

**12.4. RECOMMENDATION:**

**Should MIDWIVES insert and remove contraceptive implants?**

**Problem:** Poor access to contraception  
**Option:** Midwives 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

Recommendation	<i>We recommend against the option</i>	<i>We suggest considering the option with targeted monitoring and evaluation</i>	<i>We recommend the option</i>
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	We recommend the use of midwives to insert and remove contraceptive implants. We suggest using this intervention where a well-functioning midwife programme already exists.		
<b>Justification</b>	There is insufficient evidence on the effectiveness of this intervention and acceptability is uncertain. However, this intervention would require minimal additional skills. In addition, this intervention is probably a cost-effective and feasible approach to contraception and may also reduce inequalities by extending care to underserved populations.		
<b>Implementation considerations</b>	<p>The following should be considered when using midwives to insert and remove IUDs or contraceptive implants:</p> <ul style="list-style-type: none"> <li>- The relevant professional bodies should be involved in the planning and implementation of the intervention to ensure acceptability among affected health workers</li> <li>- The distribution of roles and responsibilities between midwives and other health workers needs to be made clear, including through regulations and job descriptions</li> <li>- Changes in regulations may be necessary to support any changes in midwives' scope of practice</li> <li>- Programmes need to ensure that this task promotes continuity of care, for instance by ensuring that all midwives are "upskilled" to deliver this task for all potential recipients</li> <li>- Implementation needs to be in the context of a comprehensive remuneration scheme, in which salaries or incentives reflect any changes in scope of practice. Giving incentives for certain tasks but not for others may negatively affect the work that is carried out</li> <li>- Referral systems need to function well, i.e. financial, logistical (e.g. transport) and relational barriers need to be addressed. Specifically, local health systems need to be strengthened to improve quality of care at the first referral facility</li> <li>- Supplies of equipment needs to be secure</li> <li>- Responsibility for supervision needs to be clear and supervision needs to be regular and supportive</li> <li>- Midwives and their supervisors need to receive appropriate initial and ongoing training, including in communicating with recipients and in side effects of different contraceptive methods. Training needs to reinforce that midwives should avoid introducing their own criteria for determining who should receive contraception</li> <li>- Midwives need to be trained in confidentiality issues and recipients need to be made aware that their interactions with health workers regarding contraception are confidential.</li> </ul>		
<b>Monitoring and evaluation</b>			
<b>Research priorities</b>	Studies of the acceptability to midwives of inserting IUDs and contraceptive implants		

12.4. EVIDENCE BASE:

Should MIDWIVES insert and remove contraceptive implants?

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CRITERIA	JUDGEMENT	EVIDENCE	COMMENTS AND QUERIES										
BENEFITS & HARMS OF THE OPTIONS	<p>Are the anticipated desirable effects large?</p> <p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Varies <input type="checkbox"/></p>	<p>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 midwives, in improving the delivery of health care services (Lassi 2012). However, none of these reviews identified any studies that assessed the effects of using midwives to insert and remove contraceptive implants. <b>We are therefore unable to draw any conclusions about the desirable or undesirable effects of this intervention.</b></p> <p><b>Indirect evidence:</b> The same review (Polus 2012a) also identified two studies from Brazil and Columbia where <u>IUD insertion by nurses</u> was compared with <u>IUD insertion by doctors</u>. 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).</p> <p><b>Annex:</b> page 58 (Polus 2012a – Table 1)</p>											
	<p>Are the anticipated undesirable effects small?</p> <p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Varies <input type="checkbox"/></p>												
	<p>What is the certainty of the anticipated effects?</p> <p>Very low <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> No direct evidence <input checked="" type="checkbox"/> Varies <input type="checkbox"/></p>												
	<p>Are the desirable effects large relative to the undesirable effects?</p> <p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Varies <input type="checkbox"/></p>												
RESOURCE USE	<p>Are the resources required small?</p> <p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Varies <input type="checkbox"/></p>	<p><b>Main resource requirements</b></p> <table border="1"> <thead> <tr> <th>Resource</th> <th>Settings in which midwives already provide other care</th> </tr> </thead> <tbody> <tr> <td>Training</td> <td>Some training for midwives to insert and remove a contraceptive implant</td> </tr> <tr> <td>Supervision and monitoring</td> <td>Regular supervision by senior midwife or doctor</td> </tr> <tr> <td>Supplies</td> <td>Contraceptive implant, insertion equipment and local anaesthetic</td> </tr> <tr> <td>Referral</td> <td>Patients may need to go to a referral centre for removal difficulties</td> </tr> </tbody> </table>	Resource	Settings in which midwives already provide other care	Training	Some training for 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	
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	CRITERIA	JUDGEMENT	EVIDENCE	COMMENTS AND QUERIES
	Is the incremental cost small relative to the benefits?	<p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Varies <input type="checkbox"/></p>	The costs of this intervention by midwives are likely to be small in relation to the benefits	
ACCEPTABILITY	Is the option acceptable to most stakeholders?	<p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input checked="" type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> Varies <input type="checkbox"/></p>	<p>A systematic review of task-shifting in midwifery programmes (Colvin 2012) did not identify any studies that evaluated the acceptability of contraceptive implants when inserted and removed by midwives. <b>We are therefore uncertain about the acceptability of this intervention to key stakeholders.</b></p> <p><b>Indirect evidence:</b> For <u>other midwife-delivered interventions</u>, the same review suggests the following:</p> <ul style="list-style-type: none"> <li>• Midwives and their supervisors and trainers generally felt midwives had no problem learning new medical information and practicing new clinical techniques. Midwives may also be motivated by being “upskilled” as it can potentially lead to increased status, promotion opportunities and increased job satisfaction (moderate certainty evidence)</li> <li>• However, midwives may be unwilling to take on tasks that requires them to move beyond obstetric care, such as tasks related to family planning and sexual health, possibly because this is not viewed as part of their role and may entail an increased workload (moderate certainty evidence)</li> <li>• A lack of clarity in roles and responsibilities between midwives and other health worker cadres, as well as status and power differences may also lead to poor working relationships and ‘turf battles’ (moderate certainty evidence)</li> </ul> <p>A review of country case studies of task shifting for family planning (Polus 2012b), which mainly included <u>LHW programmes</u>, 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.</p> <p><b>Annex:</b> page 20 (Colvin 2012); page 63 (Polus 2012b)</p>	
FEASIBILITY	Is the option feasible to implement?	<p>No <input type="checkbox"/> Probably no <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Varies <input type="checkbox"/></p>	<p>The intervention requires very few supplies (contraceptive implants, insertion equipment, local anaesthetic). In addition, it is unlikely to require changes to norms or regulations.</p> <p>Some training and supervision is necessary, particularly regarding the removal of contraceptive implants. However, a systematic review (Colvin 2012) suggests that ongoing support, training and supervision was often insufficient in midwife taskshifting programmes (moderate certainty evidence).</p> <p>Adequate referral to a higher level of care for further management may be necessary if removal leads to complications.</p> <p><b>Annex:</b> page 20 (Colvin 2012)</p>	