12.4. EVIDENCE BASE:

Should NURSES insert and remove contraceptive implants?

***Problem**:* Poor access to contraception
***Option**:* Nurses inserting and removing contraceptive implants
***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 nurse-led primary care compared to care that was given by primary care doctors (Laurant 2012). However, none of these reviews identified any studies that specifically assessed the effects of nurses inserting and removing contraceptive implants. **We are therefore unable to draw any conclusions about the desirable or undesirable effects of this intervention.** **Indirect evidence**: One of these systematic reviews (Polus 2012a) did identify 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). The other systematic review (Laurant 2012) suggests that nurse-led care for a range of other health issues may improve several health outcomes while it may make no difference to other outcomes. However, the quality of this evidence varies. **Annex:** page 58 (Polus 2012a – Table 1); page 6 (Laurant 2012).	
	Are the anticipated 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 nurses already provide other care
Training	Some training for auxiliary nurse midwives to insert and remove a contraceptive implant
Supervision and monitoring	Regular supervision by senior midwife or doctor
Supplies	Contraceptive implant, insertion equipment and local anaesthetic
Referral	Patients may need to go to a referral centre for removal difficulties

	Is the incremental cost small relative to the benefits?	*No* ☐ *Probably no* ☐ *Uncertain* ☐ *Probably yes* ☑ *Yes* ☐ *Varies* ☐	Indirect evidence from the review referred to above (Laurant 2012) suggests that, compared to doctor-led care: • Overall, studies showed lower costs for nurse-led care • Consultation length was longer for nurses • For the frequency of consultations, results were mixed • For most studies there were no differences in the use of healthcare services and prescriptions	
	CRITERIA	**JUDGEMENT**	**EVIDENCE**	**COMMENTS AND QUERIES**
ACCEPTABILITY	**Is the option acceptable to most stakeholders?**	*No* ☐ *Probably no* ☐ *Uncertain* ☐ *Probably yes* ☑ *Yes* ☐ *Varies* ☑	A systematic review of doctor-nurse substitution (Rashidian 2012) did not identify any studies that evaluated the acceptability of contraceptive implants when inserted and removed by nurses. **We are therefore uncertain about the acceptability of this intervention to key stakeholders.** **Indirect evidence:** For other maternal and child health interventions, the same review suggests that: • Nurses may be motivated to offer advanced care by increased recognition and job satisfaction (moderate certainty evidence) • Recipients may regard nurses as more accessible and better at listening and caring than doctors (moderate certainty evidence). For tasks that are considered sensitive (such as pelvic exams) patients may prefer (female) nurses, although views may vary (low certainty evidence). They may also prefer nurses for services that require more attention and time (low certainty evidence). However, in some settings, recipients may experience nurses as too overworked to explain things to recipients (low certainty evidence) In addition, some recipients may have concerns about nurses' competence and willingness to provide high quality care compared to doctors (low certainty evidence). • Doctors may welcome the contribution of nurses where it reduces doctors' workloads (moderate certainty evidence). Doctors may also welcome the transfer of certain repetitive tasks to nurses (e.g. pap smears) and nurses seem to be happy with these tasks (low certainty evidence). • Doctors may also be comfortable with nurse prescribing, believing that it improves the continuity of care that patients receive (low certainty evidence). However, a lack of clarity about nurse roles and responsibilities in relation to other health workers may be a challenge (low certainty evidence) A review of country case studies of task shifting for family planning (Polus 2012b), which mainly included LHW programmes, 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. **Annex**: page 43 (Rashidian 2012)**;** page 63 (Polus 2012b)	

SIBILITY	**Is the option feasible to implement?**	*No* ☐ *Probably no* ☐ *Uncertain* ☐ *Probably yes* ☐ *Yes* ☑ *Varies* ☐	The intervention requires very few supplies (contraceptive implants, insertion equipment, local anaesthetic). In addition, it is unlikely to require changes to norms or regulations. Some training and supervision is necessary, particularly regarding the removal of contraceptive implants. However, a systematic review (Rashidian 2012) suggests that nurses may be unprepared or not adequately trained or supervised when they are given advanced and substitution roles (low certainty). Adequate referral to a higher level of care for further management of implant removal may be necessary. **Annex**: page 43 (Rashidian 2012)	