Studies leeg

	A	B	C	D	E	F	G	H	I
1	**Toegevoegd door**	**Literatuur (titel, auteur, jaartal)**	**Type literatuur (review of paper, preprint of published)**	**Quality of evidence**	**QoE check**	**Toelichting QoE 5.1.2e indirectness, inconsistency, indirectness, imprecision, effect size, right confounders, dose response)**	**Risk of bias (study limitations: design, inclusion and sample info, measurement, confounding, folluw-up)**	**Toelichting bias**	**Een zo kort mogelijke samenvatting voor in het document**
2	5.1.2e	Mask-Wearing Increased After a Government Recommendation: A Natural Experiment in the U.S. During the COVID-19 Pandemic	peer reviewed single study observationeel	moderate		5.1.2e geen gevalideerde maten, self reports. Groot N verschil in voor- na meting	participant selection	onderdeel van bestaand panel	meer kopen en dragen van mondkapjes na aanbeveling
3	5.1.2e								

Studies leeg

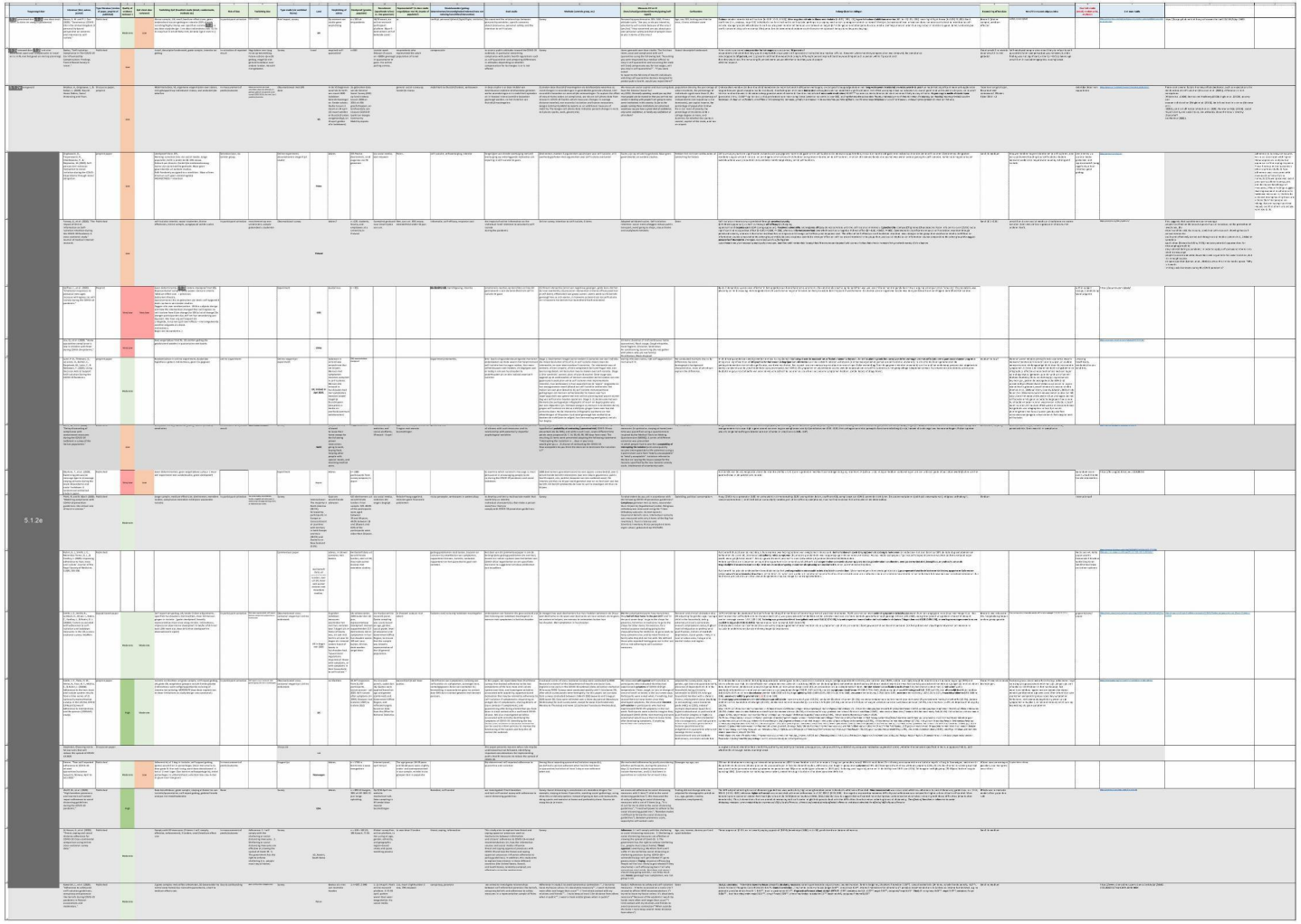
	A	J	K	L	M	N	O
1	**Toegevoegd door**	**Type studie (zie werkblad hierna)**	**Land**	**Verplichting of advies**	**Steekproef (grootte, populatie)**	**Recruitment (opvallende in/excl cr., hoe geworven)**	**Representatief? (is deze studie vergelijkbaar met NL situatie of populatie?)**
2	5.1.2e		VS	advies	3933		Westers
3	5.1.2e						

