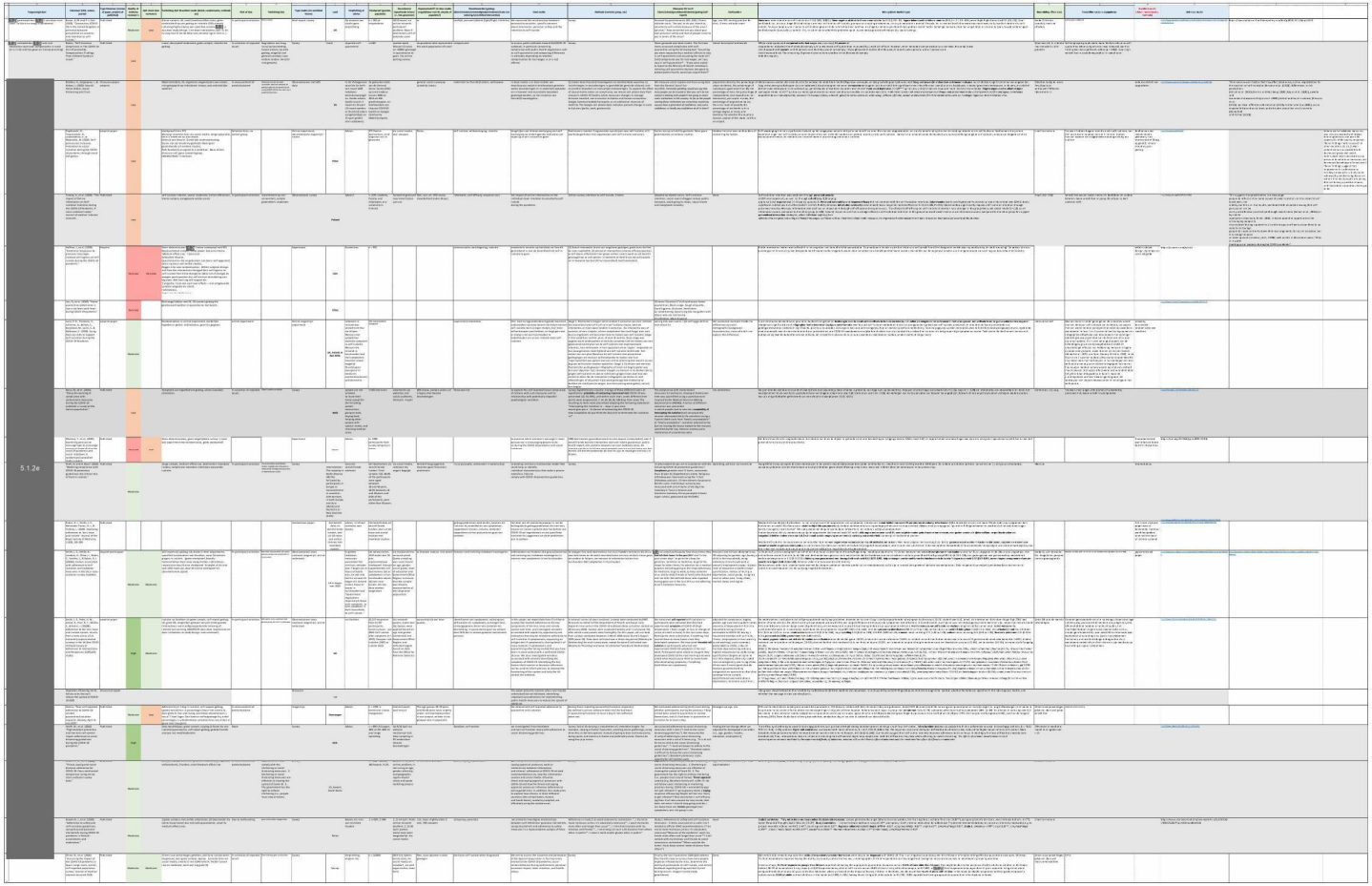
Studies keg

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
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**	**Een zo kort mogelijke samenvatting voor in het document**	**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	S.S.H.	Blackwell, C., Goya-Tocchetto, D., & Sturman, Z. (2017). Nudges in the Restroom: How Hand-Washing Can Be Impacted by Environmental cues.	Published	Moderate		Grote sample, veldexperiment, gedragsmeting (vs. baseline), weinig bekend over populatie, validiteit sensor onbekend	Sample info beperkt, outcome measurements	Niet bekend wat voor individuen onderdeel waren van de studie, enkel geslacht. Hoe valide is de sensor.	Het toepassen van een nudge in toiletruimtes, door middel van pijlen die naar wastafels leiden, laat het handenwassen significant doen toenemen. Het toevoegen van smileys op spiegels boven wastafels als nudge, laat geen significante toename zien.	Veldexperiment	VS	-	19.098 (individuen die gebruik hebben gemaakt van het toilet)	Veldexperiment, dus geen recruimtent	Ja: VS, 55% man (verder weining popiulatie informatie door opzet studie)
3	S.S.H.	Gaube, S., Fischer, P., Windl, V., & Lermer, E. (2020). The effect of persuasive messages on hospital visitors' hand hygiene behavior.	Published	Moderate		Grote sample, veldexperiment, gedragsmeting (vs. baseline), weinig bekend over populatie, validiteit monitoringssysteem onbekend	Sample info beperkt, outcome measurements	Niet bekend wat voor individuen onderdeel waren van de studie. Hoe valide is het elektronisch monitoringssysteem.	