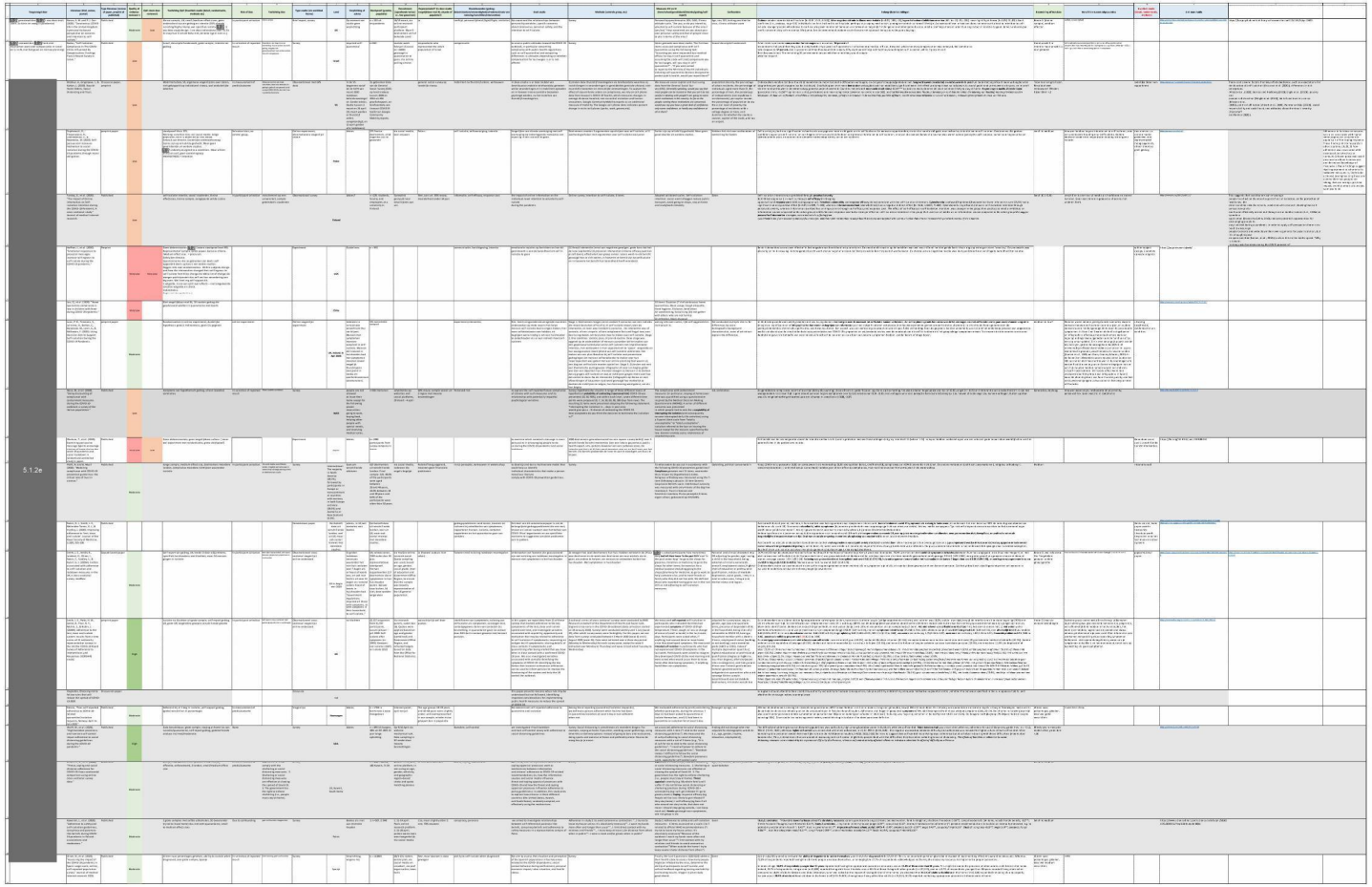
Studies leeg

	G	H	I	J	K	L	M	N	O
1	**Risk of bias (study limitations: design, inclusion and sample info, measurement, confounding, folluw-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?)**	**Sleutelwoorden (gedrag: determinanten/omstandigheden/redenen/mate van naleving/verschillen/interventies)**

