LIST OF TABLES

TABLE 1: SUMMARY OF OVERALL FINDINGS

The column heading are defined as follows: nature of evidence - research designs used by the retrieved literature; GRADE rating - very low quality, low quality, moderate quality, high quality; limitations - notable limitations above and beyond those reflected in GRADE; effect - impact of the intervention on outcome measures stated in the primary research; coverage - likely reach of an intervention such as a population, product or place; economic impact - cost-effective, cost-saving, not cost-effective or inconsistent; implementation - any known or assumed barriers to implementation; and inequalities - the impact of an intervention on an inequality group as defined by the *Equality Act 2010*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A. TAXATION AND PRICE REGULATION | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| A1. Taxation | 4 meta analyses  5 reviews  6 modelling studies | High | Not identified | Increased tax is associated with a proportionate reduction in alcohol consumption and harms  Impact starts in 1-2 years | All alcohol drinkers  Can be targeted at beverage types | Cost-effective and cost-saving | Government budgetary measure (legislation is in place)  Policy can be undermined if tax increases are not passed onto the consumers and are not adjusted for inflation | The health benefits are greater for heavy drinkers who experience the greatest harm | Increasing tax is a highly effective and cost-effective approach to health improvement |
| A2. Minimum pricing | 4 natural experiments  8 modelling studies  1 observational study  1 field study | Moderate | Not identified | UK modelling shows improvements in health, crime, and productivity.  Mortality substantially reduced in natural experiments of similar minimum pricing strategies in Canada  Impact starts within 12 months | Applies only to alcohol which is cheap relative to its strength  At levels discussed, moderate drinkers and the on-trade are minimally affected | Cost-effective and cost-saving | Requires primary legislation; low implementation costs for Government  The Court of Session in Scotland have ruled MUP is legal | Targeted at extreme and heavy drinkers.  Greater reduction in health inequalities than taxation alone | Minimum prices effectively reduces health and other harms, is targeted at the heaviest drinkers who experience the greatest harm, and is cost effective |
| A3. The relative and combined impact of taxation and other pricing policies | 2 modelling studies | Low | Not identified | Taxation + MUP improves health, crime, productivity and Exchequer revenue, to a greater extent than implementing either policy in isolation  Impact starts in 12 months, full impact in 20 years | See A1. and A2. | See A1. And A2. | See A1. And A2. | Targeted at extreme and heavy drinkers.  Greater reduction in health inequalities than taxation alone, but lower than the reduction achieved with a MUP | Combined taxation + MUP increases impact and improves cost-effectiveness compared with MUP alone |
| 4. Banning the sales of alcohol below the cost of taxation (duty+VAT) | 1 modelling study  1 observational study | Low | Not identified | Little impact on population-level alcohol consumption and no health improvement | Applies only to heavily discounted alcohol (<1% of units in the market) | Not identified | Legislation is in place; low implementation costs for Government | Not identified | The ban on selling alcohol below the cost of taxation had minimal impact |
| A5. Bans or restrictions on price promotions | 2 natural experiments  1 modelling study | Moderate | Contradictory research findings. No evidence on market response (e.g. alternative pricing strategies) | Higher quality evidence suggests that restricting price promotions was associated with reductions in consumption, especially off-trade wine and premixed beverages | Applies to alcohol being sold as part of price promotions covered by policy | Not identified | Requires primary legislation; low implementation costs for Government  Can be undermined by lowering non-promotional prices | Not identified | Restrictions on price promotions may reduce consumption, but more evidence is needed |
| B. REGULATING MARKETING | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| B1. Advertising bans | 2 reviews  3 modelling studies | Moderate | Inherent limitations in advertising elasticity studies  Contradictory research findings | International modelling shows complete advertising bans are more effective at reducing alcohol-related morbidity and mortality than partial bans | Entire population (can be targeted at under 18 year olds) | Cost-effective and cost-saving | Evidence supports a statutory approach; low implementation costs for Government  Costs of enforcement can be divided between Government and/or commercial operators | Can be designed and directed at those aged under 18 years | Complete advertising bans are a highly effective and cost-effective approach to health improvement |
