgens Amstar. Zie map 5.1.2h	Door auteurs veelal als laag beoordeeld (44 - 70%) daarna een deel unclear. Alleen blinding scoort laag op 'low risk' 28%					Patient or population: children, adolescents, and adults with a need for routine immunizations, excluding travel immunizations		Mostly USA.
3	11.1.24	Interventions to increase seasonal influenza vaccine coverage in healthcare workers: A systematic review and meta-regression analysis	Sys review and meta-regression	Moderate		Scoort niet high omdat analyseprotocol niet vooraf is geregistreerd, omdat follow-up per losse studie niet beschreven staat. RCT's en NRSI's zijn bijeen genomen	Hoog in de meeste geïncludeerde studies. Niet in de review zelf. out of the 11 RCTs or cRCTs, in 7 the method of randomization was unclear,26,34,35,51,53,58,64 and one study employed a factorial design with partial randomization. 41 Allocation concealment in the 2 RCTs was unclear.,35,53 5 studies did not report vaccination coverage at baseline for the intervention and control groups,34,35,37,47,53 and 9 studies (including the 3 controlled BnA studies) did not sufficiently report on potential baseline imbalances.34-36,47,51,53,58,68,71 Completeness of outcome data was not clarified in all but 5 studies,26,41,47,49,58 and in 3 of them the response rate was low enough to potentially bias the results.41,47,58 Most studies offered vaccination in-house and could objectively ascertain vaccine coverage26,35,36,49,53,64,68,71; one study used an external occupational health service,37 another used general practitioner claim forms,34 3 studies used self-report via quesionnaires to ascertain vaccination,41,47,58 and one study did not report the method of ascertainment.51					Health care workers		Westers, ook NL studie
4	11.1.24	Assessing Interventions To Improve Influenza Vaccine Uptake Among Health Care Workers	Sys review	low		effect van RCtB op interpretatie van resultaten wordt niet beschreven. Heterogeniteit niet verklaard. Hierna gestopt met invullen want niet gebruiken								
5	11.1.24	Interventions to increase influenza vaccination rates of those 60 years and older in the community (Review)		high	binnen studie: high to moderate	Bijna alles volgens de hoogste standaard gereviewd volgens Amstar. Zie map 5.1.2h	Review zelf lage risk. Studies daarin moderate	We assessed studies as at low risk of bias for randomisation (38%), allocation concealment (11%), blinding (44%), and selective reporting (100%). Half (51%) had missing data. Quality of the evidence Overall, we assessed the included studies as at moderate risk of bias. The overall GRADE assessment of the evidence was high to moderate quality.				people aged 60 years and older living in the community. the review now includes a total of 61 trials with 1,055,337 participants.		Studies were conducted in 12 countries: the USA (n = 36), Canada (n = 7), Australia (n = 4), the UK (n = 4), Spain (n = 3), and one each in Denmark, Germany, Hong Kong, Israel, New Zealand, Puerto Rico, and Switzerland.

