DAFTAR PUSTAKA


Devi, P., Rao, M., Sigamani, A., Faruqui, A., Jose, M., Gupta, R., … Xavier, D.


meta-analysis of the intervention studies, (February), 1–12.
https://doi.org/10.1111/jch.13852


Grassi, G., Dell’Oro, R., Seravalle, G., Foglia, G., Trevano, F. Q., & Mancia, G.


Guinard, J., Myrdal, A., Mills, K., Wong, T., Min, S., Sirimuangmoon, C., … Drescher, G. (2016). Consumer acceptance of dishes in which beef has been partially substituted with mushrooms and sodium has been reduced. *Appetite, 105*, 449–459. https://doi.org/10.1016/j.appet.2016.06.018


https://doi.org/10.1136/bmj.f1325

https://doi.org/10.1038/ki.2012.74


https://doi.org/10.1177/1090198111420286


national academies press.


Jin, A., Xie, W., & Wu, Y. (2020). Effect of salt reduction interventions in lowering blood pressure in Chinese populations: a systematic review and


in the Korea National Health and Nutrition Examination Survey. 

Epidemiology and Health, 36(e2014033), 1–5. 
https://doi.org/http://dx.doi.org/10.4178/epih/e2014033

https://doi.org/10.1371/journal.pone.0069689

https://doi.org/10.1136/bmj.b1665

https://doi.org/10.5888/pcd12.140522

https://doi.org/10.1161/HYPERTENSIONAHA.117.09950

https://doi.org/https://doi.org/10.1371/journal.pone.0183033


Miyaki, K., Song, Y., Taneichi, S., Tsutsumi, A., Hashimoto, H., Kawakami, N., … Shimbo, T. (2013). Socioeconomic status is significantly associated with


Medical Research Methodology, 18(1), 1–9. https://doi.org/10.1186/s12874-017-0468-4


https://doi.org/10.1038/nrdp.2018.14

https://doi.org/10.1038/s41591-020-0754-2


https://doi.org/http://dx.doi.org/10.3390/nu11102451

https://doi.org/10.1016/j.socscimed.2013.05.012

Peltzer, K., & Pengpid, S. (2018). The Prevalence and Social Determinants of


https://doi.org/10.1161/HYPERTENSIONAHA.117.09928


Wang, Q., Shang, S., Sun, J., Sun, G., & Gu, Z. (2019). Review of Nursing Interventions to Reduce the Sodium Intake for Patients with Chronic Heart Failure. *Cardiology and Cardiovascular Medicine, 03*(02), 59–74. https://doi.org/10.26502/fccm.92920054


## Lampiran 1: Panduan Review

### PRISMA 2009 Checklist

<table>
<thead>
<tr>
<th>Section/topic</th>
<th>#</th>
<th>Checklist item</th>
<th>Reported on page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>1</td>
<td>Identify the report as a systematic review, meta-analysis, or both.</td>
<td>Hal.i</td>
</tr>
<tr>
<td><strong>ABSTRACT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured summary</td>
<td>2</td>
<td>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.</td>
<td>Hal. xv</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>3</td>
<td>Describe the rationale for the review in the context of what is already known.</td>
<td>Hal. 4</td>
</tr>
<tr>
<td>Objectives</td>
<td>4</td>
<td>Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).</td>
<td>Hal. 5</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol and registration</td>
<td>5</td>
<td>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.</td>
<td>Hal. 41</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>6</td>
<td>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.</td>
<td>Hal. 41</td>
</tr>
<tr>
<td>Information sources</td>
<td>7</td>
<td>Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date</td>
<td>Hal. 41</td>
</tr>
<tr>
<td>Section/topic</td>
<td>#</td>
<td>Checklist item</td>
<td>Reported on page #</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>15</td>
<td>Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).</td>
<td>√ Hal. 44</td>
</tr>
<tr>
<td>Additional analyses</td>
<td>16</td>
<td>Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.</td>
<td></td>
</tr>
</tbody>
</table>

