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LAMPIRAN

Lampiran 1. Prisma Checklist

Section/topic	#	Checklist item	√	Reported on page #
TITLE				
Title	1	Identify the report as a systematic *review*, meta-analysis, or both.	√	Page i
ABSTRACT				
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic *review* registration number.	√	Page xii Line 173-120
INTRODUCTION				
Rationale	3	Describe the rationale for the *review* in the context of what is already known.	√	Page 4 Line 335-341
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, *outcome*s, and study design (PICOS).	√	Page 5 Line 371-376
METHODS				
Protocol and registration	5	Indicate if a *review* protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	√	Page 37 Line 144-146
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	√	Page 37-38 Line 146-154
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	√	Page 38 Line 175-181
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	√	Page 38-175-193
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic *review*, and, if applicable, included in the meta-analysis).	√	Page 46 Line 408-413

Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	√	Page 48 Line 408-413
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	√	Page 46-47
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or *outcome* level), and how this information is to be used in any data synthesis.	√	Page 47 Line 400-405
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).		-
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	√	Page 45 Line 317-324
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	√	Page 47 Line 277-310
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.		-
RESULTS				
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the *review*, with reasons for exclusions at each stage, ideally with a flow diagram.	√	Page 52 Line 533-544
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	√	Page 52-53 Line 539-543
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any *outcome* level assessment (see item 12).	√	Page 68
Results of individual studies	20	For all *outcome*s considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	√	Page 60-61
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.		-

Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	√	Page 56-68
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	√	
DISCUSSION				
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main *outcome*; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	√	Page 70-77 Line 55-56
Limitations	25	Discuss limitations at study and *outcome* level (e.g., risk of bias), and at *review*-level (e.g., incomplete retrieval of identified research, reporting bias).	√	Page 78 Line 283-297
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	√	Page 80 Line 303-335
FUNDING				
Funding	27	Describe sources of funding for the systematic *review* and other support (e.g., supply of data); role of funders for the systematic *review*.	√	Page 80 Line 345

LAMPIRAN 2.
TOOLS PENILAIAN KUALITAS ARTIKEL CASP RCT

11 questions to help you make sense of a trial

How to use this appraisal tool

Three broad issues need to be considered when appraising a randomised controlled trial study: Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 11 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review)
were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:
Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Randomised Controlled Trial) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed.*

(A) Are the results of the trial valid?

Screening Questions

1. **Did the trial address a clearly focused issue?**
❒Yes **❒Can't tell** **❒No**

HINT: An issue can be 'focused' In terms of

- The population studied
- The intervention given
- The comparator given
- The outcomes considered

---

2. Was the assignment of patients to treatments randomised? ❒Yes ❒Can't tell ❒No

HINT: Consider

- How was this carried out?
- Was the allocation sequence concealed from researchers and patients?

---

3. Were all of the patients who entered the trial properly accounted for at its **conclusion?** ❒Yes ❒Can't tell ❒No

HINT: Consider

- Was the trial stopped early?
- Were patients analysed in the groups to which they were randomised?

Is it worth continuing?

Detailed questions

4. **Were patients, health workers and study ❒Yes ❒Can't tell ❒No personnel 'blind' to treatment?**

HINT: Think about

- Patients?
- Health workers?
- Study personnel?

---

5. Were the groups similar at the start of the trial? ❒Yes ❒Can't tell ❒No

HINT: Look at

- Other factors that might affect the outcome such as age, sex, social class

---

6. Aside from the experimental intervention, were the groups treated equally? ❒Yes ❒Can't tell ❒No

(B) What are the results?

7. How large was the treatment effect?

HINT: Consider

- What outcomes were measured?

- Is the primary outcome clearly specified?
- What results were found for each outcome?

---

8. How precise was the estimate of the treatment effect?

HINT: Consider

- What are the confidence limits?

9. Can the results be applied in your context? ❒Yes ❒Can't tell ❒No

HINT: Consider whether

- Do you think that the patients covered by the trial are similar enough to the patients to whom you will apply this?, if not how to they differ?

10. Were all clinically important outcomes

❒Yes ❒Can't tell ❒No

HINT: Consider

a. Is there other information you would like to have seen?
b. If not, does this affect the decision?

11. Are the benefits worth the harms and costs? ❒Yes ❒Can't tell ❒No

HINT: Consider

c. Even if this is not addressed by the trial, what do you think

LAMPIRAN 3.