Studies ieeg

	A	O	P	Q	R	S	T	U	V	W
1	**Toegevoegd door**	**Sleutelwoorden (gedrag: determinanten/omstandigheden/redenen/mate van naleving/verschillen/interventies)**	**Doel studie**	**Methode (controle groep, etc)**	**Measures DV en IV (item/schaal/gevalideerd/intentie/gedrag/self-report)**	**Confounders**	**Belangrijkste bevindingen**	**Beoordeling effect sizes**	**Verschillen tussen subpopulaties**	**Link naar studie**
2	ES Jm		To evaluate and compare the eHectiveness of various types of patient reminder and recall interventions to improve receipt of immunizations.	Review. We included randomized trials, controlled before and aJer studies, and interrupted time series studies. We included good quality, controlled, non-randomized studies to provide a suHiciently large number of studies to assess each intervention sub-type. We excluded observational studies in which participants self-selected to intervention groups. We reviewed the methods of each study to determine the study design, not relying on the authors' specified designs. We accepted a study that randomly selected intervention participants and selected matched controls in a non-random fashion as a controlled before-aJer design if pre-intervention and post-intervention immunization data were collected. Due to limited resources, we excluded non-English language publications.	Our primary outcome measure was receipt of immunizations. We selected this outcome measure over other possible outcomes because of certain limitations, for example: the total number of vaccines would vary based on country, age group, and other factors; the proportion of the population that received all vaccines would depend on the specific population, such as age group; and on-time vaccination is restrictive and is not expected to support clinicians' eHorts to optimize receipt of vaccinations. We accepted outcomes for individual vaccinations or standard combinations of recommended vaccinations, such as all recommended vaccinations by a specific date or age. If outcomes for a study were measured at multiple time points, we selected the outcomes designated as primary by the study authors. If unclear, we averaged outcomes over time periods		Patient reminder or recall interventions, including telephone and autodialer calls, letters, postcards, text messages, combination of mail or telephone, or a combination of patient reminder or recall with outreach, probably improve the proportion of participants who receive immunization (risk ratio (RR) of 1.28, 95% confidence interval (CI) 1.23 to 1.35; risk diHerence of 8%) based on moderate certainty evidence from 55 studies with 138,625 participants. Three types of single-method reminders improve receipt of immunizations based on high certainty evidence: the use of postcards (RR 1.18, 95% CI 1.08 to 1.30; eight studies; 27,734 participants), text messages (RR 1.29, 95% CI 1.15 to 1.44; six studies; 7772 participants), and autodialer (RR 1.17, 95% CI 1.03 to 1.32; five studies; 11,947 participants). Two types of single-method reminders probably improve receipt of immunizations based on moderate certainty evidence: the use of telephone calls (RR 1.75, 95% CI 1.20 to 2.54; seven studies; 9120 participants) and letters to patients (RR 1.29, 95% CI 1.21 to 1.38; 27 studies; 81,100 participants). Based on high certainty evidence. reminders improve receipt of immunizations for childhood (RR 1.22. 95% CI 1.15 to 1.29: risk diHerence of 8%; 23 studies; 31,099 participants) and adolescent vaccinations (RR 1.29, 95% CI 1.17 to 1.42; risk diHerence of 7%; 10 studies; 30,868 participants). Reminders probably improve receipt of vaccinations for childhood influenza (RR 1.51, 95% CI 1.14 to 1.99; risk diHerence of 22%; five studies; 9265 participants] and adult influenza (RR 1.29, 95% CI 1.17 to 1.43; risk diHerence of 9%; 15 studies; 59,328 participants) based on moderate certainty evidence. They may improve receipt of vaccinations for adult pneumococcus, tetanus, hepatitis B, and other non-influenza vaccinations based on low certainty evidence although the confidence interval includes no eHect of these interventions (RR 2.08, 95% CI 0.91 to 4.78; four studies; 8065 participants).			
3	ES Cm		we undertook a systematic review of epidemiologic studies evaluating interventions to increase influenza vaccination coverage in HCWs, including a meta-regression analysis to quantify the benefit of each intervention component. We tried to include the widest possible range of studies in our review, but focused only in seasonal (i.e. not pandemic) influenza vaccination campaigns, in order to maximize generalizability of the results.	we undertook a systematic review of epidemiologic studies evaluating interventions to increase influenza vaccination coverage in HCWs, including a meta-regression analysis to quantify the benefit of each intervention component. We tried to include the widest possible range of studies in our review, but focused only in seasonal (i.e. not pandemic) influenza vaccination campaigns, in order to maximize generalizability of the results.	To be eligible, a study had to compare as outcome the vaccination coverage between the intervention and control groups, and provide sufficient numerical data to calculate an appropriate effect measure for the intervention, as described below. We did not include studies assessing "intention to be vaccinated" as outcome, only studies comparing actual vaccination rates		Mandatory vaccination was the most effective intervention component (Risk Ratio of being unvaccinated [RRunvacc] D 0.18, 95% CI: 0.08–0.45), followed by "soft" mandates such as declination statements (RRunvacc D 0.64, 95% CI: 0.45–0.92), increased awareness (RRunvacc D 0.83, 95% CI: 0.71–0.97) and increased access (RRunvacc D 0.88, 95% CI: 0.78–1.00). For incentives the difference was not significant, while for education no effect was observed. Heterogeneity was substantial (I2 D 0.083). These results indicate that effective alternatives to mandatory HCWs influenza vaccination do exist, and need to be further explored in future studies.			
4	ES Ch									
5	ES Ch		To assess access, provider, system, and societal interventions to increase the uptake of influenza vaccination in people aged 60 years and older in the community.	review rcts	Increasing community demand compared to no intervention or another intervention for increasing influenza vaccination uptake		Increasing community demand for vaccination (12 strategies, 41 trials, 767,460 participants] EHective interventions consisted of reminders/recalls using letters and leaflets, and nurses or pharmacists educating and nurses vaccinating patients. Individual eHective studies consisted of client outreach by retired teachers, receptionists, nurses, and medical students. It was not possible to combine some interventions for analysis as they were too varied: 17 studies of simple reminders (11 with significant results); 16 studies of personalised reminders (12 with significant results); two studies of customised letters versus form letters (both with significant results); and four studies of health risk appraisals plus vaccination recommendations (all with significant results). Improving vaccination access (6 strategies, 8 trials, 9353 participants) EHective interventions consisted of home visits, client group clinic visits, and free vaccine oHers. Improving provision by providers or the healthcare system (11 strategies, 15 trials, 278,524 participants) EHective interventions that could be combined for analysis included physician payment, physician reminders, clinic posters encouraging physician competition, and chart reviews plus benchmarking to rates of the top 10% of physicians. We could not analyse some groups of interventions: physician reminders (four studies, two of which were eHective) and facilitator vaccination encouragement (three studies, two of which were eHective). Individual studies that were not eHective consisted of posters plus postcards versus posters alone, educational reminders to physicians compared to mailed educational materials, educational outreach plus feedback to teams versus written feedback, and increasing staH vaccination rates. No studies measured if interventions reduced illness or hospital admissions or reported societal-level interventions.			



Trade name/class	Generic (INN) / active ingredient	Type Reference Number (if given) proof of market	Deadline for withdraw / transfer	Will stock be removed	Trade/selling Qty (Excel/text) (with Green / redistribute / market etc)	Risk of Sale	Trade/selling Qty	Type (wine, spirit, cocktail, bottle)	Unit	Quantity of stock	Estimated market potential	Annualised Quantity (Only complete if you have a Quantity of stock)	Potential benefit? (Is there wider corporate use for Vitality's products?)	Supply/supplier (Approved/Unapproved/Agency/Direct/Importer/Wholesaler)	Start date	Portfolio (Licensed group, etc)	Reason for sale (Discontinuing/Licensed/Licensing out)	Confirmation	Who is this working on?	Min Viability (Min Qty)	Possible / plan to relaunch/new	Could we work with them? (Yes/No/Maybe)	If no, can it be		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Samenvatting

