National Institute for Health and Care Excellence

FINAL

Antenatal care

[J] Referral and delivery of antenatal care

NICE guideline NG201

Evidence reviews underpinning recommendations 1.1.10 to 1.1.13, 1.3.1 to 1.3.4 and 1.3.8

August 2021

Final

These evidence reviews were developed by the National Guideline Alliance, which is a part of the Royal College of Obstetricians and Gynaecologists

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Review question

What aspects of (referral to and delivery of) antenatal care are valued by women?

Introduction

This review gathers evidence of women's views on how, where and by who antenatal care should be delivered. The committee agreed it was important to ask a qualitative question that captures women's experiences of and preferences for different aspects of delivery of antenatal care. This review is intended to help tailor recommendations in a way that improve women's experiences and identify opportunities to organise care more efficiently or effectively. The review is also intended to understand whether there are any gaps or issues in women's experiences of care that are not being addressed in other sections, or whether specific actions are required to improve the experiences of some groups of women. The aim of this review is to explore what aspects of referral to and delivery of antenatal care are valued by women.

Summary of the protocol

Please see Table 1 for a summary of the Population, Phenomenon of interest, and Context of this review

Table 1: Summary of the protocol (PICo table)

Population	All women
Phenomenon of interest	Views and experiences on the process of referral to antenatal services and/or the delivery of these services throughout the course of pregnancy. Themes will be identified from the available literature, but expected themes are: • Face to face vs remote care (for example Skype, phone, webchat) • Gaps between visits • Group vs 1 to 1 care • Location of visit (for example home, hospital, GP practice) • Method of referral (for example self-referral, GP, healthcare worker) • Waiting time for first appointment • Who does the woman want to see
Context	Only studies conducted in high-income countries, as defined by the World Bank, with centrally-funded healthcare systems will be included.

GP: General Practitioner

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: Developing NICE guidelines: the manual 2014. Methods specific to this review question are described in the review protocol in appendix A.

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Clinical evidence

Included studies

Fifteen qualitative studies were included in this review (Alshawish 2013, Aquino, 2018, Beake 2013, Binder 2012, Boyle 2016, Crowther 2019, Docherty 2012, Goodwin 2018, Hatherall 2016, Hunter 2018, Puthussery 2010, Raine 2010, Symon 2019, Thomson 2013 and Young 2008).

All the studies focused on the views and experiences of women on antenatal care services. However, 9 studies presented additional data relating to views on and experiences of women during the intrapartum and/or postpartum care but this was not considered for this review (Alshawish 2013, Aquino 2018, Beake 2013, Binder 2012, Boyle 2016, Crowther 2019, Puthussery 2010, Symon 2019 and Young 2008).

The included studies are summarised in Table 2.

All the studies were conducted in the UK. Ten of the studies were conducted in England (Alshawish 2013, Aquino 2018, Beake 2013, Binder 2012, Boyle 2016, Hatherall 2016, Puthussery 2010, Raine 2010, Thomson 2013 and Young 2008), 3 in Scotland (Crowther 2019, Docherty 2012 and Symon 2019), and 2 in Wales (Goodwin 2018 and Hunter 2018).

Four studies used semi-structured interviews for data collection (Alshawish 2013, Beake 2013, Crowther 2019 and Puthussery 2010), whilst 1 study (Boyle 2016) used diary interviews with semi-structured interviews. In the study, some information from the diary were used to generate additional prompts to enrich the semi-structured interview. Two studies used focus group discussions (Aquino 2018 and Symon 2019), whilst 5 studies used a combination of semi-structured interviews and focus group discussions (Binder 2012, Hatherall 2016, Raine 2010, Thomson 2013 and Young 2008). One study (Goodwin 2018) used a combination of observations with semi-structured interviews, whilst 1 study (Hunter 2018) combined semi-structured interviews with focus groups and observations. Finally, 1 study (Docherty 2012) combined observations of geographical locality and semi-structured interviews and matched the data with the Scottish Index of Multiple Deprivation (SIMD).

A total of 459 women participated in the 15 studies, with 13 men in 1 of the studies (Thomson 2013). There were also 113 health providers who participated in 4 studies (Binder 2012, Goodwin 2018, Hatherall 2016 and Young 2008), while 2 interpreters contributed to the data reported in 1 of the studies (Goodwin 2018).