Studies leeg

	A	P	Q	R	S	T	U	V
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**
2	5.1.2e	The study found significant increases in reported mask wearing (+12 percentage points) and mask buying (+7 points).	effect aanbevling op mondkapjes kopen en dragen bekijken					
3	5.1.2e							

Studies leeg

	A	W	X
1	**Toegevoegd door**	**Verschillen tussen subpopulaties**	**Link naar studie**
2	5.1.2e		
3	5.1.2e		



Toegevoegd door	Literatuur (titel, auteur, journal)	Type literatuur (review of paper, preprint of published)	Quality of evidence reviewer 1	QoE check door reviewer2	Toelichting QoE (Kwaliteit studie (detail, randomisatie, methode etc)	Risk of Bias	Toelichting bias	Type studie (zie werkblad Naming)	Land	Verplichting of advies	Steekproef (grootte, populatie)	Recruitment	Representatief?	Studiefactoren	Doel studie	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
5.1.2e	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 [illegible]	Published	Moderate	Moderate	[illegible]	[illegible]	[illegible]	Survey	Spanje	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	We aim to assess the situation and perception of the Spanish population in four key areas related to the COVID-19 pandemic: social contact behavior during confinement, personal economic impact, labor situation, and health status.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Studie	Kwal.	Risk of bias	Sample	Land	Bevindingen	Toelichting
[illegible]	Moderate	In participant selection	n = 202 UK respondents	UK	[illegible]	[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	[illegible]	Israel	[illegible]	[illegible]
Brodeur, A., [illegible] (2020). Stay-At-Home Orders, Social Distancing and Trust.	Low	In measurement of predictor/outcome	[illegible]	VS	[illegible]	[illegible]
[illegible]	Low	Selection bias, no control group.	[illegible]	Polen	[illegible]	[illegible]
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	[illegible] students, faculty, and employees at a university in Finland	Finland	[illegible]	[illegible]
[illegible]	Very Low	0	[illegible]	USA	[illegible]	[illegible]
[illegible]	Very Low	0	0	China	0	[illegible]
[illegible]	Moderate	online experiment	508, representatief steekproef	UK, Ireland, in April 2020.	[illegible]	[illegible]
[illegible]	Low	In selection of reported result	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Very Low	0	[illegible] participants from survey company in Japan	Japan	[illegible]	[illegible]
Plohl, N. and B. Musil (2020). "Modeling compliance with COVID-19 prevention guidelines: the critical role of trust in science."	Moderate	In participant selection	[illegible]	[illegible]	[illegible]	[illegible]
Rubin, G. J., [illegible] (2020). [illegible] Journal of the Royal Society of Medicine, [illegible]	0	0	[illegible]	[illegible]	[illegible]	0
Smith, L. E., [illegible] (2020). [illegible]	Moderate	In participant selection	[illegible]	UK [illegible]	[illegible]	[illegible]
Smith, L. E., [illegible] (2020). [illegible]	High	In participant selection	[illegible]	UK	[illegible]	[illegible]
Stapleton, [illegible]	0	0	0	nvt	[illegible]	0
Steens, [illegible]	Moderate	In measurement of predictor/outcome	[illegible]	Noorwegen	[illegible]	[illegible]
Wolff, W., et al. (2020). [illegible]	High	None	[illegible]	USA	[illegible]	[illegible]
Al-Hasan, A., et al. (2020). [illegible]	Moderate	In measurement of predictor/outcome	[illegible]	US, Kuwait, South Korea	[illegible]	[illegible]

Studie	GoE	Risk of bias	Sample	Land	Bevindingen	Toelichting
[illegible], 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=[illegible], 2: 840 [?]	Polen	[illegible]	[illegible]
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 = [illegible]	Spanje	[illegible]	[illegible]
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
	0	0	0	0	0	0