Studie	GoE	Risk of bias	Sample	Land	Bevindingen	Toelichting
Bacon, A. M. and P. J. Corr (2020). "Coronavirus (COVID-19) in the United Kingdom: A personality-based perspective on concerns and intention to self-isolate."	Moderate	In participant selection	n = 202 uk respondents	UK	Ouderen minder intentie tot zelf isolatie (b= 0.15 [-0.01, 0.001]). Meer negative attitude to illness meer isolatie (b=0.28, [.001, .01]), lagere behavioural inhibitions meer iso (BIS, b= .2 [.01, .001]), meer fight flight freeze (b=0.26 [.01, .01]). Goal conflicted (i.e., anxious, hoge BIS) individuals are less inclined to self-isolate, perhaps as a coping mechanism, aiming to maintain a normal lifestyle. An increased level of concern does not necessarily lead to intention to self-isolate. Younger people who choose to self-isolate geven minder om behoud van normaal en mogelijk minder geïsoleerd door gebruik social media. Sommige mensen uiten hun angst door in isolatie te gaan, terwijl anderen goal conflict ervaren (stay safe vs normal life); zo zullen de onzekerheid proberen op te lossen met approach behaviours (bv. panic buying).	Kleine sample, UK, small/medium effect sizes, geen onderscheid tussen gedrag en intentie (11% already isolating/highly intent), wat specifiek isolatie [redacted] zou door study design -1 en door indirectness ook -1). En ik snap hun CI en de Beta niet, de beta ligt er niet in..)
Bodas, "Self-Isolation Compliance In The COVID-19 Era Influenced By Compensation: Findings From A Recent Survey In Israel."	Low	In selection of reported result	n=563	Israel	When state-sponsored compensation for lost wages was assumed, 94 percent of respondents indicated that they would comply with a two-week self-quarantine instructed by a medical official. However, when monetary compensation was removed, the compliance rate dropped to 57 percent, and 11 percent said that they would not comply. Fifty-eight percent replied that they would report such a person, while 7 percent said that they would not. The remaining 35 percent were unsure whether or not they would comply with the request.	Israel, descriptief onderzoek, grote sample, intentie tot gedrag
Brodeur, A., Grigoryeva, I., & Kattan, L. (2020). Stay-At-Home Orders, Social Distancing and Trust.	Low	In measurement of predic/outcome	Ze gebruiken data van de General Social Survey (GSS) op land niveau tussen 2000 en 2014 uit 406 graafschappen, en telefoondata van Unacast COVID19 toolkit en Google Community Mobility reports.	VS	Onderzoekers vonden dat deze thuisblijf mandaten de mobiliteit met 8-10%punten verlaagde, en dat graafschappen/gebieden met hoog vertrouwen (in anderen) en vertrouwen in de pers hun mobiliteit significant meer verlaagden dan laag vertrouwen graafschappen (na de lockdown). Graafschappen met meer democraten verlaagden ook hun mobiliteit significant meer. Het effect van compliance na lockdowns is vooral groot rond vertrouwen in de pers, en relatief kleiner rond vertrouwen in de wetenschap, geneeskunde of overheid. Counties met relatief meer covid death rates (-0.129*** op non ess visits) binnen de staat are more likely to stay at home. Hogere angst s nachts alleen te lopen (perceptie crime, -0.155** op non ess visits) gerelateerd aan meer compliance (zwakker na controle voor SES). In dit artikel worden ook eerdere literatuur bevindingen rond determinanten die naleving van thuisblijf maatregelen beïnvloeden besproken: de duur van zelfisolatie, verschillen in risicopercepties, armoede, geloof en vertrouwen in de wetenschap, politieke affiliatie, sociale verantwoordelijkheid en sociaal vertrouwen, en houdingen tegenover de ernst van het virus.	Mobiliteitsdata, VS, algemene vragenlijsten over staten, niet gekoppeld op individueel niveau, wat onduidelijke tabellen
Dogikowski, D., Trepanowski, R., Chwiłkowska, F., & Majewska, M. (2020). Self-persuasion increases motivation to social isolation during the COVID-19 pandemic through moral obligation.	Low	Selection bias, no control group.	375 Poolse deelnemers, eind augustus via FB geworven	Polen	Zelf overtuiging had een significante invloed op de aangegeven morele obligatie om te self isoleren die mensen rapporteerden, en via die morele obligatie een invloed op intentie om te self isoleren. Deelnemers die grotere voordelen zagen van self isolatie, en een hogere ernst van covid-19, hadden een grotere intentie om te self isoleren. mensen die iemand kende die besmet was waren eerder geneigd te self isoleren, namen een hogere ernst en kwetsbaarheid waar, en voelden een sterkere morele verplichting om te self isoleren.	Steekproef klein 375. Werving: selection bias via social media. Jonge populatie, helft is onder de 40. 68% vrouw. Gebruik van theorie. Duidelijke onderzoeksvraag. Scales zijn op reliability gecheckt. Maar geen genuanceerde uit eerdere studies. Bijv. Randomly assigned to a condition. Maar alleen direct en self, geen controlegroep. INDIRECTNESS = intention.
Farooq, A., et al. (2020). "The Impact of Online Information on Self-isolation Intention during the COVID-19 Pandemic: A cross-sectional study." Journal of medical internet research.	Low	In participant selection	n=225. students, faculty, and employees at a university in Finland	Finland	Self-isolation intention was predicted through perceived severity (0.20 threat appraisal), as well as through self-efficacy (0.20 coping appraisal) and response cost (-0.34 coping appraisal). Perceived vulnerability and response efficacy did not correlate with the self-isolation intention. Cyberchondria (confused/frightened/frustrated na lezen info online over COVID) had a significant indirect positive effect (b=0.07, t=2.535, P=.003), whereas information overload (overwhelmed) had a negative indirect effect (b= -0.10, t=3.006, P=.003). Cyberchondria significantly impacts self-isolation intention through perceived severity, whereas information overload has an impact on it through self-efficacy and response cost. The effect of self-efficacy on self-isolation intention was stronger in the group that used social media (n=119) as an information source compared to the other group (n=106). Second, response cost had a stronger effect on self-isolation intention in the group that used social media as an information source compared to the other group. We suggest personalized intervention strategies, where individuals suffering from cyberchondria are given counseling and hopeful messages, and those with an intention to adopt health measures are targeted with communication that aims to increase their perceived severity of the situation	self-isolatie intentie, vooral studenten, kleine effectsizes, kleine sample, aangepaste valide scales