Four studies explored the views of women from minority ethnic groups living in the UK. One of the studies was focused on women originally from Palestine (Alshawish 2013), another study was focused on female migrants from Poland (Crowther 2019), whilst another study was on women originally from Pakistan (Goodwin 2018). The fourth study recruited a diverse group of minority ethnic women (Puthussery 2010) who were born in the UK to parents who were born outside of the UK.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of included studies

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
Alshawish 2013 General qualitative inquiry England	To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women.	N=22 <u>Age</u> >18 years <u>Ethnicity</u> Palestinian	Semi-structured interviews	• Female care provider preference: Some minority ethnic women preferred the presence of female antenatal care providers • Interpreter service: Minority ethnic women want to have a reliable and consistent interpreter service • Free service: Some minority ethnic women value the free NHS antenatal care service • Prompt and Simpler referral: Some minority ethnic women want a faster and less cumbersome referral process
Aquino 2018 General qualitative inquiry England	To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together.	N=12 women. <u>Parity:</u> 0: n=1 1-2: n=11 <u>Age (year) range (mean):</u> 30-44 (34.67) years Ethnicity: White English/British: n=3 White other Background: n=5 Asian/ Asian other: n=2 Mixed ethnicity (White and Black African/French; White and Black Caribbean): n=2	Focus groups	• Continuity of care and carer: women want to have continuity of care and of carers • Shared Experience: Women want to socialise with other women during antenatal care • Access to information: Women value getting adequate information on the pregnancy and antenatal care • Understanding role of providers: Some minority ethnic women want to know the role and

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
				responsibility of the care providers • Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Treated as individual: Women want to be treated more than a number in the antenatal care system. • Shared Experience: Women want to socialise with other women during antenatal care
Beake 2013 Qualitative (Grounded theory) England	To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting.	N=24 women <u>Age range:</u> 20-40 years <u>Parity:</u> 0: n= 4 1: n=12 2: n=5 3+: n=3 <u>Ethnicity:</u> White British: n=3 White other European: n=3 Black African: n=3 Black other: n=1 Indian: n=1 Bangladeshi: n=3 Oriental: n=1 Any other: n=6 Not stated: n=1	Semi-structured interviews	• Being known by providers: women want to be known by their antenatal care providers • Continuity of care and carer: women want to have continuity of care and of carers • Treated as individual: Women want to be treated more than a number in the antenatal care system. • Treated as individual: Women want to be treated more than a number in the antenatal care system.
Binder 2012	To gain a deeper understanding of the multi-ethnic	N=60 women and 62 obstetric providers	• Semi-structured interviews	• Interpreter service: Minority ethnic women

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
General qualitative inquiry England	care setting and the roles that ethnicity and language play during the sensitive care encounter between immigrant women and their western obstetric care providers.	(doctors or midwives) Demographics for women: Age (year) range of African women: 18-48 years Parity range: 1-10 Ethnicity: Somali immigrants: n=39 Ghanaian: n=11 White British Women: n=10.	• Focus groups	want to have a reliable and consistent interpreter service
Boyle 2016 General qualitative inquiry England	To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth.	N=16 pregnant women Age (year) range: 21- 41 years Parity: 0: n=9 1: n=4 2: n=2 3: n=0 4: n=0 5: n=1 Ethnicity: Caucasians: n=15 Black African: n=1	• Diary interview • Semi-structured interviews	• Continuity of care and carer: women want to have continuity of care and of carers • Empowerment: Women want to be empowered to contribute to decision making and choices • Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care • Frequent contacts: Women want to have ad-hoc contacts with the midwives between antenatal care appointments • Treated as individual: Women want to be treated more than a number in

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
				the antenatal care system.
Crowther 2019 General qualitative inquiry Scotland	To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services.	N=9 women Age (year) range: 25-39 years Parity 0: n=0 1: n=2 2: n=2 3: n=3 4: n=2	Semi-structured interviews	• Continuity of care and carer: women want to have continuity of care and of carers • Empowerment: Women want to be empowered to contribute to decision making and choices • Access to information: Women value getting adequate information on the pregnancy and antenatal care • Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care • Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Interpreter service: Minority ethnic women want to have a reliable and consistent interpreter service • Free service: Some minority ethnic women value the free NHS antenatal care service

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
Docherty 2012 Qualitative (Case study) Scotland	To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background.	N=21 pregnant women Age (year) range from least deprived tail: 17-40 years Age (year) range from most deprived tail: 17-39 years	• Scottish Index of Multiple Deprivation (SIMD) information • Observation of geographical locality • Semi-structured interviews	• Empowerment: Women want to be empowered to contribute to decision making and choices • Access to information: Women value getting adequate information on the pregnancy and antenatal care • Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care • Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Empowerment: Women want to be empowered to contribute to decision making and choices
Goodwin 2018 Qualitative (Ethnographic study) Wales	To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these	N=7 pregnant migrant Pakistani women and 11 practising midwives Demographics for women: Age (year) range: 16-45 years These women also contributed to study data n=1: Migrant Pakistani	• Semi-structured interviews • Non-participant observation	• Involvement of family: Women value the support from family member during antenatal care • Clarity of service information: Women want to know what is going to happen at every stage of pregnancy • Understanding role of providers: Some minority ethnic women