QoE

	A	B	C	D	E	F
1		**Oordeel opties (waarin zowel quality of evidence als tabblad hiernaast, Bias, zijn meegenomen)**		**QoE beoordelen. Bij zowel observationeel als RCT -->**	**Table 5.2: Factors that can reduce the quality of the evidence**	
2	**Table 5.1: Quality of Evidence Grades**			Quality of evidence hangt af van volgende factoren, waaronder design (wat je bij Bias bekijkt)	Factor	Consequence
3	Grade	Definition			Limitations in study design or execution (risk of bias)	↓ 1 or 2 levels
4	High	We are very confident that the true effect lies close to that of the estimate of the effect.			Inconsistency of results	↓ 1 or 2 levels
5	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			Indirectness of evidence	↓ 1 or 2 levels
6	Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.			Imprecision	↓ 1 or 2 levels
7	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			Publication bias	↓ 1 or 2 levels
8					**Table 5.3: Factors that can increase the quality of the evidence**	
9		**VOOR REVIEWS, gebruik dit formulier voor een oordeel en sla deze op**			Factor	Consequence
10					Large magnitude of effect	↑ 1 or 2 levels
11		[redacted]			All plausible confounding would reduce the demonstrated effect or increase the effect if no effect was observed	↑ 1 level
12					Dose-response gradient	↑ 1 level
13						
14						
15						

QoE

	G	H	I	J	K	L	M	N	O
1		**Quality of evidence is a continuum; any discrete categorisation involves some degree of arbitrariness.**							
2	**toelichting**	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.**							
3	zie linksonder Study Design en volgend tabblad voor Risk of Bias. Observationeel kan hierdoor eigenlijk niet als HIGH beoordeeld worden.								
4	Niet toegelichte heterogeniteit van resultaten (vooral bij syst reviews, als er veel verschillende bevindingen zijn, gemengd bewijs).								
5	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).	**Study Design**							
6	Kleine steekproef of kleine hoeveelheid events, dus wijd confidence interval	**Study design is critical to judgments about the quality of evidence.** **F**or recommendations regarding management strategies – as opposed to establishing prognosis or the accuracy of diagnostic tests –							
7	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	Randomized trials provide, in general, far stronger evidence than observational studies, and rigorous observational studies provide stronger evidence than uncontrolled case series.							
8									
9		**In the GRADE approach to quality of evidence:** **R**andomized trials without important limitations provide high quality evidence Observational studies without special strengths or important limitations provide low quality evidence							
10	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).	Limitations or special strengths can, however, modify the quality of the evidence of both randomized trials and observational studies. 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).							
11	Is er gecontroleerd voor plausibele confounders?	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.							
12		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							
13									
14		(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							
15		being used as the basis for interpretation.							

Bias

	A	B	C	D	E	F	G	H	I	J	K	L	M
1		**RCT's gebruik deze --> tabel 5.4**			**Table 5.4: Study limitations in randomized controlled trials**								
2	**RISK OF BIAS = Limitations in the study design and execution** may bias the estimates of the treatment effect. Ourconfidence in the									Explanation			
3	**Risk of bias**	**Uitleg**			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.).			
4	**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.			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).			
5	**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			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.			
6	**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.			Selective outcome reporting					Incomplete or absent reporting of some outcomes and not others on the basis of the results.			
7	**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			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			
8	**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)											
9	**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											
10	**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)											
11													
12													
13													
14	**Tussen studies**												
15	- Comparison: bij interventie studies, goed bekijken wat de comparison conditie is en of studies vergelijkbaar zijn met elkaar.												
16	- Outcomes: zijn gebruikte uitkomstmaten vergelijkbaar? (gaat het om intentie van gedrag, zelfgrapporteerde naleving, daadwerkelijke naleving, etc)												
17													
18													
19													
20													
21													
22											**Table 5.5: Study limitations in observational studies**		
23												Explanation	
24											Failure to develop and apply appropriate eligibility criteria (inclusion of control population)	• Under- or over-matching in case-control studies	
25												• Selection of exposed and unexposed in cohort studies from different populations	
26											Flawed measurement of both exposure and outcome	• Differences in measurement of exposure (e.g. recall bias in case-control studies)	
27												• Differential surveillance for outcome in exposed and unexposed in cohort studies	
28											Failure to adequately control confounding	• Failure of accurate measurement of all known prognostic factors	
29												• Failure to match for prognostic factors and/or adjustment in statistical analysis	
30											Incomplete or inadequately short follow-up	Especially within prospective cohort studies, both groups should be followed for the same amount of time.	

Bias

	N	O	P	Q	R	S	T	U	V	W	X	Y
1		**Observationele studies: gebruik deze link. Hieronder ook wat uitleg over factoren, staat ook in link**										
2			5.1.2h									
3		**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.	1								
4		**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.	1								
5		**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.	1								
6		**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.	0								
7		**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.	1								
8		**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	1								
9		**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?	0								
10		**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	1								
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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**				Internat	2				
8	**UK, Ireland. In Apri 2020.**				Noorwe	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					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									