Heffner, J., et al. (2020). "Emotional responses to prosocial messages increase willingness to self-isolate during the COVID-19 pandemic."	Very Low	0	n = 955	USA	Beide interventies waren even effectief in het vergroten van bereidheid tot quarantaine. De emotionele reactie op de berichten was wel verschillend: het dreigende bericht was erg onplezierig en sterk "arousing". De prosociale was plezierig en mild arousing. Het dreigende bericht werd sterker negatief ervaren dan het prosociale bericht positief werd ervaren. De sterkte van de negatieve reactie was niet gerelateerd aan een hogere bereidheid tot isolatie.	Geen determinanten [redacted] Grotere steekproef met 955. Representatief sample. Grote power. Exclusie criteria. Medium effect size. + precision. Gebruiken theorie. Questionnaires die ze gebruiken zijn deels zelf opgesteld deels op basis van eerdere studies. Zeggen niks over randomisation. Within subjects design and how the intervention changed their willingness to self-isolate from 0 (no change) to 100 (a lot of change). Ze vroegen participanten dus zelf om hun verandering aan te geven. Wel heel erg self report dit. 1 volgorde, risico van spill over effects – niet omgekeerde conditie volgorde als check. Indirectness. Begin van de epidemie.)
Liu, Q., et al. (2020). "Home quarantine compliance is low in children with fever during COVID-19 epidemic."	Very Low	0	0	China	0	Niet vergelijkbaar met NL. 10 soorten gedrag die geadviseerd werden in quarantaine met koorts
Lunn, P. D., Timmons, S., Julienne, H., Belton, C., Barjaková, M., Lavin, C., & McGowan, F. (2020). Using Decision Aids to Support Self-Isolation During the COVID-19 Pandemic.	Moderate	online experiment	500, representatieve steekproef	UK, Ierland. In April 2020	In dit experimentonderzoek werd gevonden dat beslissingsbomen beslissingen over de noodzaak tot zelfisolatie kunnen verbeteren, dat online planningstools het vertrouwen in het vermogen om met zelfisolatie om te gaan zouden kunnen vergroten (marginaal significant) en of infographics het herinneren en begrijpen van informatie over hoe zichzelf isoleren verbeteren (niet het waargenomen gemak van zelf isolatie uitvoeren). In alle drie de fasen genereerden de gedragsinterventies statistisch significante, positieve resultaten. Een aspect was een verrassingsresultaat en vereist specifieke vermelding. Toen de gegevens werden verzameld, was Ierland het onderwerp geweest van uitgebreide media aandacht voor de verscheidenheid aan presentaties van COVID-19-symptomen en wijdverbreid advies over de noodzaak om zichzelf te isoleren als het geen pachtige symptomen ervaart. Toch waren de deelnemers verrassend dubbelzinnig over de behoefte van een individu om zichzelf te isoleren als ze al een secundaire symptomen hadden, zonder koorts of droge hoest.	Randomization in online experiment, duidelijke hypothesis getest. Indirectness, geen CIs gegeven
Nese, M., et al. (2020). "Delay discounting of compliance with containment measures during the COVID-19 outbreak: a survey of the Italian population."	Low	In selection of reported result	n=931 Italianen	Italië	De gemiddelde compliance neemt af over tijd (delay discounting). Deze afname is groter bij een lage kans op besmetting. Vrouwen ervaren hoger perceived risk (r= 0.15), angst (r = 0.28) en intolerantie van onzekerheid (r= 0.13). Het waargenomen risico over tijd is gerelateerd aan een hogere compliance over tijd (correlaties van 0.24 - 0.30). Het verhogen van risicoperceptie kan daarom belangrijk zijn, hoewel dit ook angst zou kunnen verhogen. Buiten sporten was als enige behoefte gerelateerd aan een afname in compliance (-0.08, -0.07).	Acceptatie van hypothetisch gedrag, alleen (zwakke) correlaties
Okuhara, T., et al. (2020). Examining persuasive message type to encourage staying at home during the covid-19 pandemic and social lockdown: A randomized controlled study in Japan.	Very Low	0	n= 1980 participants from survey company in Japan	Japan	Het bericht van de arts vergrootte vooral de intentie om thuis te blijven in gebieden met veel besmettingen (stijging intentie 0.34 (schaal 1-6)). In Japan hebben aanbevelingen van een arts een grote impact door overblijfselen van het paternalisme in de patiënt-arts relatie.	Geen determinanten, geen vergelijkbare cultuur (maar wel experiment met randomizatie, grote steekproef)
Plohl, N. and B. Musil (2020). "Modeling compliance with COVID-19 prevention guidelines: the critical role of trust in science."	Moderate	In participant selection	617 deelnemers uit verschillende landen. Final sample: 525. 44.0% of the participants were aged between 29 and 49 years, 44.0% between 18 and 28 years and 8.0% of the participants were older than 50 years.	International: The majority in North America (48.3%), followed by participants in Europe or transcontinental countries with territory in both Europe and Asia (38.1%) and Australia or New Zealand (1.5%).	Hoog COVID risico perceptie (0.35) en vertrouwen in de wetenschap (0.26) voorspelden beide, onafhankelijk, compliance aan COVID preventie richtlijnen. De andere variabelen (political conservatism (-), religious orthodoxy (-), conspiracy ideation (-) and intellectual curiosity (+)) hadden geen direct effect op compliance, maar wel indirect door het vertrouwen in de wetenschap.	Grote sample, medium effect size, deelnemers meerdere landen, compliance meerdere richtlijnen waaronder isolatie
Rubin, G. J., Smith, L. E., Melendez-Torres, G. J., & Yardley, L. (2020). Improving adherence to 'test, trace and isolate'. Journal of the Royal Society of Medicine. 113(9): 335-338.	0	0	Het betreft data uit verschillende landen, veel uit UK, maar ook aantal sertal reviews met meerdere studies.	Het betreft data uit verschillende landen, veel uit UK, maar ook aantal reviews met meerdere studies.	Wat betreft [illegible] bij klachten, is hun analyse over het rapporteren van symptomen interessant. [illegible] Wat betreft isolatie: de onderzoekers benadrukken dat het veel ongemakken veroorzaakt [illegible]	0
Smith, L. E., Amlôt, R., Lambert, H., Oliver, I., Robin, C., Yardley, L., & Rubin, G. J. (2020). Factors associated with adherence to self-isolation and lockdown measures in the UK: a cross-sectional survey. medRxiv.	Moderate	In participant selection	UK, volwassenen, 2240 ouder dan 18 jaar, representatieve steekproef. Hiervan rapporteerden 217 deelnemers dat ze symptomen in hun huishouden waren. 163 wel naar buiten, 54 niet, deze worden vergeleken	UK in begin mei 2020	9.7% (n=217) van de steekproef had zelf of een huishoud lid met hoest of koorts/hoge temp i week voor deelname. 75.1% van mensen met covid-19 symptomen in huishouden waren hun huis uitgegaan in de 24uur voor vragenlijst. [illegible] Onderzoekers raden aan: communicatie over welke stappen genomen moeten worden als er symptomen zijn of als je in contact bent geweest met een besmet persoon. Ook het gebruik van vrijwilligersnetwerken om mensen in isolatie te ondersteunen kan de naleving mogelijk bevorderen.	Self-report van gedrag, UK, brede CI door adjustments, specifiek huishouden met klachten, maar 54 mensen gingen in isolatie (grote steekproef, broadly representative maar voor weg minder. indirectness, imprecision door kleine steekproef. Ik twijfel of dit wel toch LOW moet zijn, door de kleine steekproef en observationele opzet)