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
	relationships, and the ways in which these relationships might affect women's experiences of care.	language interpreter: Aged= 47 years. Mother of 1 participant: Aged=56 years.		want to know the role and responsibility of the care providers • Frequent contacts: Women want to have ad-hoc contacts with the midwives between antenatal care appointments
Hatherall 2016 General qualitative inquiry England	To explore the factors influencing the timing of the antenatal booking appointment from the perspectives of women with recent experience of pregnancy as well as health service staff.	N=21 pregnant and postnatal women 75% born in 13 countries outside the UK. N=32 other women originated from Bangladesh, Somalia, Lithuania and Poland (not necessarily having recent personal experience of pregnancy) N=26 health service staff members (midwives and health advocates). Demographics for women: <u>Age (years):</u> n=14 aged 20-34 years. n=4 aged <20 years <u>Parity:</u> 0: n=16 1: n=5	• Semi-structured interview • Focus groups	• Prompt and Simpler referral: Some minority ethnic women want a faster and less cumbersome referral process • Shared Experience: Women want to socialise with other women during antenatal care • Independence from men: Some women want to have freedom from male domestic partners through the antenatal care
Hunter 2018	To determine if group antenatal care is	N=26 women in pre-	• Semi-structured interviews	• Treated as individual: Women want to

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
Qualitative (Phenomenological study) Wales	acceptable to women in an area of the UK with high levels of socio-economic and cultural diversity, and how the participating women experience the care. To explore and make sense of the perceptions and experiences of women before and after the introduction of four Pregnancy Circle groups.	implementation Group N=24 women in pregnancy circle Pre-implementation Group <u>Ethnicity:</u> White British: n=0 White other (All Albanian): n=3 Black Afro-Caribbean: n=2 South Asian (Mostly Pakistani, Indian and Bangladeshi): n=16 Mixed/Other (Mostly Latin American/Middle Eastern): n=5 <u>Parity:</u> 0: n=5 1: n=7 2-3: n=10 ≥4: n=4 (maternal experience not ascertained) Pregnancy Circle Group <u>Age (years) range:</u> 24-41 years <u>Ethnicity:</u> Asian British: n=1 British Bangladeshi: n=1 Bangladeshi/British Bangladeshi: n=3 White British: n=4 White European: n=15 Black African: n=1 Black British: n=2 Chinese: n=2	• Focus groups • Observations	be treated more than a number in the antenatal care system.

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
		Middle Eastern: n=1 Indian British: n=2 Algeria: n=1 <u>Parity:</u> 0: n=11 Multiple: n=12 Not stated: n=1		
Puthussery 2010 Qualitative (Grounded theory) England	To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women.	N=34 women born in the UK with parents born outside the UK. <u>Age:</u> ≤ 20: n=2 20-29: n=12 30-39: n=18 ≥ 40: n=2 <u>Parity:</u> Primipara: n=22 Multipara: n=12 <u>Ethnicity:</u> Indian: n=11 Pakistani: n=4 Bangladeshi: n=2 Black Caribbean: n=10 Black African: n=2 Irish: n=5	Semi-structured interviews	• Sub-theme: Continuity of care and carer: women want to have continuity of care and of carers • Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care • Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care • Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system. • Sub-theme: Continuity of care and carer:

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
				women want to have continuity of care and of carers
Raine 2010 General qualitative inquiry England	To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users.	N=30 pregnant women <u>Age (years) mean:</u> 30.2 years <u>Previous Pregnancies</u> Primiparous: n=12 Multiparous: n=18 <u>Ethnicity</u> English Speaking Bengali: n=6 Non-English Speaking Bengali: n=4 Non-English Speaking Somali: n=5 High educated White British: n=8 Low educated White British: n=7	• Semi-Structured interviews • Focus groups	• Theme: Clarity of service information: Women want to know what is going to happen at every stage of pregnancy • Theme: Clarity of service information: Women want to know what is going to happen at every stage of pregnancy • Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Sub-theme: Adequate communication between providers: Women feel adequately cared for when care providers share information about them for antenatal care. • Sub-theme: Remote contact: Women value having remote contacts with the midwives • Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.
Symon 2019	To identify the most salient	N=31 women	Focus groups	• Access to information:

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
General qualitative inquiry Scotland	aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated.	N=13 pregnant women and 18 new mothers. <u>Age</u> >16 years		Women value getting adequate information on the pregnancy and antenatal care • Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them • Remote contact: Women value having remote contacts with the midwives • Treated as individual: Women want to be treated more than a number in the antenatal care system.
Thomson 2013 Qualitative (Thematic network analysis) England	To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services.	N=92 (79 women and 13 men not necessarily having direct perinatal service experience). <u>Age (years) range (mean):</u> 17-74 (35 years) <u>Ethnicity</u> White British: n=54 Other White/White Mixed: n=5 India: n=11 Pakistani: n=6 Bangladeshi: n=3 Other Asian background: n=1 N= 73 had/were currently experiencing at least one priority vulnerability issues, with 25	• Semi-structured interviews • Focus groups	• Shared Experience: Women want to socialise with other women during antenatal care • Access to information: Women value getting adequate information on the pregnancy and antenatal care • Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care • Frequent contacts: Women want to have ad-hoc contacts with

Study Country	Aim	Population	Data collection method(s)	Synthesised themes
		experiencing ≥3 vulnerability issues.		the midwives between antenatal care appointments • Treated as individual: Women want to be treated more than a number in the antenatal care system.
Young 2008 General qualitative inquiry England	To identify where improvements could be made in preparing parents for their new role by encouraging more realistic expectations and support.	Women: N=11 first time mothers Providers: Health visitors: n=10 Midwife: n=1 Community Psychiatric nurse: n=1 Nursery nurse: n=1 Midwifery student: n=1 Demographics for women: Age (years) range: 24-40 years	• Semi-structured interviews • Focus group discussions	• Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E). See appendix M for a full table of quotes supporting the themes identified in this review.

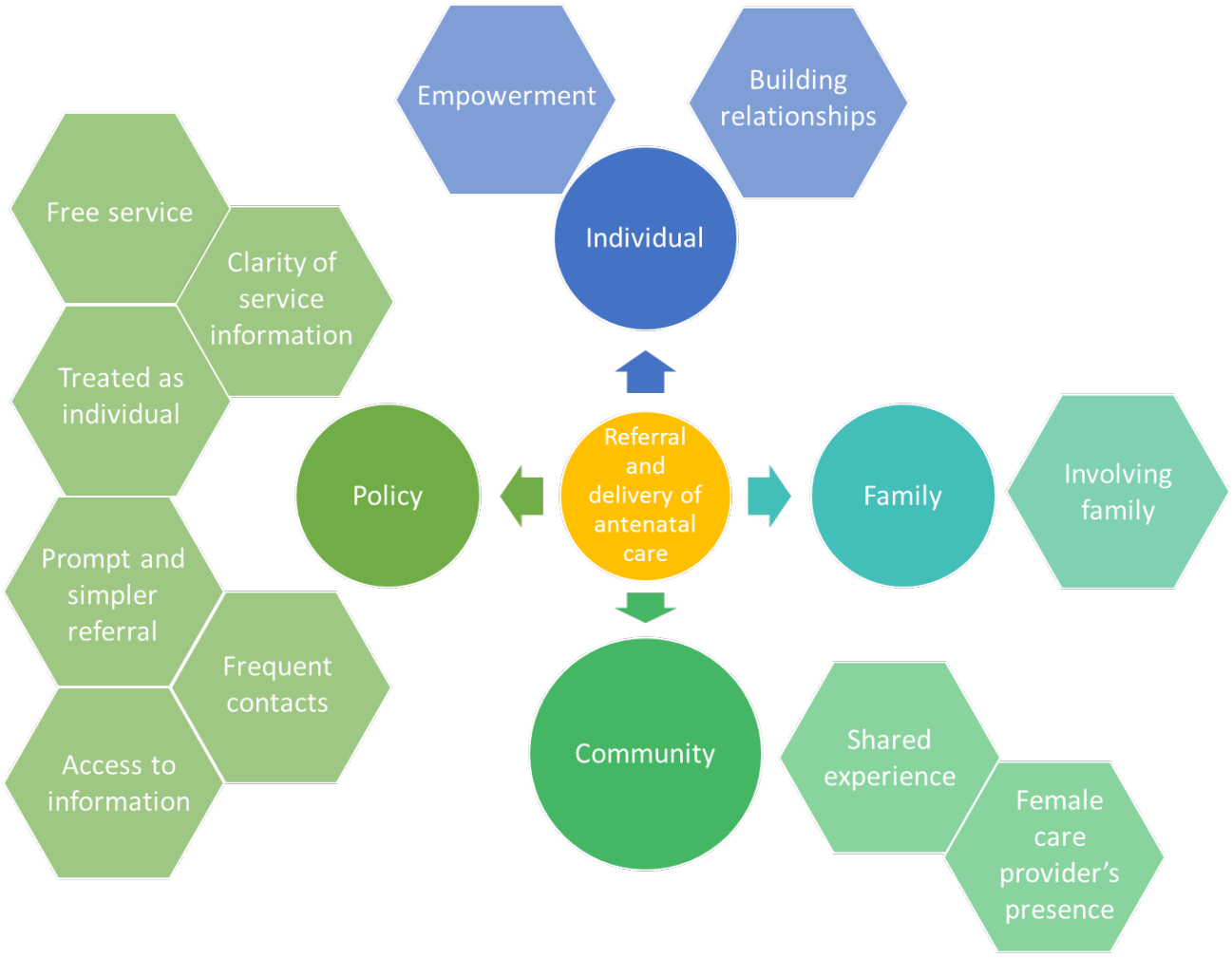
Quality assessment of studies included in the evidence review