JBI Critical Appraisal tools (Checklist for Quasi experimental tools)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer_____Date_____

Author_____Year_____Record Number _____

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	□	□	□	□
2. Were the participants included in any comparisons similar?	□	□	□	□
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	□	□	□	□
4. Was there a control group?	□	□	□	□
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	□	□	□	□
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	□	□	□	□
7. Were the outcomes of participants included in any comparisons measured in the same way?	□	□	□	□
8. Were outcomes measured in a reliable way?	□	□	□	□
9. Was appropriate statistical analysis used?	□	□	□	□

Overall appraisal: Include □ Exclude □ Seek further info □

Comments (Including reason for exclusion)_____

LAMPIRAN 4. PENILAIAN RISIKO BIAS

Cochrane Collaboration's tool for assessing risk of bias (adapted from Higgins and Altman13)

Bias domain	Source of bias	Support for judgment	Review authors' judgment (assess as low, unclear or high risk of bias)
Selection bias	Random sequence generation	Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups	Selection bias (biased allocation to interventions) due to inadequate generation of a randomised sequence
	Allocation concealment	Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen before or during enrolment	Selection bias (biased allocation to interventions) due to inadequate concealment of allocations before assignment
Performance bias	Blinding of participants and personnel*	Describe all measures used, if any, to blind trial participants and researchers from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Performance bias due to knowledge of the allocated interventions by participants and personnel during the study
Detection bias	Blinding of outcome assessment*	Describe all measures used, if any, to blind outcome assessment from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Detection bias due to knowledge of the allocated interventions by outcome assessment
Attrition bias	Incomplete outcome data*	Describe the completeness of outcome data for each main outcome, including attrition and exclusions from the analysis. State whether attrition and exclusions were reported, the numbers in each intervention group (compared with total randomised participants), reasons for attrition or exclusions where reported, and any reinclusions in analyses for the review	Attrition bias due to amount, nature, or handling of incomplete outcome data
Reporting bias	Selective reporting	State how selective outcome reporting was examined and what was found	Reporting bias due to selective outcome reporting
Other bias	Anything else, ideally Prespecified	State any important concerns about bias not covered in the other domains in the tool	Bias due to problems not covered elsewhere

*Assessments should be made for each main outcome or class of outcomes

LAMPIRAN 5.

Oxford Centre for Evidence-based Medicine – Levels of Evidence

(March 2009)

What are we to do when the irresistible force of the need to offer clinical advice meets with the immovable object of flawed evidence? All we can do is our best: give the advice, but alert the advisees to the flaws in the evidence on which it is based.

The CEBM 'Levels of Evidence 1' document sets out one approach to systematising this process for different question types.

(For definitions of terms used see our glossary)

Level	Therapy / Prevention, Aetiology / Harm	Prognosis	Diagnosis	Differential diagnosis / symptom prevalence study	Economic and decision analyses
1a	SR (with homogeneity *) of RCTs	SR (with homogeneity *) of inception cohort studies; CDR" validated in different populations	SR (with homogeneity *) of Level 1 diagnostic studies; CDR" with 1b studies from different clinical centres	SR (with homogeneity *) of prospective cohort studies	SR (with homogeneity *) of Level 1 economic studies
1b	Individual RCT (with narrow Confidence Interval"¡)	Individual inception cohort study with > 80% follow-up; CDR" validated in a single	Validating** cohort study with good" " " reference standards; or CDR" tested within	Prospective cohort study with good follow-up****	Analysis based on clinically sensible costs or alternatives; systematic review(s) of

		population	one clinical centre		the evidence; and including multi-way sensitivity analyses
1c	All or none§	All or none case-series	Absolute SpPins and SnNouts” “	All or none case-series	Absolute better-value or worse-value analyses ” ” ” “
2a	SR (with homogeneity *) of cohort studies	SR (with homogeneity *) of either retrospective cohort studies or untreated control groups in RCTs	SR (with homogeneity *) of Level >2 diagnostic studies	SR (with homogeneity *) of 2b and better studies	SR (with homogeneity *) of Level >2 economic studies
2b	Individual cohort study (including low quality RCT; e.g., <80% follow-up)	Retrospective cohort study or follow-up of untreated control patients in an RCT; Derivation of CDR” or validated on split-sample§§§ only	Exploratory** cohort study with good” ” ” reference standards; CDR” after derivation, or validated only on split-sample§§§ or databases	Retrospective cohort study, or poor follow-up	Analysis based on clinically sensible costs or alternatives; limited review(s) of the evidence, or single studies; and including multi-way sensitivity analyses
2c	“Outcomes” Research; Ecological	“Outcomes” Research		Ecological studies	Audit or outcomes research