Smith, L. E., Potts, H. W., Amlot, R., Fear, N. T., Michie, S., & Rubin, J. (2020). Adherence to the test, trace and isolate system: results from a time series of 21 nationally representative surveys in the UK (the COVID-19 Rapid Survey of Adherence to Interventions and Responses [CORSAIR] study).	High	In participant selection	42,127 responses from 31,787 participants, tussen januari - juli 2020. Self-isolate after symptoms (n= 1939). Groepen: not isolate (1587) vs isolate (352)	UK	De onderzoekers concludeerden dat zelfgerapporteerde naleving van testen, traceren en isoleren laag is (zelfgerapporteerde naleving van isoleren was 18.2%, stabiel over tijd), terwijl de intentie om dit te doen hoger ligt (70%) met kleine afname over tijd. [illegible] In het algemeen, voor alle uitkomsten, hing niet-naleving samen met man zijn, jongere leeftijd, een afhankelijk kind in het huishouden hebben, lagere sociaal economische status, het lastiger hebben tijdens de pandemie en in een belangrijke sector werken. Praktische hulp en financiële vergoedingen zullen, verwachten zij, de naleving vergroten.	Isolatie na klachten uit grote sample, self-report gedrag, UK, grote OR, vergelijken groepen verschillende grootte (indirectness want zelfgerapporteerde naleving of intentie tot naleving. MODERATE door deze imprecision en door limitations to study design: crosssectional).
Stapleton, Choosing not to follow rules that will reduce the spread of COVID-19. 2020	0	0	0	nvt	rule-givers should attend to their credibility, authority and ability to mediate consequences, rule plausibility, establishing adequate motivative augmental control, whether the behavior specified in the rule opposes habits, and whether the message incites counter-compliance.	0
Steens, "Poor self-reported adherence to COVID-19 related quarantine/isolation requests, Norway, April to July 2020."	Moderate	In measurement of predic/outcome	n = 1704 in tenminste 1 wave meegedaan	Noorwegen	25% van de deelnemers ontving een verzoek tot quarantaine; 42% hiervan hebben zich hier minstens 1 dag aan gehouden, terwijl 63% dit nooit deed. De naleving aan quarantaine en isolatie regels is laag in Noorwegen, met name in de periode na de eerste infectie piek en de versoepelingen in fysieke afstand houden. Adherence voor hoger in groep met symptomen (71%, 63-79) compared with those without symptoms (28%, 23-34). De afname in naleving over tijd was vooral onder personen zonder symptomen en personen van 50 jaar en ouder (geen afname in 18-29 jaar). Naleving was hoger bij personen in de leeftijd van 18-29 jaar (72%). De hoogste leeftijdsgroep (70-89 jaar) had de laagste naleving (30%). Deze studie kan naleving overschatten, omdat één dag in isolatie al voldoet aan deze definitie.	Adherent bij al 1 dag in isolatie, self report gedrag, (grote) verschillen in percentages (maar met smalle CI, door grote N. Hier ook laag, want door observationeel is het al 1 level lager. Dan komt er selfrapportage bij, enkel percentages in uitkomstmaat, selection bias zou ik dan al gauw naar low gaan)
Wolff, W., et al. (2020). "High boredom proneness and low trait self-control impair adherence to social distancing guidelines during the COVID-19 pandemic."	High	Geen	n = 855 US burgers, 38% uit NL, 86% 13 jaar lange opleiding	USA	The difficulty of adhering to social distancing guidelines was particularly high among boredom prone individuals with low self-control. More boredom trait was associated with less adherence to social distancing guidelines, b = −0.12, 95% CI [−0.18, −0.05], whereas higher self-control was associated with more adherence, b = 0.17, 95% CI [0.08, 0.26]. the negative association between difficulty and adherence was reduced for higher values of trait self-control. More boredom prone personen vonden het moeilijker om aan de richtlijnen te houden, b=0.58, [0.51, 0.66]. Our results suggest that self-control not only improves adherence but also helps in dealing with these difficulties (moeite door boredom). Thus, interventions that are aimed at increasing trait self-control might help people deal with the difficulties they face when adhering to social distancing. The effects of boredom on adherence to social distancing measures were mediated by the experienced difficulty of adherence, whereas self-control directly affected adherence and also moderated the effect of difficulty on adherence	Data beschikbaar, grote sample, staying at home los van isolatie/quarantaine, self-report gedrag, gedetailleerde analyse incl med/moderatie
Al-Hasan, A., et al. (2020). "Threat, coping and social distance adherence for COVID-19: Cross-continental comparison using online cross-sectional survey data."	Moderate	In measurement of predic/outcome	n = 413 = 162 US, 185 Kuwait, 71 SK	US, Kuwait, South Korea	Threat appraisal (0.215, ns in kuwait), coping appraisal (0.531), knowledge (0.061, ns in SK) gerelateerd aan betere adherence.	Comply with SD measures (3 items: I will comply, effective, enforcement), 3 landen, small/medium effect size
Kowalski, J., et al. (2020). "Adherence to safety and self-isolation guidelines, conspiracy and paranoia-like beliefs during COVID-19 pandemic in Poland - associations and moderators."	Moderate	Due to confounding	1: n=507, 2: 840	Polen	Study1: correlaties: "I try not to leave my house unless it's absolutely necessary": corona gerelateerde angst [illegible] conspiracy beliefs [illegible] Green Paranoid Thoughts Scale-Revised [illegible] internal motivation for adherence [illegible] protect my and/or others health") 0.45**, trust in government 0.2** [illegible] trust in media (ander model) 0.57**, conspir*trust 0.026**. Internal motivation to isolation 3.5** (ander model), conspiracy*internal 0.015*	2 grote samples met aselfde uitkomstmaat, SD (waaronder try not to leave home) dus niet echt quarantaine, small to medium effect sizes
Oliver, N., et al. (2020). "Assessing the impact of the COVID-19 pandemic in Spain: Large-scale, online, self-reported population survey." Journal of medical internet research 22(9).	Moderate	In selection of reported result	n = 141865	Spanje	Q21 (n=141,919) aimed to evaluate the ability of respondents to isolate themselves were they to be diagnosed with COVID-19. This is an important question given the relevance of implementing effective quarantine measures. Whereas 72.3% of respondents reported having the ability to properly isolate themselves, a nonnegligible 27.7% of respondents acknowledged not having the necessary resources to implement a proper quarantine. In terms of age, 31.9% of respondents younger than 50 years reported not having the appropriate quarantine resources versus 21.6% of those older than 50 years. This might be due to the presence of other adults or children in the home. Indeed, 90.7% of respondents living alone [illegible] reported being able to self-isolate versus 68.6% of those living with other people [illegible], and only 5.7% of respondents younger than 50 years reported living alone when compared to 18.3% of adults 50 years and older. Moreover, when we looked at the impact of having children in the home, we observed that 41.1% of adults with children in the home (n=28,159) responded not being able to properly isolate versus 28.0% of adults without children in the home (n=63,659, P<.001). Among those living with older adults (n=15,136), 10.8% reported not having appropriate quarantine infrastructure at home.	Alleen naar percentages gekeken, ability to isolate when diagnosed, zeer grote sample, Spanje (selectie bias via social media, smalle CI van 0.843 rond %. Twijfel tussen low en moderate, want wel erg grote N)
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QoE