| B2. Industry self-regulation of alcohol marketing | 2 systematic reviews  1 qualitative study | Low | Not identified | The current self-regulatory systems that govern marketing are not meeting their intended purpose of restricting children from exposure to marketing in the UK | Entire population (can be targeted at under 18 year olds) | Not identified | Low implementation for costs for Government; costs borne by commercial operators; evidence supports statutory approaches | Can increase health and social harm among young people | Industry self-regulation is unlikely to be effective  Little evidence of beneficial effect |
| B3. Specific actions to protect children from exposure to alcohol marketing | 1 modelling study  1 observational study  1 field study | Very Low | Research evaluated a poorly implemented intervention | ‘Watershed’ bans decrease exposure of young children  Age verification filters currently ineffective (easily circumvented) | Primarily under 18 year olds (interventions will also impact on the adult population) | Not identified | Low implementation for costs for Government; costs borne by commercial operators and/or Government; evidence supports statutory approaches  Impact on older children undermined if commercial operators respond by increasing the number of adverts after the watershed | Can be designed and directed at those aged under 18 years | Reducing child exposure to alcohol marketing would theoretically impact alcohol consumption by children |
| C. REGULATING AVAILABILITY | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| C1. Density of alcohol outlets | 5 systematic reviews  2 critical reviews  3 observational studies | Low/Moderate | Mostly international evidence base | Strong relationship between greater outlet density and levels of social disorder; mixed findings on consumption, emerging evidence for chronic health harms | Licensed premises | Not identified | Using the evidence within the *Licensing Act 2003* is challenging  Administrative and enforcement costs borne by licensing authorities and police  Undermined if alcohol is readily available from neighbouring areas | Can be implemented in areas with greater deprivation | Reducing the density of alcohol outlets may reduce social disorder and RTC |
| C2. Hours and days of sale | 2 expert reviews  4 systematic reviews  8 natural experiments | Moderate | Mixed research findings internationally and within England | International evidence links hours of sale to alcohol consumption and harm, particularly for availability during late night hours in the on-trade  English research suggests violence shifted later into the night and hospital admissions increased by a small amount in some areas | Licensed premises | Cost-effective | Using the evidence within the *Licensing Act 2003* is challenging  Costs borne by licensing authorities and police  Undermined if alcohol is readily available from neighbouring areas | None identified | Reducing hours of sale may reduce alcohol-related harm |
| C3. The responsibility deal pledge to *“remove 1bn units of alcohol sold annually from the market by”…“improving consumer choice of lower alcohol products”* | 1 critical review  2 observational studies | Very low | Over simplistic assumptions regarding consumer response and changes in duty | Most actions would have occurred regardless of the pledge, no demonstrable impact on harm | All alcohol drinkers | Not identified | Potential for new low alcohol products to expand the alcohol market overall | Not identified | Public-private partnerships are not shown to bring about effective changes which benefit public health |
| D. PROVIDING INFORMATION AND EDUCATION | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| D1. Mass media campaigns which aim to change alcohol consumption | 1 review of reviews  2 expert reviews  1 systematic review  2 cross-sectional studies  1 experimental study  1 field study | Low | Research outcomes poorly specified | Can increase knowledge and awareness, direct impacts on behaviour usually small and short-term  Commercially sponsored messages have no health benefits | Entire population (can be targeted at specific groups) | Not cost-effective | Cost of development and deployment  Policy can be undermined by pro-drinking marketing | Can be directed at inequality groups | (Non-industry sponsored) campaigns increase knowledge and awareness, little direct impact on behaviour, not cost-effective |