**RESULTS**

<table>
<thead>
<tr>
<th>Section/topic</th>
<th>#</th>
<th>Checklist item</th>
<th>Reported on page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study selection</td>
<td>17</td>
<td>Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow</td>
<td>√ Hal. 51</td>
</tr>
<tr>
<td>Study characteristics</td>
<td>18</td>
<td>For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.</td>
<td>(\checkmark) Hal. 52</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Risk of bias within studies</td>
<td>19</td>
<td>Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).</td>
<td>(\checkmark) Hal. 56</td>
</tr>
<tr>
<td>Results of individual studies</td>
<td>20</td>
<td>For all outcomes 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.</td>
<td>(\checkmark) Hal. 67</td>
</tr>
<tr>
<td>Synthesis of results</td>
<td>21</td>
<td>Present results of each meta-analysis done, including confidence intervals and measures of consistency.</td>
<td></td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>22</td>
<td>Present results of any assessment of risk of bias across studies (see Item 15).</td>
<td>(\checkmark) Hal. 56</td>
</tr>
<tr>
<td>Additional analysis</td>
<td>23</td>
<td>Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).</td>
<td></td>
</tr>
</tbody>
</table>

**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). | \(\checkmark\) Hal. 89 |
| 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). | \(\checkmark\) Hal. 95 |
| Conclusions | 26 | Provide a general interpretation of the results in the context of other evidence, and implications for future research. | \(\checkmark\) Hal. 99 |

**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. | \(\checkmark\) Hal. 101 |


For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).
Lampiran 2: Critical Appraisal Skills Programme

CASP Checklist: 11 questions to help you make sense of a Randomised Controlled Trial

How to use this appraisal tool: Three broad issues need to be considered when appraising a trial:

- 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 three 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.

About: 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 (2018). CASP (insert name of checklist i.e. Randomised Controlled Trial) Checklist. (online) Available at: URL. Accessed: Date Accessed.

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Critical Appraisal Skills Programme (CASP) part of Oxford Centre for Triple Value Healthcare Ltd www.casp-uk.net
4. Were patients, health workers and study personnel ‘blind’ to treatment?

- Yes
- Can’t Tell
- No

Comments:

5. Were the groups similar at the start of the trial?

- Yes
- Can’t Tell
- No

* HINT: Consider other factors that might affect the outcome, such as: age, sex, social class

Comments:

6. Aside from the experimental intervention, were the groups treated equally?

- Yes
- Can’t Tell
- No

Comments:

Section 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

Comments:

8. How precise was the estimate of the treatment effect?  
HINT: Consider  
- what are the confidence limits

Comments:

Section C: Will the results help locally?

9. Can the results be applied to the local population, or in your context?  
HINT: Consider whether  
- the patients covered by the trial are similar enough to the patients to whom you will apply this  
- how they differ

Yes  
Can't Tell  
No

Comments:

10. Were all clinically important outcomes considered?  
HINT: Consider whether  
- there is other information you would like to have seen  
- if not, does this affect the decision

Yes  
Can't Tell  
No

Comments:
Lampiran 3: The Cochrane collaboration:s tool for assessing risk of bias
<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Review authors’ judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequence generation.</td>
<td>Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups.</td>
<td>Was the allocation sequence adequately generated?</td>
</tr>
<tr>
<td>Allocation concealment.</td>
<td>Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen in advance of, or during, enrolment.</td>
<td>Was allocation adequately concealed?</td>
</tr>
<tr>
<td>Blinding of participants, personnel and outcome assessors Assessments should be made for each main outcome (or class of outcomes).</td>
<td>Describe all measures used, if any, to blind study participants and personnel from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective.</td>
<td>Was knowledge of the allocated intervention adequately prevented during the study?</td>
</tr>
<tr>
<td>Incomplete outcome data Assessments should be made for each main outcome (or class of outcomes).</td>
<td>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 randomized participants), reasons for attrition/exclusions where reported, and any re-inclusions in analyses performed by the review authors.</td>
<td>Were incomplete outcome data adequately addressed?</td>
</tr>
<tr>
<td>Selective outcome reporting.</td>
<td>State how the possibility of selective outcome reporting was examined by the review authors, and what was found.</td>
<td>Are reports of the study free of suggestion of selective outcome reporting?</td>
</tr>
<tr>
<td>Other sources of bias.</td>
<td>State any important concerns about bias not addressed in the other domains in the tool.</td>
<td>Was the study apparently free of other problems that could put it at a high risk of bias?</td>
</tr>
</tbody>
</table>
Lampiran 4: Level of evidence

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' document sets out one approach to systematising this process for different question types.