Quality of evidence is a continuum; any discrete categorisation involves some degree of arbitrariness.

While factors influencing the quality of evidence are additive – such that the reduction or increase in each individual factor is added together with the other factors to reduce or increase the quality of evidence for an outcome – grading the quality of evidence involves judgements which are not exclusive. Therefore, GRADE is not a quantitative system for grading the quality of evidence. Each factor for downgrading or upgrading reflects not discrete categories but a continuum within each category and among the categories. When the body of evidence is intermediate with respect to a particular factor, the decision about whether a study falls above or below the threshold for up- or downgrading the quality (by one or more factors) **depends on judgment.**

Table 5.1: Quality of Evidence Grades

Grade	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Table 5.2: Factors that can reduce the quality of the evidence

Factor	Consequence	toelichting
Limitations in study design or execution (risk of bias)	↓ 1 or 2 levels	zie linksonder Study Design en volgend tabblad voor Risk of Bias.
Inconsistency of results	↓ 1 or 2 levels	Niet toegelichte heterogeniteit van resultaten (vooral bij syst reviews, als er veel verschillende bevindingen zijn, gemengd bewijs).
Indirectness of evidence	↓ 1 or 2 levels	Bijvoorbeeld gemeten met een surrogaat maat (niet gedrag, maar intentie of zelfgerapporteerd gedrag) Of nt andere interventie (niet thuisblijven bij klachten maar thuisbiljven in het algemeen).
Imprecision	↓ 1 or 2 levels	Kleine steekproef of kleine hoeveelheid events, dus wijd confidence interval
Publication bias	↓ 1 or 2 levels	resultaten niet zijn gepubliceerd en dus niet zijn opgenomen. Vooral voor syst reviews relevante factor. Bij losse studies gaat het om reporting bias (zijn er

Table 5.3: Factors that can increase the quality of the evidence

Factor	Consequence	
Large magnitude of effect	↑ 1 or 2 levels	Als er een groot effect wordt gevonden. For simple regression β is like R. Thus I would use R rules of thumb…I use the follwoing with my Psychology students: $\beta < 0.1$ - Small effect size $\beta \in [0.1; 0.5[$ - Medium effect size $\beta \geq 0.5$ - Large effect size. For multiple regression these rules are not that straightfoward, but for Social Sciences they seem to hold (also following Cohen's d suggestions).
All plausible confounding would reduce the demonstrated effect or increase the effect if no effect was observed	↑ 1 level	Is er gecontroleerd voor plausibele confounders?
Dose-response gradient	↑ 1 level	

Study Design

Study design is critical to judgments about the quality of evidence.

