Examples of Summary of Findings tables

1. Summary of Findings – Substitution of nurses for physicians in primary care

Patients or population: All presenting patients in primary care
Settings: Primarily Canada, the United States of America (USA) and the United Kingdom (UK)
Intervention: Substitution of nurses for physicians (nurse-led primary care)
Comparison: Routine care provided by physicians (physician-led primary care)

Outcomes	Impacts	Number of studies	Quality of the evidence (GRADE)*
Patient outcomes	The care provided by nurses and physicians may lead to similar health outcomes for patients.	4	⨁⨁⨀⨀ Low
Quality of care	The extent to which care provided by nurses was more or less appropriate than the care provided by physicians was not reported.	0	–
Patient satisfaction	On average patients are probably more satisfied with care provided by nurses, but some prefer care provided by nurses, and some prefer care provided by doctors.	3	⨁⨁⨁⨀ Moderate
Direct costs	The lower salary costs of nurses may be offset by their increased use of resources or lower productivity so that there may be little if any difference in the cost of care provided by nurses compared to the cost of care provided by physicians. Because the difference in salary between nurses and doctors may vary from place to place and over time, the net saving, if any, is likely to depend on the context.	2	⨁⨀⨀⨀ Very low

*GRADE Working Group grades of evidence

⨁⨁⨁⨁ **High:** We are confident that the true effect lies close to what was found in the research

⨁⨁⨁⨀ **Moderate:** The true effect is likely to be close to what was found, but there is a possibility that it is substantially different

⨁⨁⨀⨀ **Low:** The true effect may be substantially different from what was found

⨁⨀⨀⨀ **Very low:** We are very uncertain about the effect

Footnotes

1.

From the SURE Guides for Preparing and Using Evidence-Based Policy Briefs. Version 2.1 [updated November 2011]
Available from www.evipnet.org/sure

2. Summary of Findings – Lay health workers as an add on to usual care

Patients or population: Mothers and children under five
Settings: Mixed (high-income countries for immunisations, mixed for breast feeding, low-income countries for morbidity and mortality in children)
Intervention: Lay health workers (LHWs) (members of the community who are not health professionals and have received some training to promote health or to provide some health care services)
Comparison: Usual care (varied across studies)

Outcomes	Impacts			Number of studies	Quality of the evidence (GRADE)*
	Without lay health workers	With lay health workers	Relative		
Mortality in children under five	5 per 100 children	4 per 100 children	25% relative reduction in child deaths	3	⊕⊕⊖⊖ Low
Neonatal mortality	4 per 100 infants	3 per 100 infants	24% relative reduction in infant deaths	4	⊕⊕⊖⊖ Low
Morbidity in children under five (e.g. fever, diarrhoea)	50 per 100 children	43 per 100 children	14% relative reduction in child morbidity	7	⊕⊕⊖⊖ Low
Care seeking for children under five	20 per 100 children	27 per 100 children	33% relative increase in care seeking for children	3	⊕⊕⊖⊖ Low
Completed infant immunisations	50 per 100 infants	61 per 100 infants	22% relative increase in infant immunisations	4	⊕⊕⊕⊖ Moderate
Initiation of breastfeeding	50 per 100 mothers	68 per 100 mothers	36% relative increase in initiated breastfeeding	12	⊕⊕⊕⊖ Moderate
Exclusive breastfeeding	20 per 100 mothers	36 per 100 mothers	178% relative increase in exclusive breastfeeding	10	⊕⊕⊕⊖ Moderate

*GRADE Working Group grades of evidence

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⊕⊕⊖⊖ **Low:** The true effect may be substantially different from what was found

⊕⊖⊖⊖ **Very low:** We are very uncertain about the effect

Footnotes

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3. Summary of Findings – Educational meetings for health professionals

Patient or population: Health care professionals
Settings: Primary and secondary care
Intervention: Educational meetings with or without other interventions*
Comparison: No intervention

Outcomes	Adjusted absolute improvement (risk difference)† Median (Interquartile range)	Number of studies	Quality of the evidence (GRADE)*	Comments
Compliance with desired practice	Median 6% (1.8 to 15.9)	30	⊕⊕⊕⊖ Moderate‡	The effect appears to be larger with higher attendance at the educational meetings and with mixed interactive and didactic educational meetings. Educational meetings did not appear to be effective for complex behaviours and they appeared to be less effective for less serious outcomes.
Patient outcomes	Median 3.0% (0.1% to 4.0%)	5	⊕⊕⊕⊖ Moderate‡	

*GRADE Working Group grades of evidence

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⊕⊕⊕⊖ **Moderate:** The true effect is likely to be close to what was found, but there is a possibility that it is substantially different

⊕⊕⊖⊖ **Low:** The true effect may be substantially different from what was found

⊕⊖⊖⊖ **Very low:** We are very uncertain about the effect

Footnotes

* The effect of educational meetings alone on professional practice was the same as for multifaceted interventions that included educational meetings

†The post-intervention risk differences are adjusted for pre-intervention differences between the comparison groups

‡We have downgraded the evidence from high to moderate because of inconsistency in the results that could not be fully explained

4. Summary of Findings – Introducing user fees

Population: Anyone using any type of health service in low- and middle-income countries
Settings: Burkina Faso, Kenya, Lesotho, Papua New Guinea
Intervention: Introducing or increasing user fees
Comparison: No user fees

Outcomes	Relative change in utilisation[1]	Number of studies	Quality of the evidence (GRADE)*	Comments
Healthcare utilisation – preventive care	-15.4% immediately -17% after 12 months	2	⊕⊖⊖⊖ Very low[2]	Antenatal care visits dropped in one study where fees were introduced. One additional study found a decrease in utilisation of deworming drugs following an introduction of fees, but did not report the results in a way that the relative change in utilisation could be calculated.
Healthcare utilisation – curative care	-28% to -51% immediately -9% to +8% after 12 months	6	⊕⊖⊖⊖ Very low[2]	All but two studies showed a decrease in the number of outpatient visits in different types of facilities, although not all drops in attendance were statistically significant. Two controlled before-and-after studies where fees were introduced with quality improvements reported an increase in utilisation. However the authors did not report the results in a way that the relative change in utilisation could be calculated.
Equitable access – healthcare utilisation by quintile	N/A	1	⊕⊖⊖⊖ Very low[3]	This study where quality improvements were introduced at the same time as user fees found an increase in utilisation for poor groups but not the very poorest (only quintiles 2 and 3). The authors did not report the results in a way that the relative change in utilisation could be calculated.

*GRADE Working Group grades of evidence

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⊕⊕⊕⊖ **Moderate:** The true effect is likely to be close to what was found, but there is a possibility that it is substantially different

⊕⊕⊖⊖ **Low:** The true effect may be substantially different from what was found

⊕⊖⊖⊖ **Very low:** We are very uncertain about the effect

Footnotes
1. Results from CBA studies report a relative change compared to the control group, and results from ITS studies report a relative change compared to utilisation levels that would have been expected without the intervention

2. Most studies used no control or controls that were not equivalent

3. Only one study – the analysis suffered from many problems (the method of analysis was not appropriate and was performed on a sample of [only?] 61 individuals)