See the evidence profiles in appendix F for GRADE-CERQual tables.

Theme map

The evidence was categorised into 4 levels using Brofenbrenner's socioecological model (Brofenbrenner's 1979). Framework analysis was used to identify themes, presented as a theme map in Figure 1. For further details about the methods, see Supplement 1: methods.

Figure 1: Theme map for referral and delivery



Economic evidence

This review question is not relevant for economic analysis. Therefore, no economic studies on this topic were identified by the global guideline systematic search of the economic literature and no primary economic modelling was undertaken.

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline. See supplementary material 2 for details.

Excluded studies

Economic studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the economic evidence review

See the economic evidence tables in appendix H and economic evidence profiles in appendix I.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Qualitative evidence statements

See appendix M for a full table of quotes supporting the themes identified in this review.

Level 1. Individual level

Theme 1. Building relationships

High quality evidence from 5 studies reported on this theme. This finding revealed that women want to be known by their antenatal care providers to build trusting relationship with the carers. Moreover, the women also want to have continuity of care and of carers for their antenatal care.

Sub-theme 1a: Being known by care provider

High quality evidence from 1 study reported on this sub-theme. The evidence revealed that women valued being known by their midwives in order to form a relationship that is similar to those with family members. Some of the benefits that the women valued in being known by their carers include the feeling of being safe and relaxed with the carer and the ability to confide in them. This relationship was particularly important to vulnerable women who were able to discuss important issues with their midwives even though they could not discuss such issues with anyone else. The women also valued being known by their carer because it allowed them to avoid repeating their histories every time they meet someone new. This was particularly important to women with complicated obstetric histories.

Sub-theme 1b: continuity of care

Moderate quality evidence from 5 studies reported on this sub-theme. Women desire continuity of care and of carers because it allows them to build trusting relationships with their midwives and makes them feel like being cared for as an individual. The women want to be cared for by a named midwife or group of antenatal care providers so that they could avoid variations in the quality of care and conflicting advice on the pregnancy. The women also do not want to have fragmented care, to avoid repeating their histories. Therefore, some of the women reported that being with same midwives allowed them to develop trust and confidence in their carer, and described changing midwives as confusing. While it was important to women to have continuity of care and of carer, they emphasised that it is also important for them to have their emotional needs met through the contact with the midwives and that this is not automatically addressed merely by having the same midwives or group of carers.

Theme 2. Empowerment

Low quality evidence from 3 studies reported on this theme. The finding shows that women value being able to contribute to decision making and choices about their antenatal care. The women therefore want to be provided with adequate information or support to aid them in decision making. Some of the women appreciated being guided by the midwives to make decisions largely because they felt that they did not have the knowledge and experience to decide for themselves. However, the evidence further revealed that there were instances where decisions were made for these women without an opportunity to discuss alternatives with them. This approach was unpleasant to some women who reported that they sometimes feel pressured when midwives made decisions for them based on the assumption of what they would want.

In respect of information support, consistent evidence from the reviewed studies showed that women felt empowered to contribute to the decision making and informed choices when they

are provided with sufficient information to make judgements. However, provision of such information to contribute to decision making does not often occur and were sometimes not provided for the women in a timely manner. Hence, the women reported that they would appreciate if they were provided with written information in advance and supported with discussion with the midwives.

Furthermore, the evidence showed that women would like to make certain decisions at different stages in the pregnancy continuum, when they would have had sufficient knowledge about the options that they could have. For instance, some women were concerned that they were asked to make decisions about the place of birth at the initial antenatal care booking appointment, without any information on which to make such decision. Hence, the women emphasised that they would like to revisit such discussions later in the pregnancy.