	studies				
3a	SR (with homogeneity *) of case-control studies		SR (with homogeneity *) of 3b and better studies	SR (with homogeneity *) of 3b and better studies	SR (with homogeneity *) of 3b and better studies
3b	Individual Case-Control Study		Non-consecutive study; or without consistently applied reference standards	Non-consecutive cohort study, or very limited population	Analysis based on limited alternatives or costs, poor quality estimates of data, but including sensitivity analyses incorporating clinically sensible variations.
4	Case-series (and poor quality cohort and case-control studies§§)	Case-series (and poor quality prognostic cohort studies***)	Case-control study, poor or non-independent reference standard	Case-series or superseded reference standards	Analysis with no sensitivity analysis
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”	Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”	Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”	Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”	Expert opinion without explicit critical appraisal, or based on economic theory or “first principles”

Produced by Bob Phillips, Chris Ball, Dave Sackett, Doug Badenoch, Sharon Straus, Brian Haynes, Martin Dawes since November 1998. Updated by Jeremy Howick March 2009.

Notes

Users can add a minus-sign “-” to denote the level of that fails to provide a conclusive answer because:

- ***EITHER*** a single result with a wide Confidence Interval
- ***OR*** a Systematic Review with troublesome heterogeneity.

Such evidence is inconclusive, and therefore can only generate Grade D recommendations.

*	By homogeneity we mean a systematic review that is free of worrisome variations (heterogeneity) in the directions and degrees of results between individual studies. Not all systematic reviews with statistically significant heterogeneity need be worrisome, and not all worrisome heterogeneity need be statistically significant. As noted above, studies displaying worrisome heterogeneity should be tagged with a “-” at the end of their designated level.
“	Clinical Decision Rule. (These are algorithms or scoring systems that lead to a prognostic estimation or a diagnostic category.)
“¡	See note above for advice on how to understand, rate and use trials or other studies with wide confidence intervals.
§	Met when all patients died before the Rx became available, but some now survive on it; or when some patients died before the Rx became available, but none now die on it.
§§	By poor quality cohort study we mean one that failed to clearly define comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both exposed and non-exposed individuals and/or failed to identify or appropriately control known confounders and/or failed to carry out a sufficiently long and complete follow-up of patients. By poor quality case-control study we mean one that failed to clearly define comparison groups and/or failed to measure exposures and outcomes in the same (preferably blinded), objective way in both cases and controls and/or failed to identify or appropriately control known confounders.
§§§	Split-sample validation is achieved by collecting all the information in a single tranche, then artificially dividing this into “derivation” and “validation” samples.

” “	An “Absolute SpPin” is a diagnostic finding whose Specificity is so high that a Positive result rules-in the diagnosis. An “Absolute SnNout” is a diagnostic finding whose Sensitivity is so high that a Negative result rules-out the diagnosis.
“¡”¡	Good, better, bad and worse refer to the comparisons between treatments in terms of their clinical risks and benefits.
” ” “	Good reference standards are independent of the test, and applied blindly or objectively to applied to all patients. Poor reference standards are haphazardly applied, but still independent of the test. Use of a non-independent reference standard (where the ‘test’ is included in the ‘reference’, or where the ‘testing’ affects the ‘reference’) implies a level 4 study.
” ” ” “	Better-value treatments are clearly as good but cheaper, or better at the same or reduced cost. Worse-value treatments are as good and more expensive, or worse and the equally or more expensive.
**	Validating studies test the quality of a specific diagnostic test, based on prior evidence. An exploratory study collects information and trawls the data (e.g. using a regression analysis) to find which factors are ‘significant’.
***	By poor quality prognostic cohort study we mean one in which sampling was biased in favour of patients who already had the target outcome, or the measurement of outcomes was accomplished in <80% of study patients, or outcomes were determined in an unblinded, non-objective way, or there was no correction for confounding factors.
****	Good follow-up in a differential diagnosis study is >80%, with adequate time for alternative diagnoses to emerge (for example 1-6 months acute, 1 – 5 years chronic)

Grades of Recommendation

A	consistent level 1 studies
B	consistent level 2 or 3 studies ***or*** extrapolations from level 1 studies
C	level 4 studies ***or*** extrapolations from level 2 or 3 studies
D	level 5 evidence ***or*** troublingly inconsistent or inconclusive studies of any level

“Extrapolations” are where data is used in a situation that has potentially clinically important differences than the original study situation.