| D2. Social marketing approaches | 1 systematic review | Low | Not identified | Mixed findings of impact on risky drinking and behaviour | Entire population (can be targeted at specific groups) | Not identified | Cost of development and deployment  Policy can be undermined by pro-drinking marketing | Can be directed at inequality groups | No firm conclusions can be made |
| D3. Social norm approaches | 1 meta-analysis | Very Low/Low | Failure to report allocation concealment  High levels of attrition | Effects were small and inconsistent among students | Entire population (can be targeted at specific groups) | Not identified | Cost of development and deployment | Can be directed at inequality groups | No firm conclusions can be made |
| D4. Alcohol education programmes | 1 expert review  1 review of reviews  2 systematic reviews  1 RCT | Very Low/Low | Contradictory research findings with methodological issues. | Evidence inconclusive. Small, short term beneficial effects have not been replicated | Under 18 year olds | Not cost-effective | Cost of development and deployment  Implementation has proven difficult with many schools not able to deliver education programmes in their entirety | Designed and directed at those aged under 18 years | Little (lasting) evidence of effectiveness or cost-effectiveness |
| D5. Labelling of alcoholic beverages | 5 reviews  1 modelling study  2 surveys  1 focus group | Low | Research evaluated a poorly implemented intervention | Improvements in consumer knowledge and awareness, no impact on behaviour  Voluntary implementation by commercial operators ineffective | All alcoholic beverages | Not identified | Evidence supports a statutory approach; low costs are borne by commercial operators | Not identified | Labels increase knowledge and awareness |
| E. MANAGING THE DRINKING ENVIRONMENT | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| E1. Multicomponent community programmes | 1 systematic review  1 RCT  3 natural experiments  1 experimental study  1 survey  1 health economic analysis | Low/  Moderate | Not identified | Small reductions in alcohol-related violence with benefits seen in neighbouring areas | Drinkers in and around the night-time environment | Cost-saving and cost-effective | Can be implemented at scale  Costs borne by local authorities, licensing authorities, police and commercial operators | Can be implemented in areas with greater deprivation | Small reductions in acute harms, cost-effective, cost-saving and can be scaled up |
| E2. Server training | 1 review of reviews  2 systematic reviews  1 experimental study | Very Low/Low | Most outcomes measure self-reported behaviour | Mixed results, at best a small impact on violence or propensity to serve | Customers in on- and off-trade premises | Not identified | Low implementation costs for Government  Training costs borne by commercial operators | Can prevent the sale of alcohol to underage consumers | Impact is small and the research is characterised by self-reported measurements |
| E3. Server liability | 1 systematic review | Moderate | Entirely international evidence base | Small reductions in RTC fatalities, homicide and poor health | Customers and servers in on and off-trade premises | Not identified | Requires primary legislation, possible legal issues around burden of proof  Legal costs borne by servers | Can prevent the sale of alcohol to underage consumers | Impacts are small and predominantly focus on acute harms |
| E4. Replacing glassware with safer alternatives | 1 experimental study  1 field study | Very Low | Small sample size (number of observations) | Small number of observations, some evidence for reduced violent injuries | Customers in on-trade premises | Not identified | Low implementation costs for Government  Costs borne by commercial operators | The health benefits may be greatest for young men | Replacing glassware with safer alternatives is based on sound principle and may reduce injuries |
| E5. Voluntary removal of the sale of high strength alcohol | 1 experimental study | Very Low | Small sample size (number of observations) | Infrequently evaluated with an association between intervention and small reductions in alcohol-related crime and anti-social behaviour | Customers in off-trade premises | Not identified | Policy can be undermined if high strength alcohol is readily available from neighbouring areas | Can be implemented in areas with greater deprivation | Voluntary removals of high strength alcohol may reduce acute alcohol-related harm but easily undermined |
| E6. Policing and enforcement approaches | 1 systematic review | Low/Moderate | Inconsistent findings: may result from increased detection | Some beneficial effects on sales to underage or intoxicated customers, effects small and short term | Drinkers and servers in and around the night-time economy | Not identified | Costs of enforcement borne by police | Can prevent the sale of alcohol to underage consumers | Resource intensive interventions with possible short term reductions in acute harm |
