MAKING PREGNANCY A POSITIVE EXPERIENCE:

Women's and health care providers' voices in the WHO ANC guideline

World Health Organization

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Photo: UNICEF/Sibiloni

Background

Background

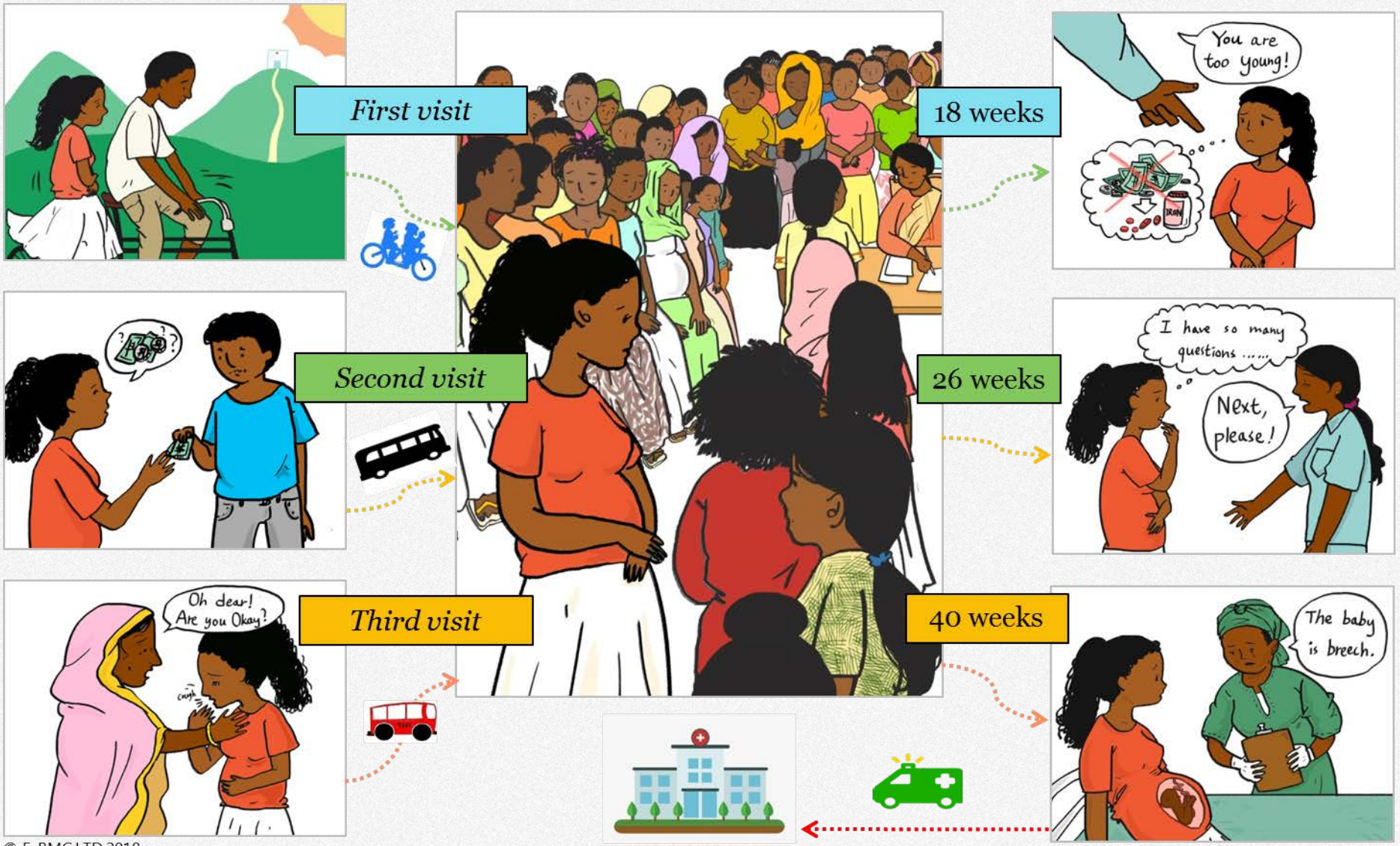
Antenatal care (ANC) is an essential component of maternity care. However, uptake and quality of ANC service provision in many contexts globally is inadequate.

There are many reasons for poor uptake of services, including a lack of recognition by pregnant women and their communities of the need for professional care in pregnancy, the cost of formal or informal payments for service, the absence of local provision, and infrequent, expensive or non-existent transport to distant clinics.

Even when services are relatively accessible and affordable, some women don't use them, especially women from vulnerable or marginalized population groups.

For example, take Naledi's experience of ANC…

Naledi's experience of antenatal care



Assumptions about pregnancy versus women's beliefs

There are differences between the assumptions that underpin standard ANC programmes and women's beliefs and attitudes to pregnancy.

Assumptions about pregnancy:		Women's beliefs and attitudes that:
Pregnancy is potentially risky for mother and baby	VS	Pregnancy is a healthy state for mother and baby mother and baby
Pregnancy is a positive social state that will be welcomed by the family and the community	VS	Pregnancy can be socially risky and may be subject to malign forces, superstitions and stigma
Women and families have enough resources to make rational economic choices to access ANC	VS	A choice to access care might mean a risk to survival due to resource challenges

Consequences of the difference between ANC assumptions and woman's beliefs

= *Lack of initial access to ANC*

Source: Finlayson et al, 2013

Photo: Dominic Chavez / World Bank

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Photo : AMISOM

Assumptions about service delivery versus woman's experiences

Negative experiences of service provision are common and there is a contrast between the assumptions of service delivery and women's experiences of care.

Assumptions about service delivery:		Women's views and experiences:
ANC is affordable	VS	ANC is subject to unexpected costs levied at the point of need
Staff attitude is not relevant and/or is generally positive	VS	Staff attitude is highly relevant and can be discriminatory, neglectful or even abusive
All the resources needed for the level of care on offer are present	VS	Resources are often not available, and transfer is then necessary to the next level of care

Consequences of the difference between ANC assumptions about service delivery and woman's experiences

= *Lack of repeat access to ANC*

Source: Finlayson et al, 2013

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Photo: WHO/Natalie Behring-Chisholm

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The WHO ANC guideline

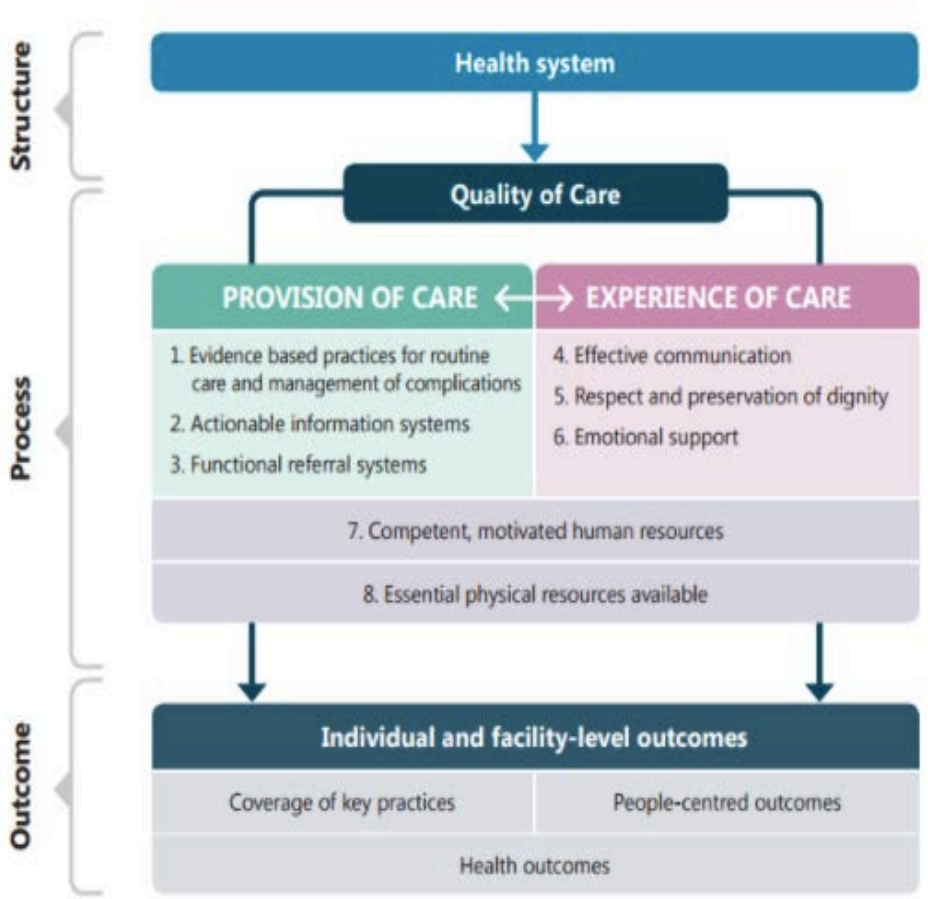
The ANC guideline

"The WHO envisions a world where every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period."

In line with this vision, WHO has produced a framework to facilitate quality of care improvements in maternal and newborn health. This framework seeks to ensure that provision of care and experience of care are aligned.

