12.3. EVIDENCE BASE:

Should AUXILIARY NURSES insert and remove intrauterine device (IUDs)

***Problem**:* Poor access to contraception
***Option**:* Auxiliary nurses inserting and removing IUDs
***Comparison**:* Care delivered by other cadres or no care
Setting: Community/primary health care settings in LMICs with poor access to health professionals

	CRITERIA	JUDGEMENT	EVIDENCE	COMMENTS AND QUERIES
BENEFITS & HARMS OF THE OPTIONS	**Are the anticipated desirable effects large?**	No ☐ / Probably no ☐ / Uncertain ☑ / Probably yes ☐ / Yes ☐ / Varies ☐	A systematic review (Polus 2012a) searched for studies that assessed the effects and safety of task shifting for family planning delivery in low and middle income countries. Another systematic review searched for studies that assessed the effects of midlevel providers, including auxiliary nurses, in improving the delivery of health care services (Lassi 2012). However, neither of these reviews identified any studies that assessed the effects of using auxiliary nurses to insert and remove IUDs. **We are therefore unable to draw any conclusions about the desirable or undesirable effects of this intervention.** **Indirect evidence:** The same systematic review (Polus 2012a) identified two studies from the Philippines and Turkey where IUD insertion by auxiliary nurse midwives was compared with IUD insertion by doctors. These studies show that the use of auxiliary nurse midwives probably leads to little or no difference in expulsion rates, removal rates, continuation rates (moderate certainty evidence). There may also be little or no difference in rates of unintended pregnancies or in referral rates before and after IUD insertion (low certainty evidence). The studies did not assess pain at insertion, insertion failure, and complications at insertion. The review also identified two studies from Brazil and Columbia where IUD insertion by nurses was compared with IUD insertion by doctors. These studies show that the use of nurses may lead to little or no difference in expulsion rates and continuation rates (low certainty evidence), and probably leads to less pain (moderate certainty evidence). We are uncertain about the differences between nurses and doctors for removal rates, rates of unintended pregnancies, and complication rates (very low certainty evidence). Other outcomes show mixed results (low certainty evidence). **Annex:** pages 58-60 (Polus 2012a – Table 1 and Table 2)	
	Are the undesirable effects small?	No ☐ / Probably no ☐ / Uncertain ☑ / Probably yes ☐ / Yes ☐ / Varies ☐		
	What is the certainty of the anticipated effects?	Very low ☐ / Low ☐ / Moderate ☐ / High ☐ / No direct evidence ☑ / Varies ☐		
	Are the desirable effects large relative to the undesirable effects?	No ☐ / Probably no ☐ / Uncertain ☑ / Probably yes ☐ / Yes ☐ / Varies ☐		
RESOURCE USE	**Are the resources required small?**	No ☐ / Probably no ☐ / Uncertain ☐ / Probably yes ☑ / Yes ☐ / Varies ☐	***Main resource requirements***	

Resource	Settings in which auxiliary nurses already provide other care
Training	Some training for auxiliary nurses to insert and remove an IUD
Supervision and monitoring	Regular supervision by senior midwife or doctor
Supplies	IUD, antiseptic solution, insertion equipment
Referral	This may be needed for a small number of women

	CRITERIA	JUDGEMENT	EVIDENCE	COMMENTS AND QUERIES
	Is the incremental cost small relative to the benefits?	*No* ☐ *Probably no* ☐ *Uncertain* ☑ *Probably yes* ☐ *Yes* ☐ *Varies* ☐	Uncertain as there is insufficient evidence on effectiveness	
ACCEPTABILITY	**Is the option acceptable to most stakeholders?**	*No* ☐ *Probably no* ☐ *Uncertain* ☐ *Probably yes* ☑ *Yes* ☐ *Varies* ☐	A review of country case studies of task shifting for family planning (Polus 2012b) identified one programme where IUDs were delivered by auxiliary nurses. Overall, the review suggests that recipients appreciate the easy access that community-based provision of contraceptives provides and appreciate the use of female health workers in the delivery of contraceptives. However, the review also suggests that some health workers may introduce their own criteria when determining who should receive contraceptives, including criteria tied to the recipient's marital status and age. Other factors that may affect the uptake of the intervention are primarily tied to the contraceptives themselves rather than the use of specific types of health workers, including a lack of knowledge about different methods of contraception; religious and other beliefs regarding family planning; a fear of side effects, service fees; and a lack of support from husbands. **Indirect evidence:** A systematic review (Rashidian 2012) exploring factors that influence the success of doctor-nurse substitution suggests that the acceptability of this intervention to key stakeholders may be mixed: • Nurses may be motivated to take on new tasks by increased recognition and job satisfaction (moderate certainty evidence) • Doctors may welcome the contribution of nurses where it reduces doctors' workloads (moderate certainty evidence). They may welcome the transfer of certain repetitive tasks to nurses (e.g. pap smears) and nurses seem to be happy with these tasks • However, a lack of clarity about nurse roles and responsibilities in relation to other health workers may be a challenge (low certainty evidence) **Annex:** page 33 (Glenton, Khanna 2012); page 43 (Rashidian 2012); page 63 (Polus 2012b)	
FEASIBILITY	**Is the option feasible to implement?**	*No* ☐ *Probably no* ☐ *Uncertain* ☐ *Probably yes* ☑ *Yes* ☐ *Varies* ☐	The intervention requires very few supplies (IUDs, antiseptic solution, insertion equipment). However, changes to drug supplies may be needed and the intervention is also likely to require changes to norms or regulations. Training in IUD insertion and removal and in communication about family planning, and supervision is necessary. However, a review of country case studies of task shifting for family planning (Polus 2012b) suggests that auxiliary nurses felt that training in IUD insertion was insufficient. The auxiliary nurses also lacked confidence in their skills, partly because they had insufficient opportunities to practice these skills in settings were demand was low. In addition, systematic reviews of lay health worker, nurse and midwife programmes suggest that sufficient training and supervision is often lacking (moderate certainty evidence) (Glenton, Colvin 2012, Rashidian 2012, Colvin 2012). **Annex**: page 63 (Polus 2012b); page 26 (Glenton, Colvin 2012); page 43 (Rashidian 2012) ; page 20 (Colvin 2012).	