(For definitions of terms used see our glossary [https://wwwceb.m.njmu.edu/] )

<table>
<thead>
<tr>
<th>Level</th>
<th>Therapy / Prevention, Aetiology / Harm</th>
<th>Prognosis</th>
<th>Diagnosis</th>
<th>Differential diagnosis / symptom prevalence study</th>
<th>Economic and decision analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>SR (with homogeneity) of RCTs</td>
<td>SR (with homogeneity) of inception cohort studies; CDR* validated in different populations</td>
<td>SR (with homogeneity) of Level 1 diagnostic studies; CDR* with 1b studies from different clinical centres</td>
<td>SR (with homogeneity) of prospective cohort studies</td>
<td>SR (with homogeneity) of Level 1 economic studies</td>
</tr>
<tr>
<td>1b</td>
<td>Individual RCT (with narrow Confidence Interval)</td>
<td>Individual inception cohort study with &gt; 90% follow-up; CDR* validated in a single population</td>
<td>Validating** cohort study with good reference standards; or CDR* tested within one clinical centre</td>
<td>Prospective cohort study with good follow-up***</td>
<td>Analysis based on clinically sensible costs or alternatives; systematic review(s) of the evidence; and including multi-way sensitivity analyses</td>
</tr>
<tr>
<td>1c</td>
<td>All or none§</td>
<td>All or none case-series</td>
<td>Absolute SpPins and Safety*</td>
<td>All or none case-series</td>
<td>Absolute better-value or worse-value analyses</td>
</tr>
<tr>
<td>2a</td>
<td>SR (with homogeneity)</td>
<td>SR (with homogeneity)</td>
<td>SR (with homogeneity)</td>
<td>SR (with homogeneity)</td>
<td>SR (with homogeneity)</td>
</tr>
</tbody>
</table>

[https://www.celb.m.njmu.edu/2009/09/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/]
| 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-samples only | Exploratory** cohort study with good ** reference standards; CDR* after derivation, or validated only on split-samples 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 studies | "Outcomes" Research | Ecological studies | Audit or outcomes research |
| 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) | Case-series (and poor quality prognostic) | Case-control study, poor or non-independent | Case-series or superseded reference standards | Analysis with no sensitivity analysis |
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.)

*i 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
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 equality 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 **

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>consistent level 1 studies</td>
</tr>
<tr>
<td>B</td>
<td>consistent level 2 or 3 studies or extrapolations from level 1 studies</td>
</tr>
<tr>
<td>C</td>
<td>level 4 studies or extrapolations from level 2 or 3 studies</td>
</tr>
<tr>
<td>D</td>
<td>level 5 evidence or troublingly inconsistent or inconclusive studies of any level</td>
</tr>
</tbody>
</table>

*Extrapolations* are where data is used in a situation that has potentially clinically important differences than the original study situation.
Lampiran 5: Pencarian artikel di database

Pencarian PUBMED
Pencarian Wiley

0 results for "Hypertension OR high blood pressure OR hypertensive" anywhere and "Strategies OR program OR salt restriction education OR low salt education OR sodium restricted dietary OR low salt intervention OR low salt implementation OR low salt diet model OR salt reduction intervention OR dietary intervention" anywhere and "No comparison OR control" anywhere and "Lower blood pressure OR normotensive OR reduce blood pressure" anywhere.
Pencarian Ebsco
Pencarian di proquest
Population-level interventions in government jurisdictions for dietary sodium reduction

Excess dietary sodium consumption in a risk factor for high blood pressure, stroke and cardiovascular disease. Currently, average dietary sodium intake in many countries is too high, which is associated with increased risk of hypertension, which is in turn associated with increased risk of cardiovascular disease. A number of governments have implemented policies to lower dietary sodium intake to reduce the risk of cardiovascular disease. This review identifies policies that have been implemented in government jurisdictions and evaluates whether these policies have led to a reduction in average dietary sodium intake.

100 Cochrane Reviews matching Hypertension OR high blood pressure OR hypertension in Title Abstract
Keyword AND Strategies OR program OR salt-restriction education OR low salt education OR sodium restricted dietary OR low salt intervention OR low salt implementation OR low salt diet model OR salt reduction intervention OR dietary intervention in Title Abstract
Keyword AND comparison OR control in Title Abstract
Keyword AND Lower blood pressure OR normotensive OR reduce blood pressure in Title Abstract
Keyword - with Cochrane Library publication date Between 1 Jan 2013 and 31 Dec 2020 (584 variations have been searched)