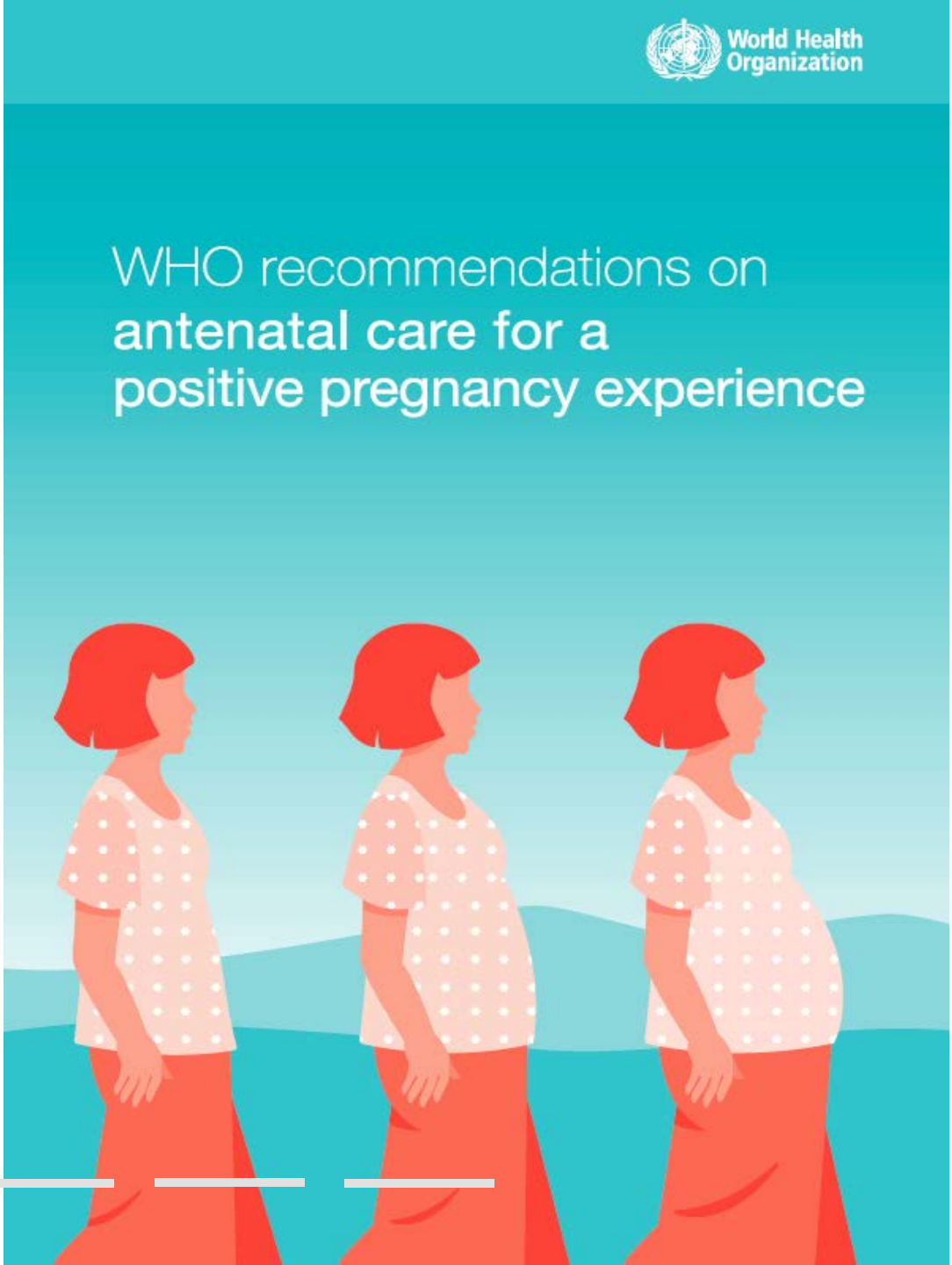
So how do we achieve this?

Fig. 1. WHO framework for the quality of maternal and newborn health care



The ANC guideline

"The aim of the new ANC guideline is to provide pregnant women and adolescents with ***respectful, individualized, person-centred care at every ANC contact****, with provision of effective clinical practices, relevant and timely information, and psychosocial and emotional support, by practitioners with good interpersonal skills* ***within a well-functioning health system****."*



CHANGING THE CONVERSATION

To be relevant to different contexts and populations, evidence other than on the effectiveness of an intervention needs to be considered, such as user values and preferences, acceptability, feasibility, resources, and the equity implications of the intervention.

Evidence on these factors can seldom be obtained through quantitative research and reviews designed to assess effectiveness, safety or coverage of an intervention.

Photo : USAID/MCHIP

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What makes the ANC guideline different?

The WHO has listened to, and prioritised, women's voices throughout the development of the new ANC guideline.

To complement evidence from systematic reviews on the effectiveness of ANC interventions, WHO looked to qualitative research to answer the following questions:

1. What do women want, need, and value in ANC?
2. What are women's views and experiences of using ANC services?
3. What are health providers' views and experiences of providing ANC services?

Photo UNICEF/Nesbitt

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Qualitative Research

Qualitative research is an ideal vehicle for answering questions of acceptability and feasibility, and for exploring the kinds of values and beliefs that might explain the uptake and quality of provision of antenatal care programmes.

Photo UNICEF/Romana

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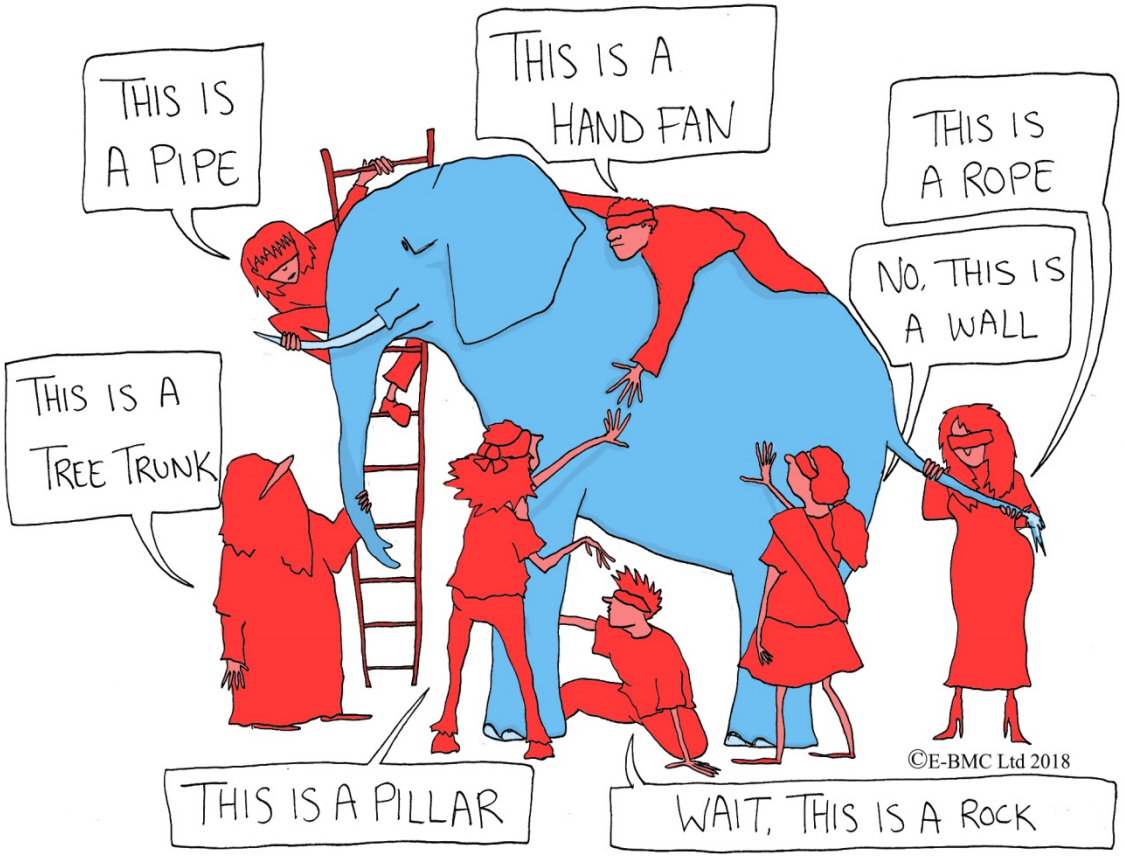
Photo Arturo Sanabria, Photoshare

Qualitative evidence synthesis

Qualitative evidence synthesis (QES): what is it?

People's views and experiences of any phenomenon can be very different. Therefore, taking a limited perspective on it can give us an element of the truth, but not the whole truth.

It is only when we consider many perspectives that we get the full picture.



How does this relate to developing the ANC guideline?

There are many studies describing women's experiences of ANC and factors that affect their uptake of ANC.

However, women's experiences of ANC are likely to differ widely between individuals, countries and settings.

How do we know whether their findings apply to a specific context, or which study's findings are most generalizable?

By conducting qualitative evidence synthesis (QES).

Qualitative Evidence Synthesis: what is it?

Qualitative evidence synthesis (QES) is a research method that:

A. systematically identifies qualitative studies on a phenomenon of interest

B. assesses the quality (methodological limitations) of these individual studies

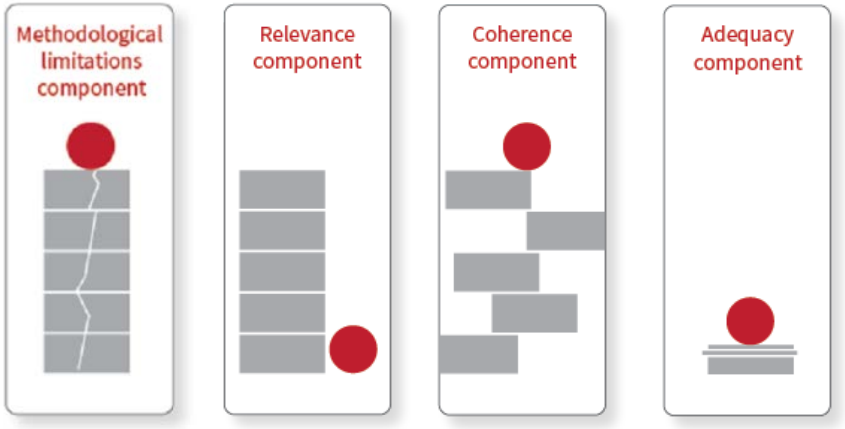
and

C. summarizes the findings according to the common themes that emerge

For guideline purposes, the quality (confidence in the evidence) of the summary findings is assessed.