Het toepassen van persuasive messages gebaseerd op autoriteit en social-proof, laten een significante toename van handdispenser-gebruik in de lobby van een ziekenhuis zien. Persuasive messages gebaseerd op wederkerigheid, consistentie, eenheid, sympathy en schaarste laten geen significante toename zien.	Veldexperiment	Duitsland	-	246.098 (individuen die de lobby van het ziekenhuis betraden en verlieten)	Veldexperiment, dus geen recruimtent	Ja: Duitsland (verder weinig popiulatie informatie door opzet studie)
4	S.S.H.	Gould, D. J., Moralejo D., Drey, N., Chudleigh, J. H., & Taljaard, M. (2017). Interventions to improve hand hygiene compliance in patient care (Review)	Published	Moderate		Voldoet aan de gehele checklist, enkel geen meta-analyse. Moderate/High wellicht gepast?			Er kunnen geen conclusies worden getrokken over welke strategieën leiden tot klinische verbeteringen van handhygiëne naleving in de patiëntenzorg. Dit is te wijten aan de variabiliteit van de resultaten tussen en binnen de geïncludeerde onderzoeken.	Systematic review	Wereldwijd (Azië, Europa, Amerika, Australië)	-	26 studies	Review: systematic searches, 26 studies	
5	S.S.H.	Mobekk, H., Hessen, D. O., Fagerstrøm, A., & Jacobsen, H. (2020). For Your Eyes Only: A Field Experiment on Nudging Hygienic Behavior.	Published	Low		Vrij kleine sample, veldexperiment, gedragsmeting (vs. baseline), erg beperkte analyses	Sample info beperkt, beperkte analyses (enkel N en %)			Veldexperiment	Noorwegen	-	254 individuele keuzesituaties	Veldexperiment, dus geen recruimtent	Ja: Noorwegen