| E7. Public drinking bans | 1 systematic review | Very Low | All studies included in the review were from grey literature | Harmful impact on marginalised groups, small increases in perception of public safety, no impact on consumption and harm | Drinkers consuming alcohol in prohibited public spaces | Not identified | Legislation is in place  Costs of enforcement borne by police  Public drinking bans are infrequently enforced | Can displace marginalised groups to new, less safe, areas | Negatively impact marginalised groups, such as the homeless with little benefit |
| F. REDUCING DRINK-DRIVING | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| F1. BAC limits | 1 meta-analysis  4 reviews (2 systematic) | High | Not identified | Small reductions in drinking driving and related crashes resulting from reducing BAC limits from 80mg to 50mg  Effects seen within one year | All drivers | Not identified | Legislation is in place  Policy can be undermined if not enforced | Affects all drinking drivers equally | Lowering the drink-driving limit would reduce RTC, casualties and fatalities, by a small amount |
| F2. Breath testing | 1 meta-analysis  2 systematic reviews | High | Not identified | Breath testing drivers (selective or random testing) reduces drink-driving and RTC, casualties and fatalities | All drivers | Both random and selective breath testing shown to be cost saving and cost-effective | Legislation is in place for selective breath testing, primary legislation is required for random breath testing  Costs of enforcement borne by the police | Not identified | Breath testing drivers is an effective and cost-effective way of reducing drink-driving, RTC, casualties and fatalities |
| F3. Graduated driver licensing | 3 systematic reviews  1 retrospective analysis | High | The retrospective analysis was not able to take account of the lower legal BAC component of a graduated driver licensing programme | Graduated driver licensing programmes reduce drink-driving and the associated RTC, casualties and fatalities  Effects are seen within the first year of implementation | Novice drivers | Cost-effective | Requires primary legislation; costs of enforcement borne by the police and courts  Undermined if drivers reach an age threshold and believe they can drink more  May restrict civil liberties or economic and education opportunities for young drivers, particularly in rural areas | The health benefits of graduated driver licensing programmes are greatest for young, predominantly male, drivers | Effective in reducing RTC, casualties and fatalities in novice drivers. Cost-effective but requires resources |
| F4. Immediate licence revocation | 1 meta-analysis  2 natural experiments | High | Entirely international evidence base | Modest reduction in drink-driving and casualties and fatalities compared to current process | All drivers | Not identified | Requires primary legislation  Low implementation costs for Government  Costs of enforcement borne by the police and courts | Not identified | Immediate licence revocation is effective in North America, transferability may be limited |
| F5. Alcohol ignition interlock devices | 2 systematic reviews  1 health economic analysis | High | Not identified | Ignition interlocks reduce reoffending in first time and repeat offenders by a modest amount | Drink-driving offenders | Results depend on the level of effectiveness | Administrative and enforcement costs divided between offender and/or Government  Following removal of the device, reoffending rates return to those prior to installation | Not identified | Alcohol ignition interlock effectively reduce drink-driving reoffending whilst installed and can be cost-effective |
| F6. Preventive education programmes targeting drink-driving offenders | 1 systematic review | Low | Research was not able to exclude confounders | Small variable reductions in reoffending findings variable, independent effect unclear | Drink-driving offenders | Not identified | Costs borne by Government | Not identified | Preventive education programmes may reduce reoffending |
| F7. Designated driver programmes | 1 systematic review  1 experimental study | Low | Most outcomes measure self-reported behaviour | Small impact on behavioural intentions no impact on behaviour (drink-driving or passenger of a drink-driver) | All alcohol drinkers/drivers | Not identified | Cost of development and deployment | Not identified | Firm conclusions cannot be made, on balance, may reduce the propensity to drink-drive or agree to be a passenger of a drink-driver |