GRADE CERQual

Confidence in the Evidence from Reviews of Qualitative Research



www.cerqual.org

Photo UNICEF/Asselin

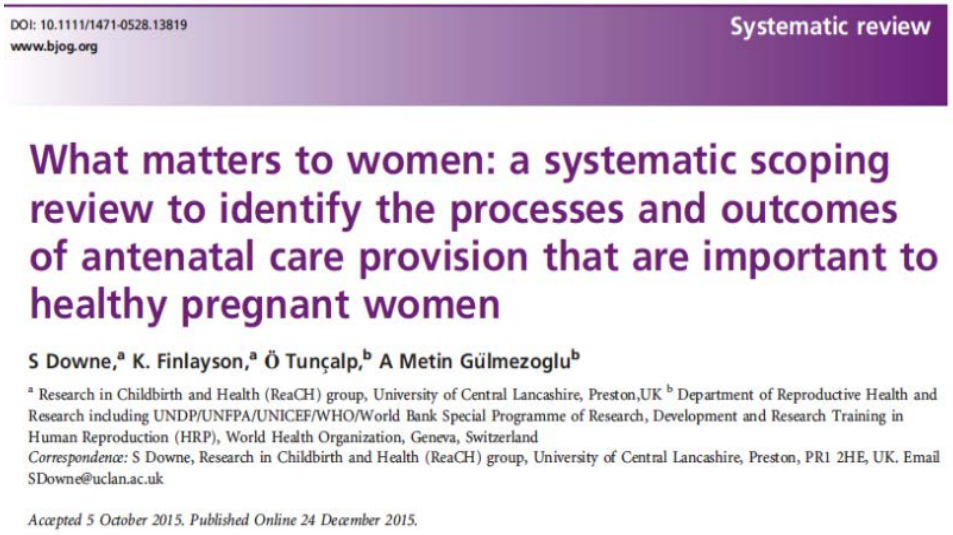
Scoping what matters to women

The aim of the scoping review

“What matters to women in pregnancy?”

This question was the starting point of the ANC guideline development process.

*The aim of the scoping review was to explore the **views, attitudes and experiences of pregnancy** accounted by individual women in low-, middle- and high-income countries, and to summarise the findings to inform the ANC guideline.*



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www.bjog.org

Systematic review

What matters to women: a systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women

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How the QES at the scoping stage was conducted

Thirty-eight studies were identified from 1994 onwards.

*These included the **voices of 1264 women from 26 countries**.*

Studies were from North America (13), South America (8), Africa (6), Europe (4), Asia (4), Middle East (2),and 1 from four countries (Cuba, Thailand, Argentina, Saudi Arabia).

Authors used data-mining software to help to identify the common themes in the individual studies.

They examined the included papers, and an index paper was selected, chosen to best reflect the focus of the review. The themes and findings identified by the authors of this paper were entered onto a spread sheet to develop an initial thematic framework.

The findings of the remaining papers were then mapped to this framework, which continued to develop as the data from each paper were added.

All the themes were translated (or synthesized) into a ‘line of argument synthesis’. This was based on theoretical concepts that explained the data at a conceptual level.

Themes from the scoping QES

Four core themes emerged namely:

1. Maintaining physical and sociocultural normality;
2. Maintaining a healthy pregnancy for mother and baby (including preventing and treating risks, illness and death);
3. Effective transition to positive labour and birth; and
4. Achieving positive motherhood (including maternal self-esteem, competence, autonomy).

These themes were all encapsulated in the composite outcome: a 'positive pregnancy experience'.

Table 1. Final analytic framework (1): positive pregnancy experience

Themes	Subthemes	Studies including these themes (step two in black, step three in red)	Country/quality score (step two in black, step three in red	Comment
Positive pregnancy Achievement/maintenance of optimal health and psycho-social wellbeing for mother and baby	Sociocultural normality	1, 6, 7, 11, 16, 17, 18, 24, 27, 31, 32, 34, 38	Turkey (B), Indonesia (B), Ghana (B), Taiwan (B), Gambia (B), Brazil (B) USA (B), Mozambique (B), UK (A), USA (B−), Swaziland (B), USA (B), Thailand (B+)	Even where pregnancy is unwanted, but kept. In some settings this is about demonstrably following the biomedical model, in others it is the opposite
	Healthy pregnancy/normal birth/healthy baby	1, 2, 4, 6, 7, 8, 9, 11, 12, 18, 19, 23, 25, 28, 32, 34, 36, 37, 38	Turkey (B), Vietnam (B), USA (B), Indonesia (B), Ghana (B), Ghana (B−), Brazil (C), Taiwan (B), Jordon (C), USA (B), USA (B), USA (B), Argentina (C−), Sweden (B), Swaziland (B), USA (B), Canada (B), Finland (B−), Thailand (B+)	Including support and promotion of wellbeing and prevention of death and morbidity in mother and baby
	Effective transition through the childbirth continuing, including positive labour and birth	4, 9, 13, 19, 21, 28, 30, 34, 35, 36, 37, 38	USA (B), Brazil (C), Mexico (B), USA (B), Canada (B), Sweden (B), Brazil (B), USA (B), Brazil (B), Canada (B), Canada (B), Finland (B−), Thailand (B+)	Even where pregnancy is unwanted, but kept. Including being validated in her beliefs, social circumstances, interpretations of the health or otherwise of her pregnancy based on embodied/cultural experiences and norms
	Positive mothering, maternal self-esteem, competence, autonomy	18, 9, 11, 17, 18, 21, 23, 28, 34, 37	USA (B), Brazil (C), Taiwan (B), Brazil (B), USA (B), Canada (B), USA (B), Sweden (B), USA (B), Canada (B), Finland (B−)	Including validation of embodied experiences and interpretations

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Summary of findings from the scoping QES

During pregnancy, women want:

1. Support (social, cultural, emotional and psychological support)
2. Relevant and timely information (physiological, biomedical, behavioural, sociocultural information)
3. Effective clinical care/therapeutic practices (biomedical interventions and tests) integrated with therapeutic spiritual and religious practices, where appropriate


Photo UNICEF/Romana

The confidence in this evidence is high because of the large numbers studies contributing to the findings on framework themes and subthemes, and because the findings were consistent across a wide range of cultural, linguistic and socio-economic contexts.

What else did we learn?

- Outcomes that are important for pregnancy go far beyond ANC coverage, skilled birth attendance, and mortality and morbidity.
- There is little evidence from clinical trials and systematic reviews on issues that matter to women in pregnancy.
- Pregnant women are considering their birth experience, how they will emerge from the process, and their capacity for effective mothering into the future.

Photo: WHO-Yoshi Shimizu

SO… identifying and treating problems that arise during pregnancy is just one component of what women want from ANC!

How was this evidence used?

"The aim of the new ANC guideline is to provide pregnant women and adolescents with ***respectful, individualized, person-centred care at every ANC contact****, with provision of effective clinical practices, relevant and timely information, and psychosocial and emotional support, by practitioners with good interpersonal skills* ***within a well-functioning health system****."*

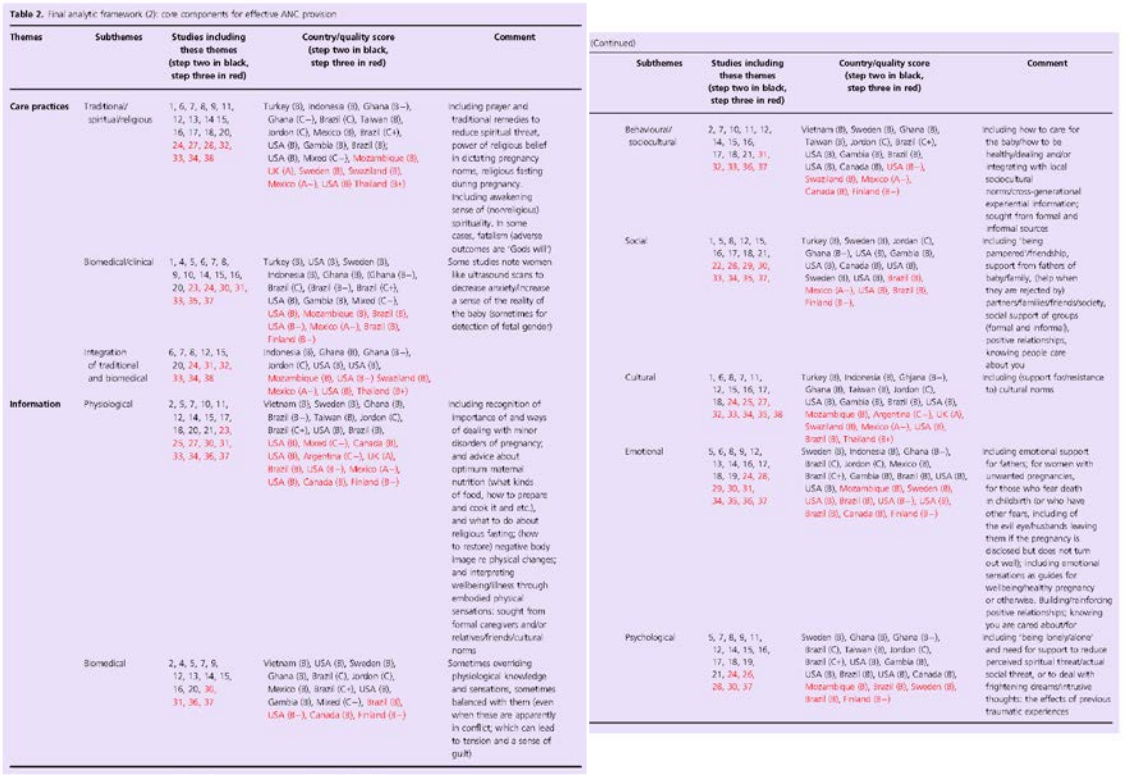

Table 2. Final analytic framework (2): core components for effective ANC provision