Studies leeg

	P	Q	R	S	T	U	V	W
1	**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**



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Samenvatting

Studie	Cert	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 self isolatie (b= 0.15 [.0.01, 0.001]). Meer negative attitude to illness meer isolatie (b=0.23, [.001, .01]). [illegible] behavioural inhibitions meer iso (BIS; b=.2 [-.01 -.001]), meer fight flight freeze (b=0.23 [.01, .03]). Goal-conflicted (i.e., anxious, high 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 (53% already isolating/highly likely), wel specifiek isolatie [redacted] zou door study design -1 en door indirectness ook -1). Ik kijk nu naar CI en de Beta niet, de betrouwbaarheid [illegible]
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=503	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 predictor/outcome	De gebruiken data van de General Social Survey (GSS) op land niveau tussen 2000 en 2014 uit 436 graafschappen, en Interfonds data 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 (-0.128*** 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, wel onduidelijke tabelen
Drążkowski, D., Trepanowski, R., Chwiłkowski, F., & Majewski, 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, sterk via FB geworven	Polen	Self overtuiging had een significante invloed op de aangegeven morele obligatie om te zelf isoleren die mensen rapporteerden, en via die morele obligatie een invloed op intentie om te zelf isoleren. Deelnemers die grotere voordelen zagen van zelf isolatie, en een hogere ernst van covid-19, hadden een grotere intentie om te zelf isoleren, [illegible] verplichting om te zelf isoleren.	steekproef klein 375. Warning, selection bias via social media. Jonge populatie, helft is onder de 40. 63% vrouw. Gebruik van theorie. Duidelijke onderzoeksvraag. Scales zijn op reliability getoetst. Maar geen [illegible] [redacted] Randomly assigned to a condition. Maar bijna 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 (0.30 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=0.27, t=2.020, P=.003), whereas information overload (overwhelmed) had a negative indirect effect (b=-0.30, t=3.086, 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=113) 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 reassuring and hopeful messages, and those with no 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 [illegible] 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] [illegible] met 955. Representatieve sample. Gross power. Exclusie criteria. Medium effect size. + precision. Gebruikte theorie. Operationaliseren die ze gebruiken zijn deels zelf opgesteld deels op basis van eerdere studies. Zeggen niks over randomization. Within subjects design. and how the intervention changed their willingness to self-isolate from 0 (no change) to 100 (a lot of change) De vragen participanten dus zelf om hun verandering aan te geven. [illegible] zelf rapport dit. 1 volgorde, risico van spill over effects – niet [illegible] conditie volgorde als check. Indirectness. Begin van de epidemie.)
Luo, 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 worden 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, Ireland. In April 2020.	In dit onlinexperiment werd gevonden dat beslissingsbomen [illegible] 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) [illegible]	Randomisatie in online experiment, duidelijke hypothesis getest. Indirectness, geen CI 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=211 Italianen	Italië	De gerapporteerde compliance neemt af over tijd (delay discounting). Deze afname is groter bij een lage kans op besmetting. [illegible] (r=0.15), angst (r=0.29) [illegible]	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 [illegible]	Geen determinanten, geen vergelijkbare cultuur (maar wel experiment met randomisatie, 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. 48.0% of the participants were aged between 20 and 40 years, 44.0% between 40 and 59 years and 8.0% of the participants were older than 59 years.	International. The majority in North America (49.5%), followed by participants in Europe or transcontinental countries with territory in both Europe and Asia (30.5%) and Australia or New Zealand (5.5%).	Hoog COVID risico perceptie (0.35) en vertrouwen in de wetenschap (0.26) voorspellen 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.	Jonge sample, medium effect size, deelnemers verschillende 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 reviews met meerdere studies.	Het betreft data uit verschillende landen, veel uit UK maar ook aantal reviews met meerdere studies.	Wat betreft thuisblijven bij klachten, is hun analyse over het rapporteren van symptomen interessant: [illegible] Wat betreft isolatie: de onderzoekers benadrukken dat het veel nagemaakt? [illegible]	0