| F8. Mass media campaigns to prevent drink-driving | 2 systematic reviews | Moderate/High | Not identified | Modest reductions in drink-driving and alcohol-related RTC | Entire population | Not identified | Cost of development and deployment  Policy can be undermined by pro-drinking marketing | Can be directed at inequality groups | Mass media campaigns are effective in reducing drink-driving and the associated crashes, casualties and fatalities |
| F. BRIEF INTERVENTIONS AND TREATMENT | | | | | | | | | |
| INTERVENTION | NATURE | GRADE | LIMITATIONS | EFFECT | COVERAGE | ECONOMIC IMPACT | IMPLEMENTATION | INEQUALITIES | SUMMARY |
| G1. IBA in primary care | 1 review of reviews  2 meta-analyses  2 systematic reviews  1 RCT  1 modelling study | High | Not identified | IBA is effective for reducing the prevalence of harmful and hazardous consumption over 6 and 12 months | Harmful and hazardous drinkers attending primary health care | Cost-effective | The effectiveness depends on sufficient health delivery systems and dedicated funding | Those in the lowest socioeconomic groups are estimated to experience the greatest absolute reduction in harms | IBA is effective in reducing hazardous and harmful consumption in primary health care, and is cost-effective |
| G2. IBA in ED | 1 meta-analysis  1 RCT | Moderate | Not identified | Small to moderate beneficial effect of IBA | Harmful and hazardous drinkers attending ED | Not identified | The effectiveness depends on sufficient health delivery systems and dedicated funding | Not identified | IBA is efficacious at reducing hazardous and harmful alcohol consumption |
| G3. IBA in CJS | 1 RCT | Low | Not identified | Hazardous and harmful alcohol consumption reduced, offending reduced with most intensive interventions | Harmful and hazardous drinkers in the probation setting | Not identified | The effectiveness depends on sufficient delivery systems | Reduces alcohol consumption and harm in offenders | Hazardous and harmful alcohol consumption reduced, offending reduced with most intensive interventions |
| G4. eIBA | 1 meta-analysis | Moderate | High levels of attrition | eIBA reduced hazardous and harmful consumption, effect mitigated after 12 months | Harmful and hazardous drinkers recruited into digital interventions | Not identified | eIBA could be a lower cost delivery option with the potential for widespread delivery | Not identified | Short-term, reductions in hazardous and harmful consumption |
| G5. IBA in adolescents | 1 systematic review | Low | Not identified | Evidence still emerging | Adolescents who drink | Not identified | It is not clear what the appropriate setting or screening tools are for this group | Potential to reduce harm in adolescents | Currently no clear evidence of benefit in this age group |
| G7. IBA in sexual health clinics | 1 RCT | Low | Not identified | IBA did not lead to meaningful reductions in alcohol consumption | Harmful and hazardous drinkers attending sexual health clinics | Not cost-effective | Not identified | Not identified | Evidence suggests sexual health clinics are not effective settings for IBA |
| G8. IBA in pharmacies | 1 literature review  1 RCT | Moderate | It is possible that the pharmacists were undertrained in the delivery of IBA | IBA did not lead to meaningful reductions in alcohol consumption | Harmful and hazardous drinkers attending pharmacies | Not identified | Not identified | Not identified | Evidence suggests pharmacies are not effective settings for IBA |
| G9. IBA in the workplace | 1 systematic review | Low | Not identified | Effective in reducing hazardous and harmful consumption in the workplace, differing effectiveness across worker type unknown | Harmful and hazardous drinkers in employment | Not identified | Employees may not wish to disclose heavy drinking to their employer | Not identified | Promising results, not clear which employee type may benefit most. Some employees may be unwilling to disclose information |
| G9. Psychosocial and psychological interventions | 1 expert review | Moderate | Not identified | Many treatments effective: behavioural couple’s therapy, MET, CBT, SBNT and behavioural therapies compared to treatment as usual, controls and other active interventions | Alcohol dependent adults | MET was cost-effective  Coping and skills training, marital or family therapy and behavioural self-control training was cost saving | Not identified | Not identified | Behavioural couple’s therapy, CBT, SBNT, MET and behavioural interventions  recommended by NICE as an effective therapy |
| G10. Pharmacological interventions | 1 expert review  1 technical appraisal  1 health economic analysis | High | Not identified | The use of nalmefene endorsed for mild dependence, acamprosate, and naltrexone for moderate to severe dependence, disulfiram not endorsed, given that the evidence was poorer quality and the potential for harm was greater | Alcohol dependent adults | Acamprosate and naltrexone were cost-effective  Nalmefene was cost saving | Not identified | Not identified | Recommended by NICE as an effective therapy (with an adjunct of psychosocial) |