Themes	Subthemes	Studies including these themes (step two in black, step three in red)	Country/quality score (step two in black, step three in red)	Comment
Care practices	Traditional/ spiritual/religious	1, 6, 7, 8, 9, 11, 12, 13, 14 15, 16, 17, 18, 20, 24, 27, 28, 32, 33, 34, 38	Turkey (3), Indonesia (3), Ghana (3–), Ghana (C–), Brazil (C), Taiwan (B), Jordan (C), Mexico (B), Brazil (C+), USA (B), Gambia (B), Brazil (B), USA (B), Mixed (C–), Mozambique (B), UK (A), Sweden (B), Swaziland (B), Mexico (A–), USA (B) Thailand (B+)	Including prayer and traditional remedies to reduce spiritual threat, power of religious belief in dictating pregnancy norms, religious fasting during pregnancy. Including awakening sense of (non-religious) spirituality. In some cases, fatalism (adverse outcomes are 'Gods will') Some studies note women like ultrasound scans to decrease anxiety/increase a sense of the reality of the baby (sometimes for detection of fetal gender)
	Biomedical/clinical	1, 4, 5, 6, 7, 8, 9, 10, 14, 15, 16, 20, 23, 24, 30, 31, 33, 35, 37	Turkey (3), USA (3), Sweden (3), Indonesia (3), Ghana (3), (Ghana (3–), Brazil (C), (Brazil (3–), Brazil (C+), USA (B), Gambia (3), Mixed (C–), USA (B), Mozambique (B), Brazil (B), USA (B–), Mexico (A–), Brazil (3), Finland (B–)	
	Integration of traditional and biomedical	6, 7, 8, 12, 15, 20, 24, 31, 32, 33, 34, 38	Indonesia (3), Ghana (B), Ghana (3–), Jordan (C), USA (3), USA (3), Mozambique (B), USA (B–) Swaziland (B), Mexico (A–), USA (B), Thailand (B+)	
Information	Physiological	2, 5, 7, 10, 11, 12, 14, 15, 17, 18, 20, 21, 23, 25, 27, 30, 31, 33, 34, 36, 37	Vietnam (3), Sweden (3), Ghana (3), Brazil (B–), Taiwan (B), Jordon (C), Brazil (C+), USA (B), Brazil (B), USA (B), Mixed (C–), Canada (B), USA (B), Argentina (C–), UK (A), Brazil (B), USA (B–), Mexico (A–), USA (B), Canada (B), Finland (B–)	Including recognition of importance of and ways of dealing with minor disorders of pregnancy; and advice about optimum maternal nutrition (what kinds of food, how to prepare and cook it and etc.), and what to do about religious fasting; (how to restore) negative body image re physical changes; and interpreting wellbeing/illness through embodied physical sensations: sought from formal caregivers and/or relatives/friends/cultural norms
	Biomedical	2, 4, 5, 7, 9, 12, 13, 14, 15, 16, 20, 30, 31, 36, 37	Vietnam (3), USA (B), Sweden (3), Ghana (3), Brazil (C), Jordon (C), Mexico (B), Brazil (C+), USA (B), Gambia (3), Mixed (C–), Brazil (B), USA (B–), Canada (B), Finland (B–)	Sometimes overriding physiological knowledge and sensations, sometimes balanced with them (even when these are apparently in conflict, which can lead to tension and a sense of guilt)

(Continued)

Subthemes	Studies including these themes (step two in black, step three in red)	Country/quality score (step two in black, step three in red)	Comment
Behavioural/ sociocultural	2, 7, 10, 11, 12, 14, 15, 16, 17, 18, 21, 31, 32, 33, 36, 37	Vietnam (B), Sweden (B), Ghana (B), Taiwan (B), Jordon (C), Brazil (C+), USA (B), Gambia (B), Brazil (B), USA (B), Canada (B), USA (B–), Swaziland (B), Mexico (A–), Canada (B), Finland (B–)	Including how to care for the baby/how to be healthy/dealing and/or integrating with local sociocultural norms/cross-generational experential information; sought from formal and informal sources
Social	1, 5, 8, 12, 15, 16, 17, 18, 21, 22, 28, 29, 30, 33, 34, 35, 37	Turkey (3), Sweden (3), Jordan (C), Ghana (B–), USA (B), Gambia (B), USA (B), Canada (B), USA (B), Sweden (B), USA (B), Brazil (B), Mexico (A–), USA (B), Brazil (B), Finland (B–),	Including 'being pampered/friendship, support from fathers of baby/family, (help when they are rejected by) partners/families/friends/society, social support of groups (formal and informal), positive relationships, knowing people care about you
Cultural	1, 6, 8, 7, 11, 12, 15, 16, 17, 18, 24, 25, 27, 32, 33, 34, 35, 38	Turkey (3), Indonesia (B), Ghana (B–), Ghana (B), Taiwan (B), Jordon (C), USA (B), Gambia (B), Brazil (B), USA (B), Mozambique (B), Argentina (C–), UK (A), Swaziland (B), Mexico (A–), USA (B), Brazil (B), Thailand (B+)	Including (support for/resistance to) cultural norms
Emotional	5, 6, 8, 9, 12, 13, 14, 16, 17, 18, 19, 24, 28, 29, 30, 31, 34, 35, 36, 37	Sweden (B), Indonesia (B), Ghana (B–), Brazil (C), Jordon (C), Mexico (B), Brazil (C+), Gambia (B), Brazil (B), USA (B), USA (B), Mozambique (B), Sweden (B), USA (B), Brazil (B), USA (B–), USA (B), Brazil (B), Canada (B), Finland (B–)	Including emotional support for fathers; for women with unwanted pregnancies, for those who fear death in childbirth (or who have other fears, including of the evil eye/husbands leaving them if the pregnancy is disclosed but does not turn out well); including emotional sensations as guides for wellbeing/healthy pregnancy or otherwise. Building/reinforcing positive relationships; knowing you are cared about/for
Psychological	5, 7, 8, 9, 11, 12, 14, 15, 16, 17, 18, 19, 21, 24, 26, 28, 30, 37	Sweden (B), Ghana (B), Ghana (B–), Brazil (C), Taiwan (B), Jordan (C), Brazil (C+), USA (B), Gambia (B), USA (B), Brazil (B), USA (B), Canada (B), Mozambique (B), Brazil (B), Sweden (B), Brazil (B), Finland (B–)	Including 'being lonely/alone' and need for support to reduce perceived spiritual threat/actual social threat, or to deal with frightening dreams/intrusive thoughts; the effects of previous traumatic experiences

1. This summary of findings statement on women's values became integral to the guideline decision-making process.

2. A positive pregnancy experience became the overarching guideline outcome.

3. The findings also informed the design of the new women-centred ANC model of care, comprising the three core components.

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The critical question…

How can we help women achieve a positive pregnancy experience?

Building on the scoping review, WHO also conducted a review to understand:

What factors influence the **uptake of ANC services**, arising from **women's accounts** (views and experiences)

And

What factors influence the **provision of good quality ANC services**, arising from **health worker accounts** (views and experiences)

Photo UNICEF/Asselin

Factors affecting the uptake and quality of ANC for women and providers

How the QES on factors affecting the uptake and quality of ANC was conducted

Databases were searched for qualitative studies on women's and/or providers experiences of ANC.

Studies from 2001 onwards (since the introduction of FANC) from any resource or care setting, and in any language, were eligible.

As the focus of the developing ANC guideline was on routine ANC services, and not on specialist care for women with specific characteristics or conditions, studies of these specific types of populations were excluded.

Two reviewers extracted data and independently assessed study quality. The material obtained was then analysed using a method called meta-ethnography.

Summaries of findings were developed from the data, and a nuanced analysis of key factors, including barriers and facilitators, related to uptake of care and to provision of care of high quality, was done.

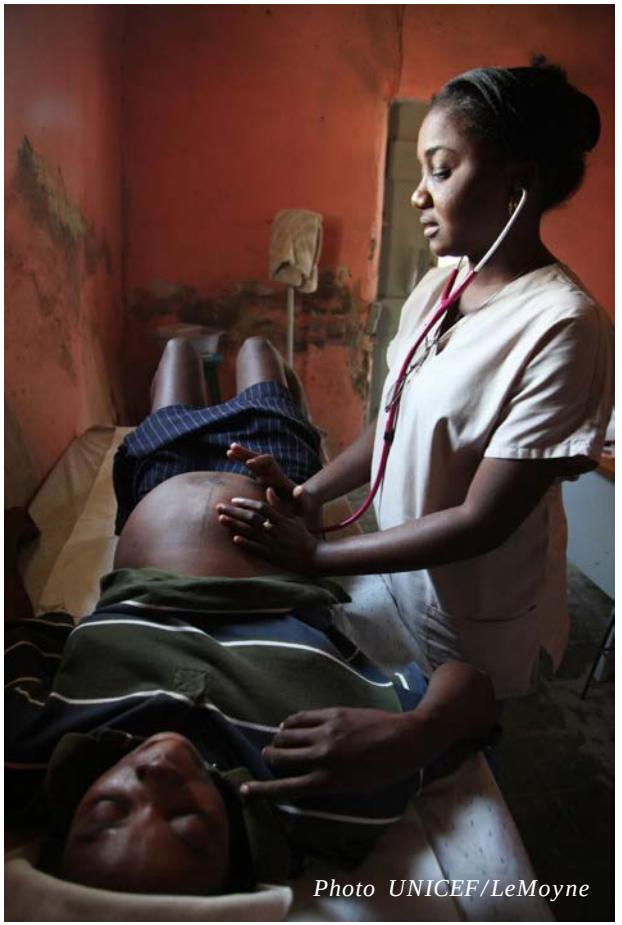
Photo UNICEF/LeMoyne

Confidence in the summary findings was assessed using the GRADE-CERQual approach.

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How this QES was conducted

Building on the scoping review, this QES included qualitative studies exploring women's views and experiences of the **content of care** (including consultations, tests, treatments, information, education, advice, support related to maintaining and monitoring a healthy pregnancy, and helping women to prepare for birth and parenting) provided as part of formal ANC provision for women/fetus without complications.

It also included studies exploring women's views and experiences about **how care is provided** (including the perceived attitudes and behaviours of healthcare providers, and biomedical, psychosocial, relational, and other approaches to care provision).

Similarly, studies that explored health care providers' perspectives, in terms of barriers and facilitators to ANC service provision, related to the content of care and how care is provided were included.