Studies keg

	A	P	Q	R	S	T	U	V	W	X
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	5.1.1H	Nudge, Handen wassen, Handhygiëne, Veldexperiment	Effectiviteitsmeting van twee verschillende nudges op het bevorderen van handen wassen na toiletgebruik, in een natuurlijke setting.	Veldexperiment in toiletruimtes (College of Charleston Beatty Center), waarbij eerst de baseline is gemeten door middel van een infrarood sensor systeem (meet hoeveel individuen de toiletruimte toetreden en verlaten) en de netto gewichtsverandering van de zeeppompjes. Vervolgens twee nudges als interventie toegepast: 1. smileys op de spiegels en 2. rode pijlen van de toilethokjes naar de wastafels.	Infrarood sensor systeem, netto gewichtsverandering zeeppompjes (Kasio milligram digital scale), nudges (rode pijlen op vloer & smilies op spiegels)	Geslacht (There are no statistically signicant interaction effects, suggesting that men and women react similarly to the treatments.)	Women use more soap than men. Although the impact of the Smiles treatment is positive, it is not statistically significant. The Arrows treatment is statistically significant in the most powerful models (those with fewer explanatory variables, and higher adjusted R2), and is always positive.	*Enkel regressiecoëfficient en standaard error gegeven*	Vrouwen gebruiken meer zeep dan mannen.	https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3007866.
3	5.1.1H	Nudge, Handen desinfecteren, Handhygiëne, Veldexperiment	Effectiviteitsmeting van verschillende persuasive messages, ter verbetering van het handhygiënegedrag van bezoekers.	Gedurende het 14 weken durende veldexperiment werden zeven borden ontworpen, op basis van de volgende principes: wederkerigheid, consistentie, sociaal bewijs, eenheid, sympathie, autoriteit en schaarste. Elk bord werd een week lang op een scherm getoond, direct boven de handdispenser in een ziekenhuislobby. Een elektronisch monitoringssysteem is gebruikt om te meten hoe vaak de handdispenser is gebruikt. Tevens is baseline gemeten.	Persuasive messages (pre-tested), elektronisch monitoringssysteem	*"The baseline usage did not significantly vary over time, indicating that no confounding variables (e.g., weather) seemed to influence visitor behavior."*	The consistency in baseline usage affirms that the seven signs' effects are independent. Two of the seven signs significantly increased the dispenser usage rate compared to the average baseline level. **The sign based on the authority principle led to the highest dispenser usage rate of 7.7%**. This constitutes a relative increase of 27.8% from the baseline usage rate of 6.4% directly preceding the sign at baseline week six (W6 Baseline). **The second sign that significantly outperformed the baseline dispenser usage rate was based on the principle of social-proof with a dispenser usage rate of 6.9%**. It showed a relative increase of 14.7% from the baseline usage rate of 6.1% directly preceding the sign at baseline week four (W4 Baseline). The dispenser usage rate at the weeks with the other signs being presented did not differ statistically significant from the baseline level.	Authority principle: relative increase of 27.8% (95% CI [16.8%, 38.7%] and a relative increase of 19.8% (95% CI [9.5%, 30.1%]). Social-proof: relative increase of 14.7% (95% CI [3.4%, 26.0%]) and a relative increase of 12.8% (95% CI [1.7%, 23.9%]).	-	https://psycnet.apa.org/record/2018-20353-001
4	5.1.2A	Handhygiëne, Review	Beoordelen van het korte- en langetermijnsucces van strategieën, om de naleving van handhygiëne aanbevelingen te verbeteren, en om te bepalen of een toename van handhygiëne naleving het percentage aan gezondheidszorg gerelateerde infecties kan verminderen.	Systematic searches in Cochrane Register of Controlled Trials, PubMed, Embase, and CINAHL. Assessment of risk of bias in included studies; GRADE was applied. No meta-analysis. Primary outcome of interest was: hand hygiene compliance, measured through observation or a proxy indicator of hand hygiene compliance (e.g. increased use of hand hygiene products). Secondary outcomes of interest: reduction in health care-associated infection and reduction in colonisation rates by clinically significant nosocomial pathogens, e.g. MRSA. This review includes 26 studies: 14 randomised trials, two non-randomised trials and 10 ITS studies. Most studies were conducted in hospitals or long-term care facilities in different countries, and collected data from a variety of healthcare workers.	Hand hygiene compliance (primary; measured through observation or a proxy indicator of hand hygiene compliance (e.g. increased use of hand hygiene products), reduction in health care-associated infection (secondary; objective measurements).		Multimodal interventions that include some but not all strategies recommended in the WHO guidelines may **slightly improve hand hygiene compliance** (five studies; 56 centres) and may slightly reduce infection rates (three studies; 34 centres), low certainty of evidence for both outcomes. Multimodal interventions that contain all strategies recommended in the WHO guidelines plus additional strategies **may slightly improve hand hygiene compliance** (six studies; 15 centres; low certainty of evidence). It is unclear whether this intervention reduces infection rates (one study; one centre; very low certainty of evidence). Performance feedback may improve hand hygiene compliance (six studies; 21 centres; low certainty of evidence). This intervention probably slightly reduces infection (one study; one centre) and colonisation rates (one study; one centre) based on moderate certainty of evidence. **Education** may improve hand hygiene compliance (two studies; two centres), low certainty of evidence. **Cues such as signs or scent** may slightly improve hand hygiene compliance (three studies; three centres), low certainty of evidence. **Placement of ABHR close to point of use** probably slightly improves hand hygiene compliance (one study; one centre), moderate certainty of evidence.	Varieert tussen studies		https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005186.pub4/full#CD005186-sec-0105
5	5.1.2A	Hygiënisch gedrag, Sportschool, Veldexperiment	Effectiviteitsmeting van een sociale nudge op het hygiënische gedrag van sportschoolleden.	De nudge betreft een foto van "observerende ogen", bevestigd aan papieren dispensers en reinigingssprayflessen in twee verschillende sportscholen in Noorwegen. Een ABAB design, met (B) en zonder (A) de aanwezigheid van de nudge, werd gebruikt om de impact van de nudge op het hygiënisch gedrag van sportschoolleden (deelnemers groepssessie) te onderzoeken. In één van de sportscholen is vervolgonderzoek gedaan om in kaart te brengen of de nudge-stimuli over tijd blijven functioneren (nudge bleef langere tijd aanwezig).	Gebruik papieren dispensers en reiningsspray na sportsessie (N; geobserveerd door aanwezige onderzoeker). Nudge (plaatje van twee ogen).	*"The gym members do not know that they are participants in an experiment; this minimizes the challenges of experimentally confounding effects."*	De resultaten van beide centra laten een sterk effect van de nudge zien (45-55% naar 81-83% in sportschool 1; 39-41% naar 65-73% in sportschool 2). Dit effect nam echter af tijdens het vervolgonderzoek. Deze bevindingen ondersteunen eerder onderzoek dat aangeeft dat menselijk gedrag wordt beïnvloed door de aanwezigheid van impliciete observatiesignalen - in dit geval - observerende ogen.	Niet gepresenteerd, enkel N	-	https://www.frontiersin.org/articles/10.3389/fpsyg.2020.603440/full