Level 2. Family level

Theme 3. Involving family

Very low quality evidence from 1 study reported on this theme: The finding shows that some minority ethnic women value the involvement of their family members in their antenatal care. Evidence from the reviewed study showed that mothers-in-law and domestic partners play significant roles in the antenatal care of some minority ethnic women. Despite the value placed on the role of the family members, the women reported that they sometimes struggle to balance the contradictory traditional advice given to them by mothers-in-law with the professional advice from the midwives. Meanwhile, the study further revealed that the presence of family members such as the domestic partners and mothers-in-law at antenatal appointments could be a barrier for midwives to establish relationships with the women, because the family members have the tendency to dominate the appointment. For instance, the male partners of the women were reported in the study to speak for the women even when the latter have sufficient English language skills to adequately communicate. Yet, the women were reported to view the behaviours of their partners positively. The minority ethnic women emphasised that they prefer family members to speak on their behalf because they rely on the greater experience and knowledge of the family members instead of having a direct communication with the midwives.

Level 3. Community level

Theme 4. Female care provider preference

Very low quality evidence from 1 study reported on this theme. This finding showed that some minority ethnic women preferred having female caregivers for their antenatal care sessions. Evidence from the reviewed study showed that the preference for female caregivers influenced the attendance of some minority ethnic women at the antenatal clinic. Some of the women therefore reported that they did not attend the antenatal care classes because of the presence of men at the sessions.

Theme 5. Shared experience

Moderate quality evidence from 3 studies reported on this theme. This finding shows that pregnant women value the opportunity to share their own experience, and learn from other's experiences that attending individual and group antenatal appointments affords. In this regard, the evidence showed that women valued the opportunity to socialise in group sessions. While reporting their experience, women in 1 of the studies valued the group sessions because they felt it was a safe place for sharing; where there is nothing they could not discuss. The women also appreciated the group sessions because it allowed them to learn together. Furthermore, the group sessions were particularly appreciated by the primiparous women who saw it as an opportunity to learn from multiparous women. However, the group sessions were also valuable to the multiparous women because of the respected status that their experience gave them in the sessions.

The women derived strength and reassurances from having contact with other pregnant women, and therefore they described their experience as “not being alone”. Moreover, the women in the group antenatal care sessions reported that they were able to learn new things and that being a part of a group of mixed ethnicities, nationalities, religion and cultures expanded their cultural horizons. The women also reported that they felt a sense of belonging by participating in the group session.

Sub-theme 5a: Independence from men

High quality evidence from 1 study contributed to this sub-theme. This finding suggests that some women valued the group antenatal care sessions because it afforded them the opportunity to have a sense of freedom from their male domestic partners. Whilst some of the women felt a greater sense of their own value because the partners were not involved in some of the group sessions, other women were concerned that their partners were missing out and that their needs were not being met. This is because the women believed that the partners would have had the opportunity to attend every session of a standard antenatal appointment or class.

Level 4. Policy level

Theme 6. Access to information

High quality evidence from 8 studies reported on this theme. This finding revealed that women value getting adequate information on the pregnancy and their antenatal care from the care providers in order to address concerns and for reassurances. Consistent evidence from the reviewed studies showed that women valued the antenatal care sessions because they regard it as an invaluable source of information on risks to maternal and infant health. Owing to their need for information, women in 1 of the studies were reported to value the antenatal or parentcrafts sessions conducted by UK NHS maternity units as an important source of information on pregnancy. However, due to inconsistent information, the study reported that the women confused the parentcrafts sessions with antenatal appointments.

Sub-theme 6a: Additional information opportunities

High quality evidence from 7 studies reported on this sub-theme: This finding revealed that most women often want to have the opportunities to get more information on their pregnancy and antenatal care than they usually receive from the antenatal sessions. Women therefore tend to seek additional the information from diverse sources. Evidence revealed that women sought additional information through sources such as friends who are midwives, television programmes, books, the internet, the National Childbirth Trust, and using child-birth forums or “Google”. Some minority ethnic women were also reported to value other forms of communicating information, which were often unavailable to them. This included information leaflets that are translated into the languages of the minority ethnic women. Owing to the frustration of not getting these additional useful sources of information from the antenatal care providers, the minority ethnic women also resorted to technology to get the answers that they needed. Despite the desire for these additional sources of information, women still valued the information that they considered as authoritative from the antenatal care providers. Hence, some of the women wanted to have open discussions with their antenatal care providers to appease their concerns, rather than just written information.