*The phenomena of interest were the **factors that influence the uptake of routine antenatal services** from the perspective of pregnant and postnatal women, and the **factors influencing the delivery of routine antenatal care** based on the views and experiences of healthcare providers*

Photo WHO / Yoshi Shimizu

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QES of women's views and experiences

The primary analysis included ***51 studies of the views and experiences of more than 1450 individual pregnant and postnatal women*** *from a variety of settings (rural, urban, peri-urban and mixed urban/rural).*

Studies came from 29 countries, including North America (7), South America (10), Africa (13), Europe (3), Asia (11), Middle East (2), Oceania (4), plus one study with data from 5 high-income countries.

What women said…

"No, they don't teach us anything concerning feeding, what to do during pregnancy or even how to look after the baby. They only tell me that I am negative (that is HIV). That is what they normally tell me." (Uganda)

"I really like that they take the time for me to just go through my list of questions. I don't feel like I'm wasting their time or that it's boring. I can just sit there and go okay, "What about this? What about that?" And they don't mind that - that's fine. So that I would say is the best part of it - is that I have the time to ask my questions." (Canada)

"We engage in 'hard' work everyday, it is only when we come here or visit the local midwives (TBAs) that we have time to relax and enjoy, even you meet other pregnant women like you and talk about many things that will help you and the baby." (Nigeria)

"The health centre is far and you can see that the road condition is so poor." (Indonesia)

"[Community] meetings are really helpful as we are only involved in trying to solve the health problems of the community through the help of community members. We believe that together we can bring about change." (India)

*"I went for a check-up once in my previous pregnancy; I had to wait in the queue. They [my in-laws and my husband] blamed me for going to see my friends for entertainment, leaving my household work undone" (*Nepal)

"I see a doctor only when it is absolutely necessary, otherwise it is not worth the effort." (Bangladesh)

"When I was having my first child, I got hit because I screamed in pain. They are not kind." (Afghanistan)

"I would say that it's [the environment] a positive one because she [the receptionist] greets me with a smile, and again, non-judgmental, even if she's really, really busy, she doesn't act like she's flustered or stressed out…." (Canada)

"They took my blood, but I was not told what they would test [it for]."…. "I was given and I took, but I did not know what they treat." (Uganda)

*"ANC services are quite helpful. For example, when I was pregnant my baby was lying in the wrong position and they helped her turn for a safe delivery." (*Tanzania)

"The health workers tell us to come with razorblade, basin, gloves, kaveera and thread. I even bought the medicine that stops bleeding (meaning ergometrine), needle and syringes." (Uganda)

"I think being able to call and get somebody to call you back in about 10 or 15 minutes has been really great." (Canada)

"To see doctors and buy medications for my pregnancy complications was an economic burden to our family. Sometimes we could not afford the planned follow-up." (Afghanistan)

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QES of maternity care providers' views and experiences

*The primary analysis included **24 studies of the views and experiences of more than 440 individual maternity care providers** from a variety of settings (rural, urban, peri-urban and mixed urban/rural).*

Studies came from 24 countries, including North America (3), South America (2), Africa (10), Europe (1), Asia (4) and Oceania (4).

Photo Nena Terrell/USAID.

What providers said…

"They said they did not want to have their pregnancy checked because they did not have any money." [Health care provider, Nigeria]

"The pregnant women living in rural areas have financial and time constraints for examination [since they need to work]. I have to explain to them that they might experience complications affecting themselves and their unborn child during their pregnancy." [Midwife, Vietnam]

"We really noticed, as midwives, that people were looking for something and they wanted to be connected to a group of women, and that's really lacking right now." [Midwife, Canada]

"The number of health workers are few compared to the number of mothers who come for antenatal care. Health workers cannot give all the necessary information required during ANC." [Health care provider, Uganda].

"Understaffing is a problem, just now I cannot go for a home visit . . . I cannot go because there will be no-one. I can't go off . . . I am always here. I work throughout the day and night." [Midwife, Zimbabwe]

" But the issue is, when you don't have space or when you have only one person attending to several hundreds of women, how are we supposed to maintain privacy? We really can't, unless we choose to take care of few women and ignore the rest." [Health care provider, Ghana]

"Not everyone wants to have their belly measured in front of a hundred people." [Midwife, Canada]

"*We don't give health education talks every day, it is organised at least twice in a week so you can see that vital things are actually left out."* [Health care provider, Uganda]

"…personally I think screening has been introduced without the resource commitment being taken on board." [Midwife, UK]

"Some years ago in the ANC program we gave pregnant women iron supplements free of charge. They visited us regularly then." [Midwife, Vietnam].

"I am sad to say that patients are afraid of us, they do not dare to ask questions. If I take good care of my patient, my colleagues ask if I am related to the patient or have received money from her." [Doctor, Afghanistan]

"When they are many (mothers) you don't attend to her. You simply examine her, you listen to complaints. You don't treat, there is no time." [Midwife, Uganda].

"It is so frustrating and disappointing to us as professionals. At times you ask yourself why you are here if you cannot give patients the service they want." [Health care provider, Zimbabwe]

"…Just look at me, I am the only midwife, and look at all the women sitting outside, how can one person take proper care of all of them. Sometimes, I believe the women are right for not coming to us." [Midwife, Ghana].

"We have no essential equipment such as a weighing scale or labour kits for childbirth. We have stopped providing DPT- Hepatitis B vaccine because we have no syringes." [Health care provider, Tanzania]

"We hardly go to any training or workshops nor do we receive any tuition reimbursement or bursary for advanced education." [Midwife, Nigeria]

What does this mean?

As with the scoping QES, included studies were examined to establish emerging themes. The primary analysis generated 32 Summary of Findings (SoF) statements relating to women's views and experiences, and 21 relating to maternity care providers views and experiences.

A line of argument synthesis was then constructed with three logic models for uptake, or lack of uptake of ANC.

Logic models like these presume that input factors relating to attitudes, subjective norms, and behavioural control lead to an output of an intended behaviour.

QES authors hypothesized that "the action of attending local ANC services is mediated by women's intentions to, attend, which are, in themselves moderated by their prior attitudes to and beliefs about the value of ANC provided locally, local social norms around such attendance, and by the degree to which they have control over enacting those beliefs and norms, e.g., through having the autonomy and finances to travel to where antenatal care is provided.

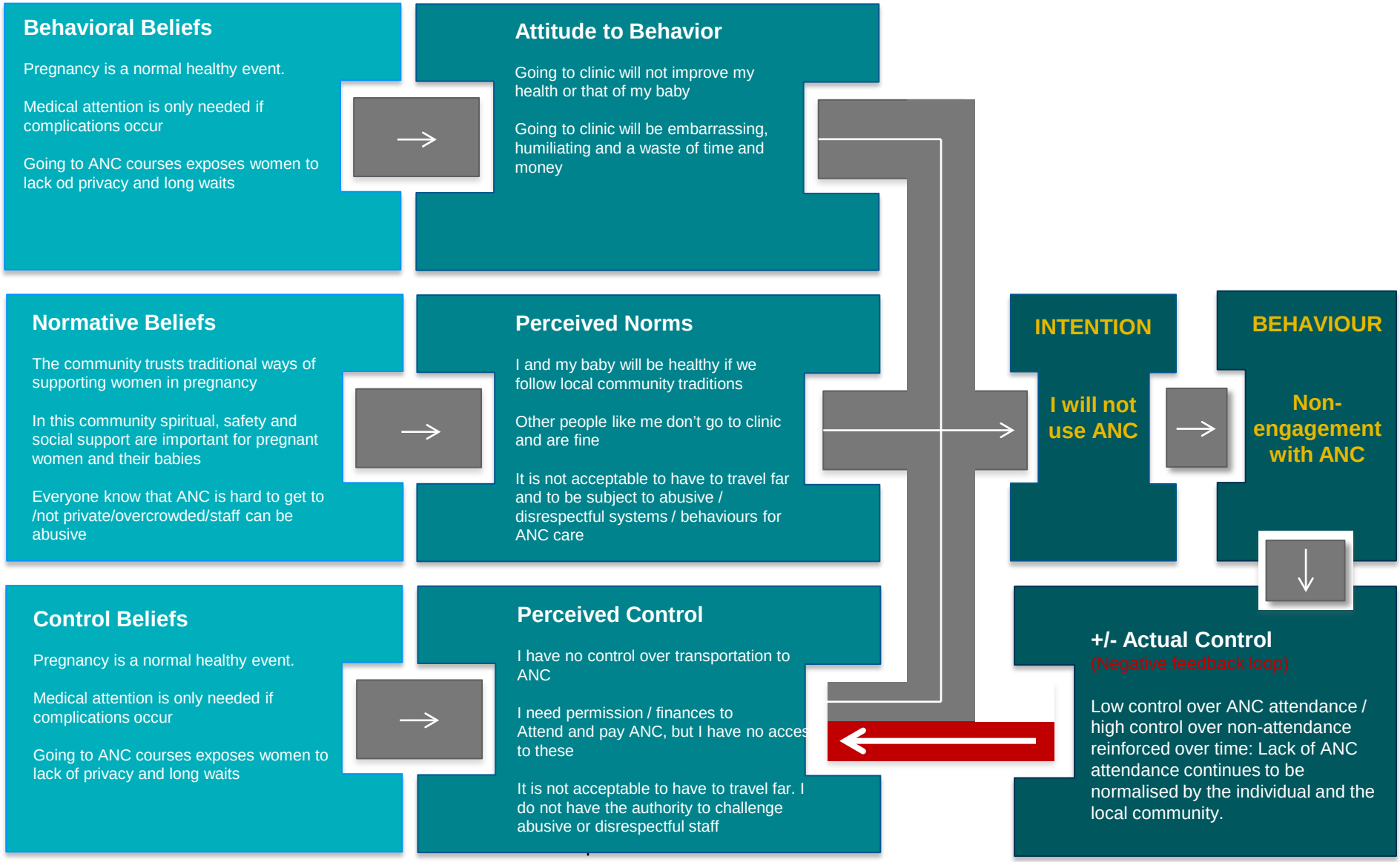
This process, in turn, is mediated by similar factors operating as mechanisms of effect for staff, creating a complex dynamic system in which both staff and service users are agents."