BAC = blood alcohol concentration; CBT = cognitive behavioural therapy; CJS = criminal justice setting; ED = emergency department; eIBA = electronic identification and brief advice; IBA = identification and brief advice; MET = motivational enhancement therapy; MUP = minimum unit price; NICE = National Institute for Health and Care Excellence; RCT = randomised controlled trial; RTC = road traffic crashes; SBNT = social behavioural and networks therapy; VAT = value added tax

LIST OF TABLES FOR ANNEXES

TABLE 1: ALCOHOL CONTROL AND DEMAND REDUCTION POLICIES

|  |  |
| --- | --- |
| Alcohol control and demand reduction policies | Specific policy |
| A. Taxation and price regulation | A1. Taxation  A2. Minimum pricing  A3. The relative and combined impact of taxation and other pricing policies  A4. Banning the sales of alcohol below the cost of taxation  A5. Bans or restrictions on price promotions |
| B. Regulating marketing | B1. Advertising bans  B2. Industry self-regulation of alcohol marketing  B3. Specific actions to protect children from exposure to alcohol marketing |
| C. Regulating availability | C1. Density of alcohol outlets  C2. Hours and days of sale  C3. The responsibility deal pledge to *“remove 1bn units of alcohol sold annually from the market by”…“improving consumer choice of lower alcohol products”* |
| D. Providing information and education | D1. Mass media campaigns which aim to change alcohol consumption  D2. Social marketing approaches  D3. Social norm approaches  D4. Alcohol education programmes  D5. Labelling of alcoholic beverages |
| E. Managing the drinking environment | E1. Multicomponent community programmes  E2. Server training  E3. Server liability  E4. Replacing glassware with safer alternatives  E5. Voluntary removal of the sale of high strength alcohol  E6. Policing and enforcement approaches  E7. Public drinking bans |
| F. Reducing drink-driving | F1. Blood alcohol concentration limits  F2. Breath testing  F3. Graduated driver licensing  F4. Immediate licence revocation  F5. Alcohol ignition interlock devices  F6. Preventive education programmes targeting drink-driving offenders  F7. Designated driver programmes  F8. Mass media campaigns to prevent drink driving |
| G. Brief interventions and treatment | G1. Identification and brief advice in primary health care  G2. Identification and brief advice in emergency departments  G3. Identification and brief advice in criminal justice settings  G4. Electronic identification and brief advice  G5. Identification and brief advice in adolescents  G6. Identification and brief advice in sexual health clinics  G7. Identification and brief advice in pharmacies  G8. Identification and brief advice in the workplace  G9. Psychosocial or psychological treatment for alcohol dependence  G9. Pharmacological for alcohol dependence |

TABLE 2: DATA EXTRACTION TEMPLATE

|  |  |
| --- | --- |
| DATA ITEM | SUMMARY |
| Reference | Author; article title; journal |
| Aims | As described in the report |
| Design/setting | Systematic review, RCT, prospective cohort, case-control, other |
| Population | Participants (including eligibility criteria, case definitions/indication) |
| Intervention/exposure | Intended for each group studied |
| Country | All countries listed |
| Outcome(s) | Definition of primary and relevant secondary outcomes |
| Results | * Number of participants randomised or allocated * Results on primary outcome (effect size estimate and precision) * Summary of sensitivity and relevant sub-group analyses * Summary of relevant synthesis (e.g. consistency in meta-analysis) |
| Conclusions | Summary of conclusions as stated |
| Strengths | * Summary of study strengths as stated * Evaluation of strengths relating to design, population, attrition, bias |
| Limitations | * Summary of study limitations as stated * Evaluation of limitations relating to design, population, attrition, bias |
| Inequalities | Summary of differential effects across groups as defined by the *Equalities Act 2010* |
| Costs | Summary of intervention costs and cost-effectiveness |
| Recommendations | As described in report |

TABLE 3: THE GRADING OF RECOMMENDATIONS ASSESSMENT, DEVELOPMENT AND EVALUATION

|  |  |
| --- | --- |
| Very low quality | Any estimate of effect is very uncertain |
| Low quality | Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate |
| Moderate quality | Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate |
| High quality | Further research is very unlikely to change our confidence in the estimate of effect |