For recommendations regarding management strategies – as opposed to establishing prognosis or the accuracy of diagnostic tests –

randomized trials provide, in general, far stronger evidence than observational studies, and rigorous observational studies provide stronger evidence than uncontrolled case series.

In the GRADE approach to quality of evidence:

randomized trials without important limitations provide high quality evidence

observational studies without special strengths or important limitations provide low quality evidence

Limitations or special strengths can, however, modify the quality of the evidence of both randomized trials and observational studies.

Note:

Non-randomised experimental trials (quasi-RCT) without important limitations also provide high quality evidence, but will automatically be downgraded for limitations in design (risk of bias) – such as lack of concealment of allocation and tie with a provider (e.g. chart number).

Case series and case reports are observational studies that investigate only patients exposed to the intervention. Source of control group results is implicit or unclear, thus, they will usually warrant downgrading from low to very low quality evidence.

Expert opinion is not a category of quality of evidence. Expert opinion represents an interpretation of evidence in the context of experts' experiences and knowledge. Experts may have opinion about evidence that may be based on interpretation of studies ranging from uncontrolled case series (e.g. observations in expert's own practice) to randomized trials and systematic reviews known to the expert. It is important to describe what type of evidence (whether published or unpublished) is being used as the basis for interpretation.

VOOR REVIEWS

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QoE

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Bias

Table 5.4: Study limitations in randomized controlled trials

	Explanation
Lack of allocation concealment	Those enrolling patients are aware of the group (or period in a crossover trial) to which the next enrolled patient will be allocated (a major problem in "pseudo" or "quasi" randomized trials with allocation by day of week, birth date, chart number, etc.).
Lack of blinding	Patient, caregivers, those recording outcomes, those adjudicating outcomes, or data analysts are aware of the arm to which patients are allocated (or the medication currently being received in a crossover trial).
Incomplete accounting of patients and outcome events	Loss to follow-up and failure to adhere to the intention-to-treat principle in superiority trials; or in noninferiority trials, loss to follow-up, and failure to conduct both analyses considering only those who adhered to treatment, and all patients for whom outcome data are available. The significance of particular rates of loss to follow-up, however, varies widely and is dependent on the relation between loss to follow-up and number of events. The higher the proportion lost to follow-up in relation to intervention and control group event rates, and differences between intervention and control groups, the greater the threat of bias.
Selective outcome reporting	Incomplete or absent reporting of some outcomes and not others on the basis of the results.
Other limitations	Stopping trial early for benefit. Substantial overestimates are likely in trials with fewer than 500 events and that large overestimates are likely in trials with fewer than 200 events. Empirical evidence suggests that formal stopping rules do not reduce this bias. Use of unvalidated outcome measures (e.g. patient-reported outcomes) Carryover effects in crossover trial Recruitment bias in cluster-randomized trials

RISK OF BIAS = Limitations in the study design and execution may bias the estimates of the treatment effect. Ourconfidence in the estimate of the effect and in the followin grecommendation decreases if studies suffer from major limitations. The more serious the limitations are, the more likely it is that the quality of evidence will be downgraded.Numerous tools exist to evaluate the risk of bias in randomizedtrials and observational studies

Risk of bias	Uitleg
None	
Due to confounding	Baseline confounding occurs when one or more prognostic variables (factors that predict the outcome of interest) also predicts the intervention received at baseline. ROBINS-I can also address time-varying confounding, which occurs when individuals switch between the interventions being compared and when post-baseline prognostic factors affect the intervention received after baseline.
In participant selection	When exclusion of some eligible participants, or the initial follow-up time of some participants, or some outcome events is related to both intervention and outcome, there will be an association between interventions and outcome even if the effects of the interventions are identical. This form of selection bias is distinct from confounding—A specific example is bias due to the inclusion of prevalent users, rather than new users, of an intervention
Due to missing data	Bias that arises when later follow up is missing for individuals initially included and followed (such as differential loss to follow-up that is affected by prognostic factors); bias due to exclusion of individuals with missing information about intervention status or other variables such as confounders.
In measurement of predic/outcome	Bias introduced by either differential or non-differential errors in measurement of outcome data. Such bias can arise when outcome assessors are aware of intervention status, if different methods are used to assess outcomes in different intervention groups, or if measurement errors are related to intervention status or effects
In selection of reported result	Selective reporting of results in a way that depends on the findings and prevents the estimate from being included in a meta-analysis (or other synthesis)
In misclassification of intervention (randomization)	Bias introduced by either differential or non-differential misclassification of intervention status Non-differential misclassification is unrelated to the outcome and will usually bias the estimated effect of intervention towards the null Differential misclassification occurs when misclassification of intervention status is related to the outcome or the risk of the outcome, and is likely to lead to bias
Due to deviation from intended intervention	Bias that arises when there are systematic differences between experimental intervention and comparator groups in the care provided, which represent a deviation from the intended intervention(s)

Tussen studies

- Comparison: blij interventie studies, goed bekijken wat de comparison conditie is en of studies vergelijkbaar zijn met elkaar.
- Outcomes: zijn gebruikte uitkomstmaten vergelijkbaar? (gaat het om intentie van gedrag, zelfgrapporteerde naleving, daadwerkelijke naleving, etc)

Table 5.5: Study limitations in

	Explanation
Failure to develop and apply appropriate eligibility criteria (inclusion of control population)	• Under- or over-matching in case-control studies • Selection of exposed and unexposed in cohort studies from different populations
Flawed measurement of both exposure and outcome	• Differences in measurement of exposure (e.g. recall bias in case-control studies) • Differential surveillance for outcome in exposed and unexposed in cohort studies
Failure to adequately control confounding	• Failure of accurate measurement of all known prognostic factors • Failure to match for prognostic factors and/or adjustment in statistical analysis
Incomplete or inadequately short follow-up	Especially within prospective cohort studies, both groups should be followed for the same amount of time.