Samenvatting

	Studie	Qual	Risk of bias	Sample	Land	Bevindingen	Toelichting
2	Bacon, A. M. and P. J. Corr (2020). "Coronavirus (COVID-19) in the United Kingdom: A personality-based perspective on concern and intention to self-isolate."	Moderate	In participant selection	n = 202 uk respondents	UK	[illegible]	[illegible]
3	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
4	Brodeur, A., Grigoryeva, I., & Kattan, L. (2020). Stay-At-Home Orders, Social Distancing and Trust.	Low	In measurement of predictor/outcome	De gebruikten data van de General Social Survey (GSS) op land niveau tussen 2008 en 2018 uit 438 graafschappen, en [illegible] Unacast COVID19 toolkit en Google Community Mobility reports.	VS	[illegible]	[illegible]
5	[illegible], D., Trepanowski, R., [illegible], P., & [illegible], 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, [illegible] via FB geworven	Polen	[illegible]	[illegible]
6	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	[illegible]	[illegible]
7	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	[illegible]	[illegible]
8	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 geobserveerd worden in quarantaine met koorts
9	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.	[illegible]	[illegible]
10	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	[illegible]	[illegible]
11	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= 1000 participants from survey company in Japan	Japan	[illegible]	[illegible]
12	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. [illegible]	International. [illegible]	[illegible]	[illegible]
13	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.	[illegible]	0
14	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 18 jaar, representatieve steekproef. [illegible]	UK in begin mei 2020	[illegible]	[illegible]
15	Smith, L. E., Potts, H. 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	[illegible]	UK	[illegible]	[illegible]
16	Stapleton, Choosing not to follow rules that will reduce the spread of COVID-19 2020	0	0	0	int.	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 induces counterpliance.	0
17	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 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 [illegible] dit niet deed. [illegible]	Adherent bij al 1 dag in isolatie, self rapport gedrag, [illegible]
18	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 = 895 US burgers, [illegible]	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 [-0.38, -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 bv). 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 (ex. social isolation/quarantine), self-report gedrag, [illegible]
19	[illegible], 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 = 162 US, 185 Kuwait, 71 SK	US, Kuwait, South Korea	Threat appraisal (0.215, 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
20	[illegible], (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]	[illegible]
21	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 = 141386	Spanje	[illegible]	[illegible]
22	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0
27	0	0	0	0	0	0	0
28	0	0	0	0	0	0	0
29	0	0	0	0	0	0	0
30		0	0	0	0	0	0
31		0	0	0	0	0	0
32		0	0	0	0	0	0
33		0	0	0	0	0	0

QoE

	A	B	C	D	E	F	G
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	**toelichting**
3	Grade	Definition			Limitations in study design or execution (risk of bias)	↓ 1 or 2 levels	zie linksonder Study Design en volgend tabblad voor Risk of Bias. Observationeel kan hierdoor eigenlijk niet als HIGH beoordeeld worden.
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	Niet toegelichte heterogeniteit van resultaten (vooral bij syst reviews, als er veel verschillende bevindingen zijn, gemengd bewijs).
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	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).
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	Kleine steekproef of kleine hoeveelheid events, dus wijd confidence interval
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	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
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	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).
11		[redacted]			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?
12					Dose-response gradient	↑ 1 level	
13							
14							
15							

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.**

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.

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

	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 executio**n may bias the estimates of the treatment effect. Ourconfidence in the estimate				Lack of allocation concealment					Explanation 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.).			
3	**Risk of bias**	**Uitleg**											
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													

Bias

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.

Bias

	N	O	P	Q
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.	
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.	
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.	
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.	
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.	
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	
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?	
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	
11				
12				

Bias

	N	O	P	Q
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				

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									