Each input box in the logic models that follow was populated by at least one statement based directly on a summary finding:

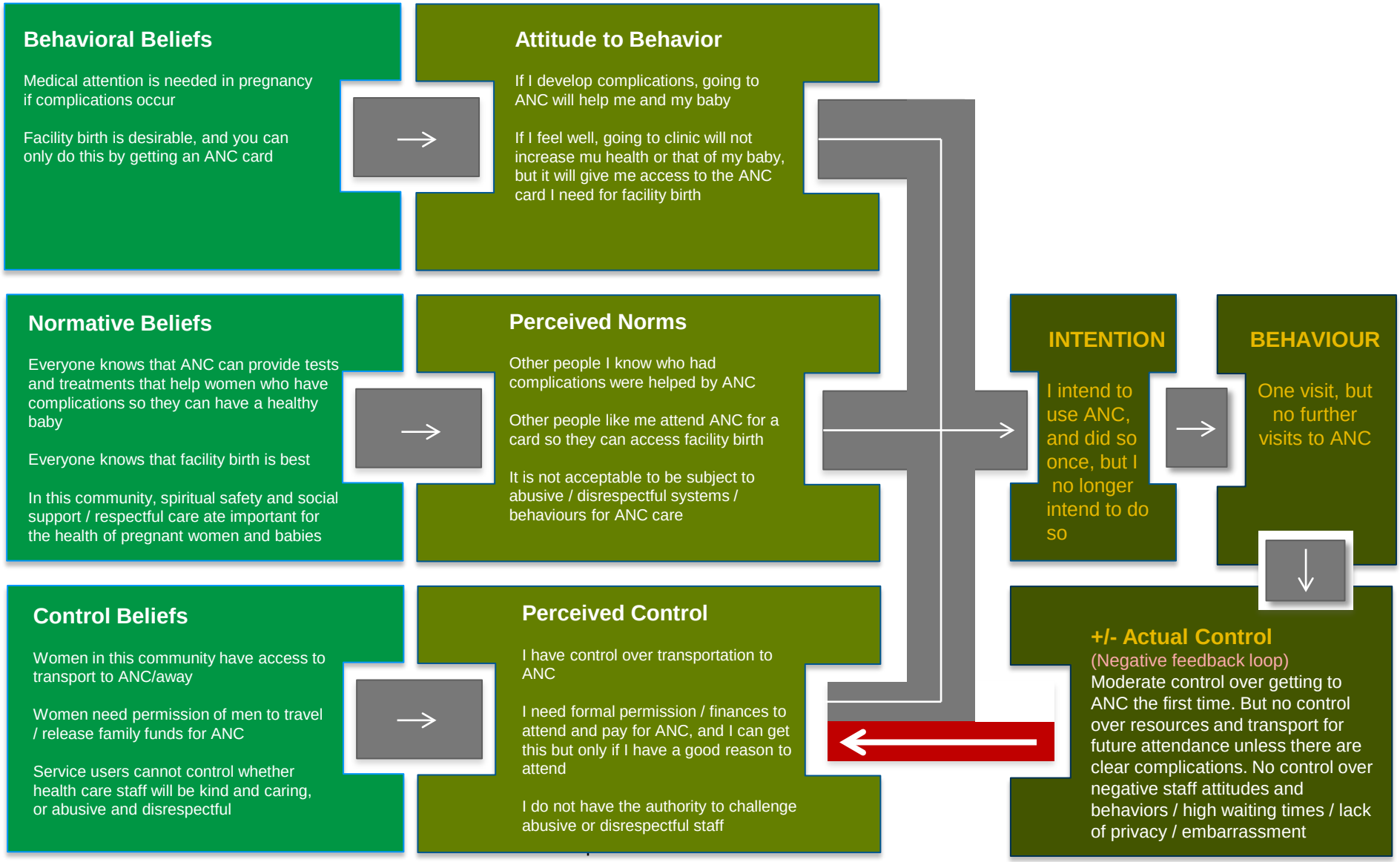
The three scenarios or logic models about ANC attendance constructed were:

- No ANC attendance
- Initial attendance followed by rejection of ANC services
- Full attendance (the 'ideal' type)

Logic model 1 (women) – No ANC attendance



Logic Model 2 (women) – Initial attendance then rejection



Logic Model 3 (women) – Full attendance (ideal type)

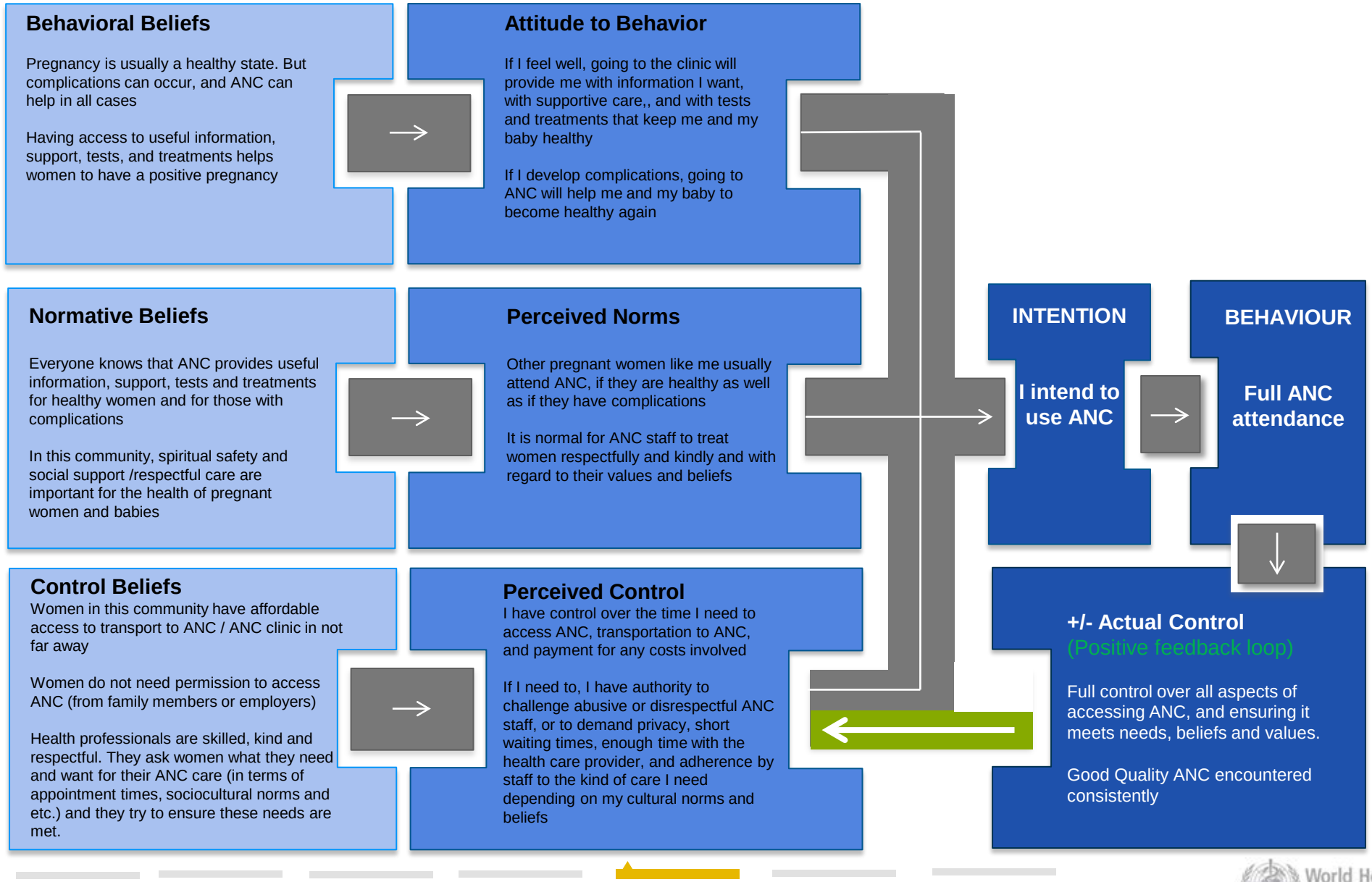


Photo UNICEF/Romana

How QES evidence was used in the ANC guideline

Example 1: Daily iron and folic acid supplements in pregnancy

The implications of the following QES evidence was considered by the guideline development panel when formulating the recommendation on daily iron and folic acid supplementation:

Women's values: Qualitative evidence shows that women from high-, medium- and low-resource settings value having a positive pregnancy experience, the components of which include the provision of effective clinical practices (including nutritional supplements), relevant and timely information (including dietary and nutritional advice) and psychosocial and emotional support, by kind, supportive and respectful health care professionals (*high confidence in the evidence*).

Acceptability: Qualitative evidence suggests that the availability of iron supplements may actively encourage women to engage with ANC providers (*low confidence in the evidence*).

Photo UNICEF/Asselin

However, where there are additional costs associated with supplementation or where the supplements may be unavailable (because of resource constraints) women are less likely to engage with ANC services (*high confidence in the evidence*).

Feasibility: Qualitative evidence about the views of health care providers suggests that resource constraints, both in terms of the availability of the supplements and the lack of suitably trained staff to deliver them, may limit implementation (*high confidence in the evidence).*

The WHO recommendations and implementation considerations on iron and folic acid supplementation in pregnancy are informed by effectiveness evidence AND qualitative evidence.

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Example 2: Fetal assessment in pregnancy

The ANC guideline recommends one ultrasound scan before 24 weeks' gestation.

Qualitative evidence from health care providers on **acceptability of antenatal ultrasound** showed that they generally want to provide screening and testing procedures, but sometimes don't feel suitably trained to do so (high confidence in the evidence).