Theme 7. Clarity of service information

Low quality of evidence from 3 studies reported on this theme. The finding revealed that women would like to know what is going to happen at every stage of the pregnancy and want more information to help them navigate the antenatal care service better. In this regard, evidence revealed that some of the women were frustrated that the antenatal care providers did not provide them with an overall picture of the care that they could expect to receive as they progressed through their pregnancy. The women were also concerned that there was no clear explanation of the appropriate times to discuss particular aspects of care. Some of

the women also emphasised that the purpose of each antenatal appointment was often unclear and the apparent duplication of visits frustrated them. Due to this lack of clear guide to the care, some women reported a reluctance to attend appointments which appeared to serve little purpose or meet their needs, while other women chose not to attend the clinic for routine ultrasound scan, because there appeared to be misunderstandings about its value and safety. Moreover, some minority ethnic women also reported that confusion regarding pre-booked appointments and poor knowledge of the UK healthcare system was preventing them from attending their antenatal appointment and sometimes led to late attendance.

Sub-theme 7a: Understanding role of care providers

Low quality evidence from 2 studies reported on this sub-theme. Some minority ethnic women were interested in knowing the role remit of their antenatal care service providers. The reviewed evidence revealed that some minority ethnic women including those who recently migrated into UK wanted to have greater clarity about the qualifications of the antenatal care providers and their professional responsibilities. While reporting their experience, some of the women in 1 of the studies reported that this lack of clarity continued until their fourth antenatal appointments.

Theme 8. Engaging and responsive communication

Low quality evidence from 10 studies reported on this theme. This finding revealed that women feel supported and respected based on the ways that their antenatal care providers communicate with them. Evidence from the review showed that women found interactions with their midwives which tended to be discourteous, abrupt or lacking in compassion as discouraging. Therefore, the women wanted to have the ability to confide in their midwives and feel responded to. Some of the women reported that they felt safe and respected when responded to by their midwives. The women also felt understood when they received responsive and caring communication approach from their midwives. The engaging and responsive approaches to communication as described by the women include being open to questions, empathic style of conversation, taking initiative to ensure the women receive prompt and appropriate healthcare, and making the women feel unrushed during antenatal appointments.

Sub-theme 8a: Adequate communication between care providers

High quality evidence from 1 study reported on this sub-theme. This finding revealed that women feel cared for when the antenatal care providers adequately share information about them for antenatal care purposes. Evidence from the reviewed study showed that women found fragmented communication between the components of the antenatal care frustrating and confusing. For instance, the study reported that the women were frustrated with failure of the General Practitioners (GPs) to exchange clinical information with other health care professionals and their inability to guide the women through the antenatal care system. Although the women acknowledged the pivotal role of the GPs, the women suggested that the disconnection between the GPs and other components of the antenatal service is a problem that should be addressed.

Sub-theme 8b: Interpreter service

Moderate quality evidence from 4 studies reported on this sub-theme. This finding showed that minority ethnic women want to have a reliable and consistent interpreter service. The reviewed evidence revealed that for some minority ethnic women, language barrier is a significant challenge to communicate with their antenatal care providers in an engaging style. To engage properly with the antenatal care providers, the minority ethnic women who were unable to speak English needed the interpreter service. The reviewed evidence showed that the interpreter service was not often available or reliable, leading to some women using their family members and friends as interpreters. However, 1 of the studies reported that the decision to use family members and friends was sometimes due to personal preferences of

the women even though the interpreter service may be available. Meanwhile, some of the women in the study emphasised that they preferred having female interpreters for their antenatal care appointments. The study further reported that the strategy to use the family members or friends was not consistently reliable especially when bad news had to be relayed during routine consultations.

Moreover, evidence from 1 of the studies showed that despite the language barrier, some minority ethnic women reported how antenatal care staff helped to mitigate their challenge by speaking slowly and simply. The study further reported that some of the women valued their experiences when they were provided with the choices concerning the interpreting and translation services by the antenatal care providers. However, the women wanted to have such choices to be provided sensitively.

Meanwhile, evidence from another study suggested that women would like to know about the interpreter services before antenatal care booking appointment. According to the study, not all the women knew prior to their antenatal booking appointment that the interpreter service was available. Therefore, some minority ethnic women who were unable to speak English, experienced challenges of registering and making antenatal appointment with a GP to obtain a referral for an antenatal booking appointment. The women also reported experiencing additional difficulty of having to arrange for trusted family members and friends to accompany them to the antenatal care appointment to translate.