Bias

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2	**1.Were the criteria for inclusion in the sample clearly defined?**	The authors should provide clear inclusion and exclusion criteria that they developed prior to recruitment of the study participants.
3	**2.Were the study subjects and the setting described in detail?**	The study sample should be described in sufficient detail so that other researchers can determine if it is comparable to the population of interest to them. The authors should provide a clear description of the population from which the study participants were selected or recruited, including demographics, location, and time period.
4	**3.Was the exposure measured in a valid and reliable way?**	The study should clearly describe the method of measurement of exposure. Assessing validity requires that a 'gold standard' is available to which the measure can be compared. The validity of exposure measurement usually relates to whether a current measure is appropriate or whether a measure of past exposure is needed. Reliability refers to the processes included in an epidemiological study to check repeatability of measurements of the exposures. These usually include intra-observer reliability and inter-observer reliability.
5	**4.Were objective, standard criteria used for measurement of the condition?**	It is useful to determine if patients were included in the study based on either a specified diagnosis or definition. This is more likely to decrease the risk of bias. Characteristics are another useful approach to matching groups, and studies that did not use specified diagnostic methods or definitions should provide evidence on matching by key characteristics.
6	**5.Were confounding factors identified?**	Typical confounders include baseline characteristics, prognostic factors, or concomitant exposures (e.g. smoking). A confounder is a difference between the comparison groups and it influences the direction of the study results. A high quality study at the level of cohort design will identify thepotential confounders and measure them (where possible). This is difficult for studies where behavioral, attitudinal or lifestyle factors may impact on the results.
7	**6.Were strategies to deal with confounding factors stated?**	Strategies to deal with effects of confounding factors may be dealt within the study design or in data analysis. By matching or stratifying sampling of participants, effects of confounding factors can be adjusted for. When dealing with adjustment in data analysis, assess the statistics used in the study. Most will be some form of multivariate regression analysis to account for the confounding factors measured
8	**7.Were the outcomes measured in a valid and reliable way?**	Importantly, determine if the measurement tools used were validated instruments as this has a significant impact on outcome assessment validity.Having established the objectivity of the outcome measurement (e.g. lung cancer)instrument, it's important to establish how the measurement was conducted. Were those involved in collecting data trained or educated in the use of the instrument/s? (e.g. radiographers). If there was more than one data collector, were they similar in terms of level of education, clinical or research experience, or level of responsibility in the piece of research being appraised?
9	**8.Was appropriate statistical analysis used?**	As with any consideration of statistical analysis, consideration should be given to whether there was a more appropriate alternate statistical method that could have been used. The methods section should be detailed enough for reviewers to identify which analytical techniques were used (in particular, regression or stratification) and how specific confounders were measured.For studies utilizing regression analysis, it is useful to identify if the study identified which variables were included and how they related to the outcome. If stratification was the analytical approach used,were the strata of analysis defined by the specified variables? Additionally, it is also important to assess the appropriateness of the analytical strategy in terms of the assumptions associated with the approach as differing methods of analysis are basedon differing assumptions about the data and how it will respond
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Sheet1

	A	B	C	D	E	F	G	H	I	J
1	**Land/ culturele context (vergelijkbaar met NL?)**				VS	3				
2	**UK**				UK	4				
3	**VS**				Finland	1				
4	**Polen**				China	1				
5	**Finland**				Italië	1				
6	**USA**				Japan	1				
7	**China**				Internationaal	2				
8	**UK, Ireland. In Apri 2020.**				Noorwegen	1				
9	**Italië**				Polen	1				
10	Japan				Israel	1				
11	International: The majority currently lives in North America (48.1%), followed by participants in Europe or transcontinental countries with territory in both Europe and Asia (38.5%) and Australia or New Zealand (5.5%).					16			Als zij waren getraceerd door de nationale gezondheidsdienst omdat zij in contact waren geweest met iemand die COVID-19 bleek te hebben, gaf 10.9% aan dat zij gedurende twee weken hun huis niet uit waren geweest. De enige factor die sterk samenhing met niet-naleving was het hebben van een afhankelijk kind in het huishouden. Zelf gegeven redenen om de quarantaine niet na te leven waren: denken dat het niet nodig is om weg te blijven van mensen buiten je eigen huishouden als je niet kan wegblijven van mensen in je eigen huishouden (14.3%), geen symptomen ontwikkelen (11.9%), om boodschappen te doen (10.9%), omdat je net klaar was met een andere quarantaine periode (10.9%). In het algemeen, voor alle uitkomsten, hing niet-naleving samen met man zijn, jongere leeftijd, een afhankelijk kind in het huishouden hebben, lagere socio economische status, het lastiger hebben tijdens de pandemie en in een belangrijke sector werken. Praktische hulp en financiële vergoedingen zullen, verwachten zij, de naleving verhogen.	Factoren geasscoeerd met alle nalevings uitkomsten: lage naleving was geassocieerd met man zijn, jonger zijn, een afhankelijk kind hebben in het huishouden, het moeilijker hebben, lagere socio economische status, minder geinformeerd zijn over covid 19 en informatie over voorkomen verspreiding virus (zoals key symptomen herkennen, niet overheidsbegeleiding weten als je symptomen ontwikkelt, en het niet eens zijn met kans op besmetting als geen symptomen.
12	**Het betreft data uit verschillende landen, veel uit UK, maar ook aantal reviews met meerdere studies.**									
13	**UK in begin mei 2020**									
14	**UK**									
15	nvt									
16	**Noorwegen**									
17	**USA.**									
18	Israel									