Photo: WHO-Yoshi Shimizu

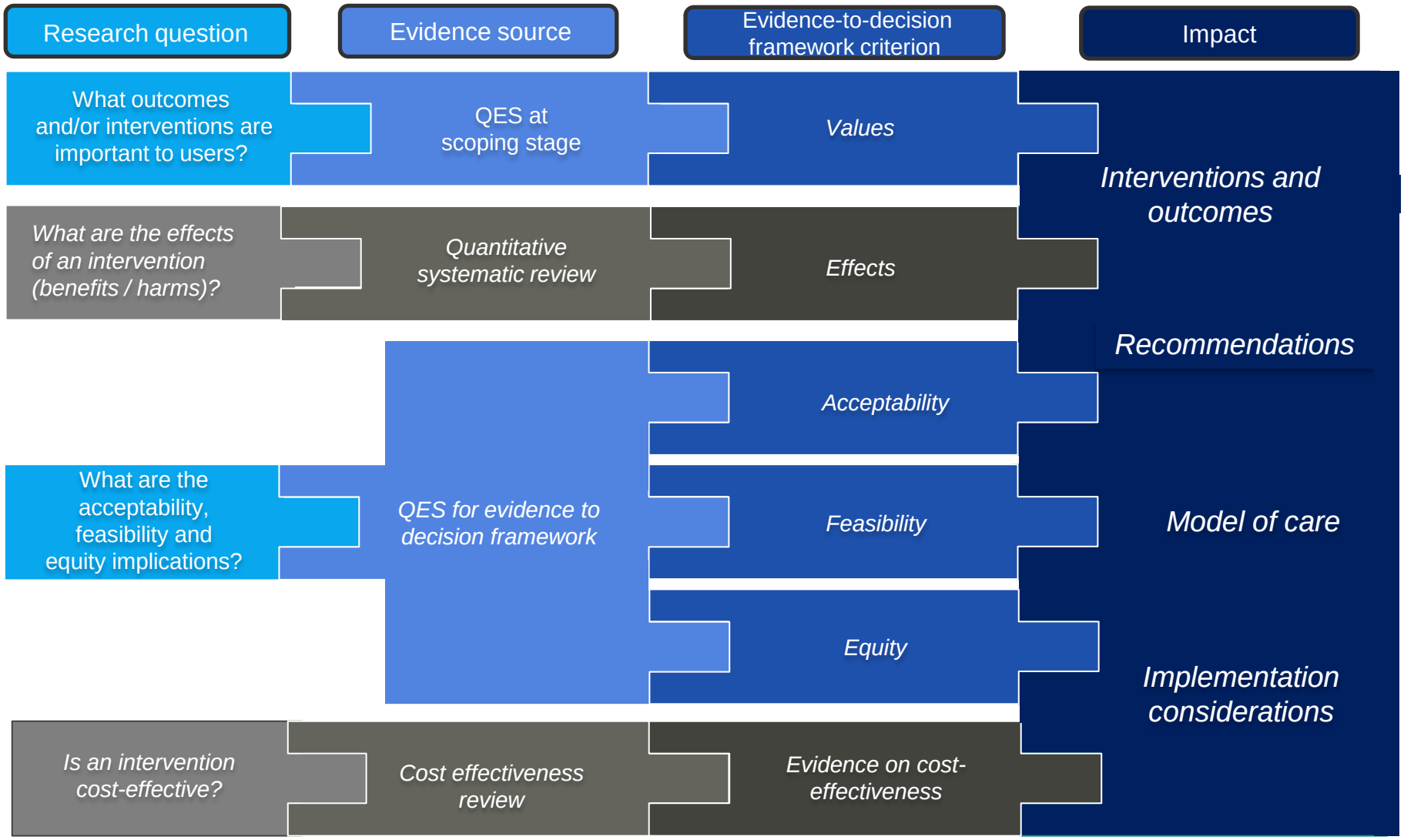
Evidence also showed that, in some LMICs, the lack of modern technology (like ultrasound equipment) at ANC facilities discourages some women from attending (high confidence in the evidence).

The ANC guideline does not recommend routine antenatal cardiotocography (CTG).

Qualitative evidence on **acceptability of CTG** showed that in some LMICs, women hold the belief that pregnancy is a healthy condition and may be resistant to CTG use unless they have experienced a previous pregnancy complication (high confidence in the evidence).

Acceptability may be further compromised if the reasons for using CTG are not properly explained (high confidence in the evidence).

Summary diagram of how QES informed the ANC guideline development



Summary

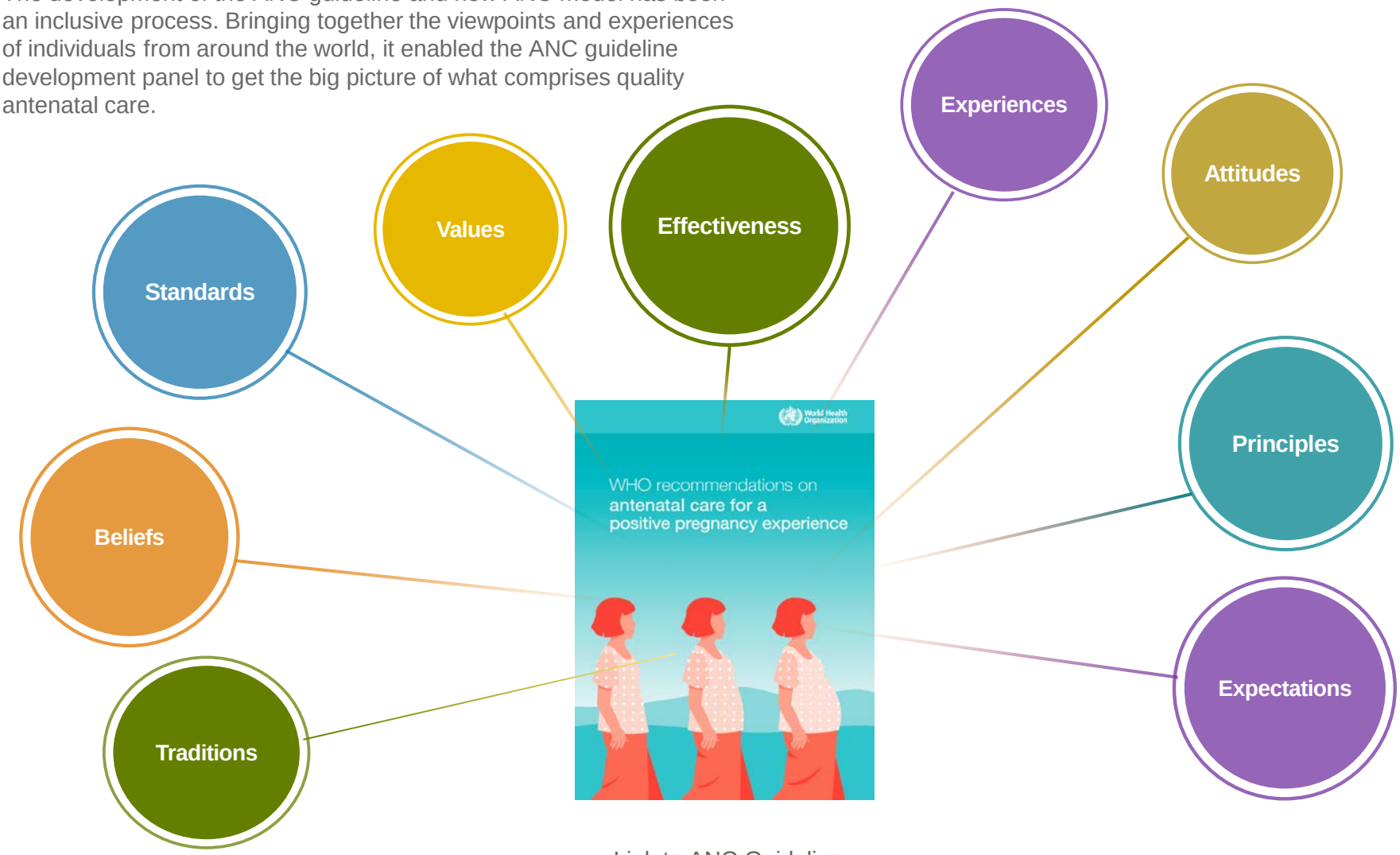
For the ANC guideline, qualitative evidence synthesized from the views and experiences of women and health care providers helped to:

- *Identify meaningful outcomes*
- *Identify important interventions*
- *Influence the recommendations through evidence on value, acceptability and equity*
- *Influence the model of care that users want and that providers want to provide.*
- *Influence the implementation considerations*
- *Frame the overarching theme/aim of the guideline and, indeed, the title.*

Photo : H6 Partners

Conclusion

The development of the ANC guideline and new ANC model has been an inclusive process. Bringing together the viewpoints and experiences of individuals from around the world, it enabled the ANC guideline development panel to get the big picture of what comprises quality antenatal care.



Link to ANC Guideline

Changing the conversation

Let's Get the Conversation Started!