Smith, L. E., Amlôt, R., Lambert, H., Oliver, I., Robin, C., Yardley, L., & Rubin, G. J. (2020a). 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 16 jaar, representatieve steekproef. Hiervan rapporteerden 217 deelnemers dat er symptomen in hun huishouden waren. 163 wel niet buiten, 54 niet, deze worden vergeleken	UK in begin mei 2020	9.7% (n=217) van de steekproef rapporteerde in hun huishouden met hoest of koorts/hoge temp in week voor deelname. [illegible]	Self report van gedrag, UK, brede CI door adjustments, specifiek huishouden met klachten, maar 54 mensen gingen in isolatie
Smith, L. E., Potts, H. W. W., Amlôt, R., Fear, N. T., Michie, S., & Rubin, J. (2020b). 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-isolatie after symptoms [illegible]	UK	De onderzoekers concluderen dat zelfgerapporteerde naleving van testen, traceren en isoleren laag is (zelfgerapporteerde naleving van isoleren was 18.2%, stabiel over tijd) [illegible]	Isolatie na klachten, erg grote sample, self-report gedrag, UK, grote OR, vergelijken groepen verschillende grootte
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 mete out consequences, rule plausibility, establishing adequate motivation augmental control, whether the behavior specified in the rule opposes habits, and whether the message incites counterpliance.	0
Steens, "Poor self-reported adherence to COVID-19-related quarantine/isolation requests, Norway, April to July 2020."	Moderate	In measurement of predictor/outcome	n = 1704 [illegible] 1 wave meegedaan	Noorwegen	25% van de deelnemers ontving een verzoek tot quarantaine; 42% hiervan hebben zich hier minstens 1 dag aan gehouden, terwijl 10% dit nooit deed. De naleving van quarantaine en isolatie regels is laag in Noorwegen, met name in de periode na de eerste infectie piek en de versoepelingen in lockdown. Adherence veel 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 [illegible] Naleving was hoger bij personen in de leeftijd van 18-29 jaar (12%). De hoogste leeftijdsgroep (70-80 jaar) had de laagste naleving (36%). Deze studie kan naleving overschatten, omdat één dag in isolatie al voldeed aan deze definitie.	Adherent bij al 1 dag in isolatie, self report gedrag, (grote) verschillen in percentages
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	None	n = 805 US burgers, 38% uit NY, 80% 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 = -0.32, 95% CI [-0.10, -0.05], whereas higher self-control was associated with more adherence, b = 0.17, 95% CI [0.08, 0.25]. 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, [0.51,0.65]. Our results suggest that self-control not only improves adherence but also helps in dealing with these difficulties [illegible]. 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, [illegible] 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 predictor/outcome	n = 418 = 182 US, 185 Kuwait, 71 SK	US, Kuwait, South Korea	Threat appraisal (0.235, ns in kuwait), coping appraisal (0.511), 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	[illegible]	2 grote samples met selfde uitkomst, [illegible] 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 = 141965	Spanje	Q9 (n=141,813) 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 73.3% 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, 34.9% of respondents younger than 50 years reported not having the appropriate quarantine resources versus 21.0% of those older than 50 years. This might be due to the presence of other adults or children in the home. Indeed, 96.7% of respondents living alone (n=13,820) reported being able to self-isolate versus 68.6% of those living with other people (n=127,493), and only 5.7% of respondents younger than 50 years reported living alone when compared to 16.3% of adults 50 years and older. Moreover, when we looked at the impact of having children in the home, we observed that 41.3% of adults with children in the home (n=18,330) reported not being able to properly isolate versus 29.0% of adults without children in the home (n=67,059, P<.001). Among those living with older adults (n=15,124), 10.8% reported not having appropriate quarantine infrastructure at home.	Alleen maar percentages gegeven, ability to isolate when diagnosed, grote sample, Spanje
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0

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	Lastig te achterhalen, gaat erom in hoevrre er studies met negatieve of andere 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 resultaten weggelaten die wel relevant zijn, nulbevindingen bijv)

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: β< 0.1 - Small effect size β∈[0.1; 0.5[- Medium effect size β≥ 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.

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: bij 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 observational studies

	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.

	M	N	O	P
1			5.1.2h	
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									