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Additional materials

Key references

WHO recommendations on antenatal care for a positive pregnancy experience.
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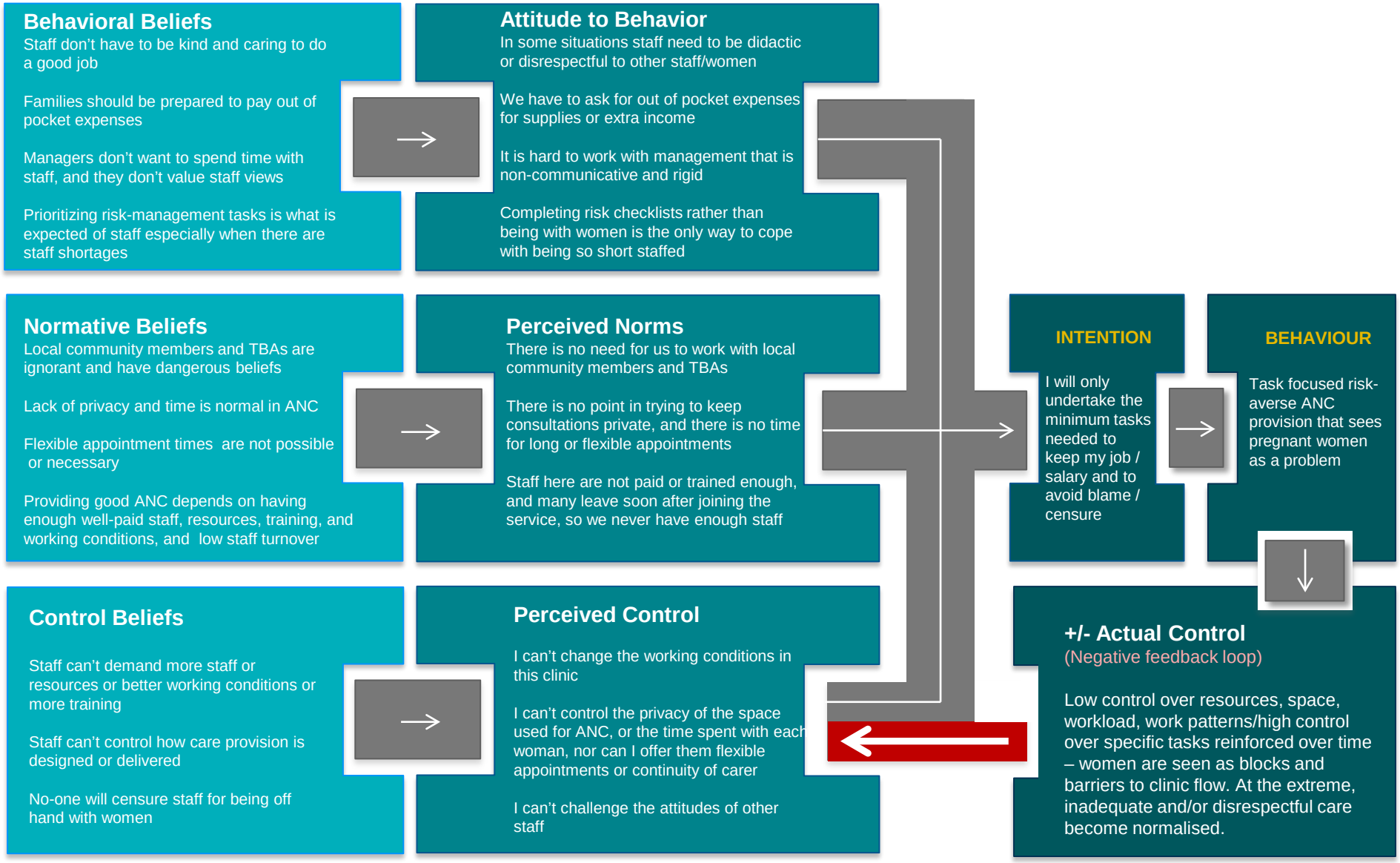
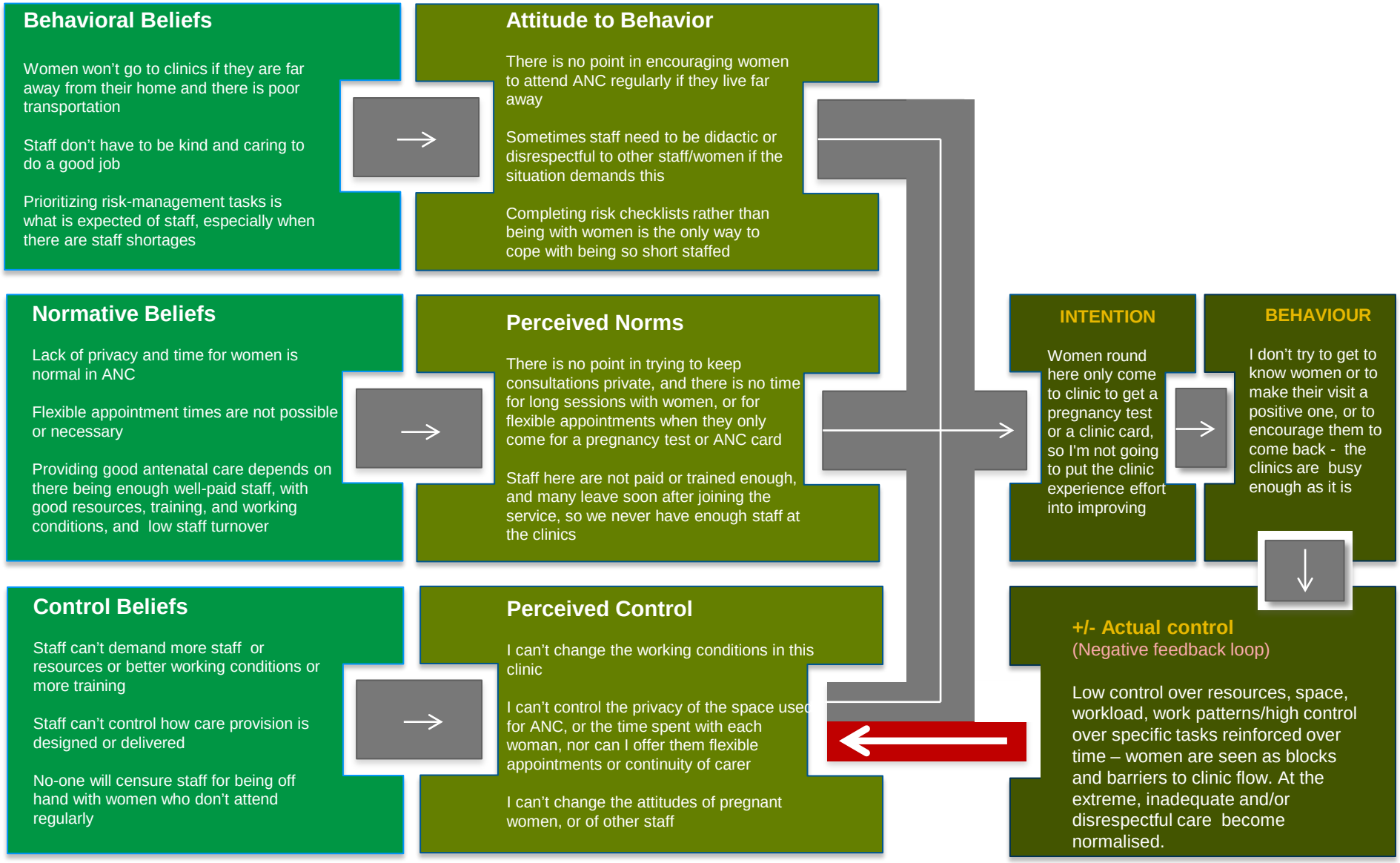
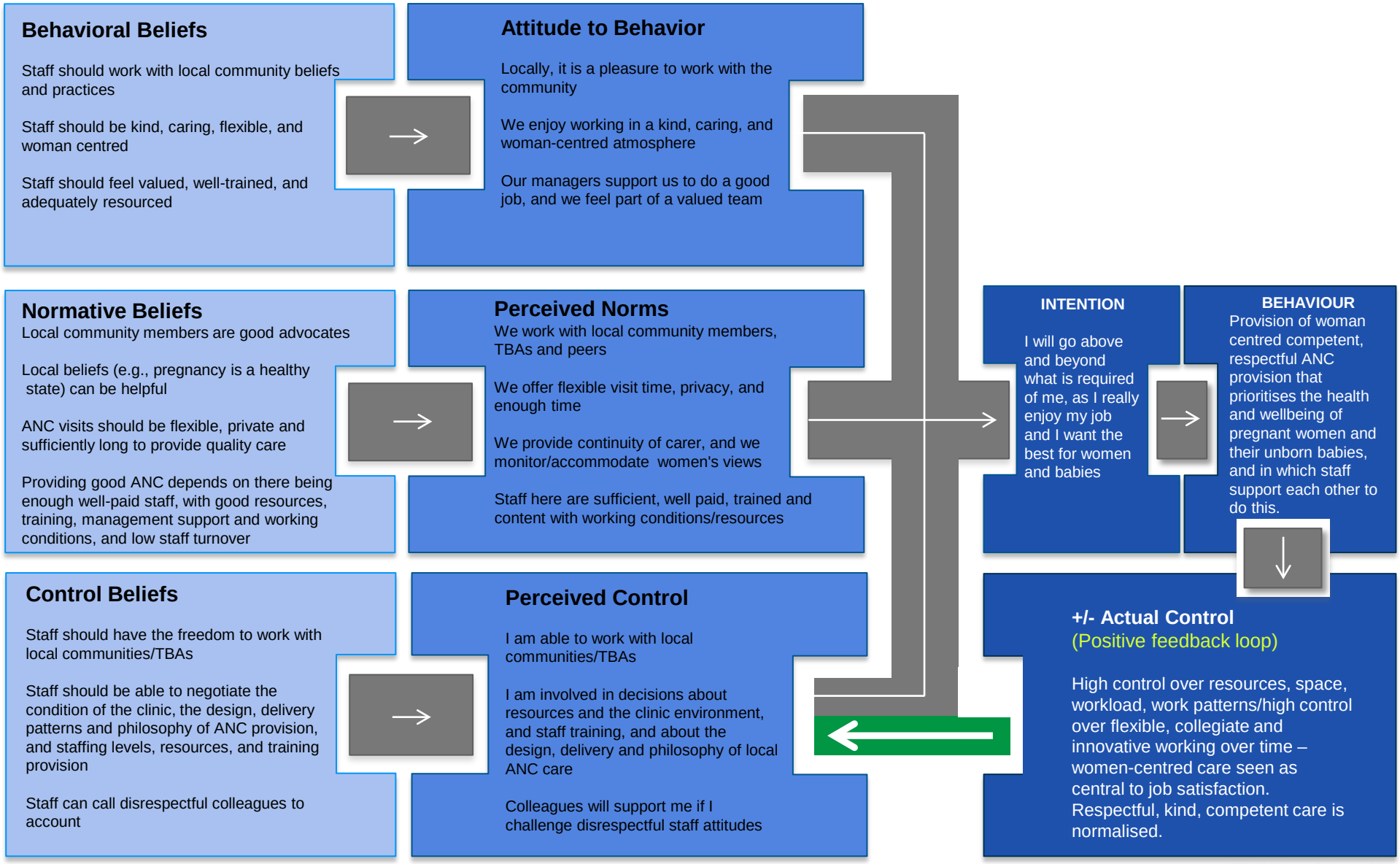
Logic model 1 (providers) – No ANC attendance



Logic model 2 (providers) – Initial attendance then rejection



Logic model 3 (providers) – Full attendance (ideal type)



THANK YOU FOR READING

Women's and health care providers' voices in the WHO ANC guideline

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