Sub-theme 8c: Remote contact

Low quality evidence from 2 studies reported on this sub-theme. This finding revealed that women value having remote contact with the midwives, in addition to the usual care antenatal appointments. The evidence revealed that some women appreciated the use of text message reminder that is sent to their mobile phones for antenatal care appointments by the midwives. Some women also reported valuing their interaction experiences with the midwives because they could be contacted on the phone. This approach to communication was described by the women as reassuring and responsive.

Theme 9. Frequent contact

Very low quality evidence from 4 studies reported on this theme. This finding showed that women want to have more contacts with their antenatal care service providers whenever they need it for support. Consistent evidence revealed that some women specifically want more frequent contacts during the first half of pregnancy. This was particularly noted among the multigravid women in 1 study which reported that the rigid schedule of appointments for multigravid women does not meet the needs of the women for psychological support and information. Some minority ethnic women in 1 of the studies also reported that they wanted to have more ad-hoc contacts with their midwives during the early period of pregnancy for support and cited the lack of flexibility for them to initiate the antenatal care contacts with the midwives as a potential problem for their on-going relationship with the midwives. However, women with low risk pregnancies in another study reported that they would also like to have additional contacts with the antenatal care service providers. The women in the study did not specify any particular period of the pregnancy for their desired increased antenatal care contact. The women emphasised that the anxiety and stress that they experience during pregnancy means that they should be able to access help and support from the maternity services whenever they need it. The women therefore considered more flexible access as important to ensure early identification of risks and complications and for appropriate individually determined support to be provided. Meanwhile, evidence from 1 of the studies further revealed that some women lacked adequate knowledge of how to contact the midwives in between appointments as there was no clear communication strategy informing them about what they should do if they needed to see a midwife in between visits.

Theme 10. Free service

Low quality evidence from 2 studies reported on this theme. This review finding revealed that some minority ethnic women greatly value the universal free access that women have in the UK to antenatal services which contrasted with the services in other countries.

Theme 11. Prompt and simpler referral

Very low quality evidence from 2 studies reported on this theme. This finding revealed that some minority ethnic women want a faster and less cumbersome process of referral so that they could have adequate care, especially during the early period of pregnancy. The reviewed evidence suggested that there was a low awareness of self-referral among the minority ethnic women who mostly sought referral for their antenatal care through the GP. Some of the women in 1 study were new to their communities and were therefore unaware of the local GP practices or have permanent address so they could register with the GP in time to secure referral for their antenatal care. Some of the women in both studies who were already registered with GP practices also reported delays in getting referred to the midwives. There were also reports of instances of delay in 1 study which was experienced by some of the women who were asked to return to their GPs for referral for the antenatal booking appointment after directly accessing other health services either to confirm their pregnancy or for problems early in their pregnancy.

Theme 12. Treated as an individual

Low quality evidence from 8 studies reported on this theme. This finding revealed that women want to be treated as an individual and not as a number in the antenatal care system. Evidence revealed that some women want their midwives and health visitors to be aware of their health status and relevant medical information to avoid narrating their needs repeatedly. Some women also emphasised that they wanted their antenatal care providers to pay more attention to their needs as individuals and to appreciate their perspective regarding pregnancy. Women who experienced personalised care reported that they felt like having someone there for them. According to some of the women, a personalised antenatal care is unrushed and flexible. Therefore, some women reported that they wanted an antenatal care that is flexible and fits with their individual and family needs. Hence, some of the women were dissatisfied with issues of accessibility, waiting times and restricted clinic appointments. In addition, some of the women emphasised that they would prefer that the information on risks associated with pregnancy to be tailored to individual needs instead of using a universal approach.

Moreover, the women emphasised that they wanted the midwives to discuss important issues with them rather than spending more time on completing medical records and physiological measurements. The experiences of the women in one of the studies suggested that they do not want to be treated like being on a production line, but want their emotional needs to be met during the interaction with the midwives.

Furthermore, evidence from 1 of the studies suggested that women who have mental health concerns related to extreme anxiety or fear of the pregnancy may prefer a more personalised antenatal care appointment instead of attending the antenatal care appointment in a clinical environment. According to the study, due to the ‘stress’ and ‘pressure’ of attending a clinical environment and having clinical tests which could potentially expose concerns for their baby’s health, the women did not attend all their antenatal care appointments. The study further suggested that teenage mothers may not be motivated to access universal antenatal care appointments, because they tend to consider the antenatal care to be for the adults partly due to the experiences of being judged by the older mothers. The teenage mothers therefore reported difficulties in organising appropriate appointment times for their antenatal care.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

This review focused on establishing what aspects of the referral process to, and delivery of, antenatal services are valued by women.

To address these issues, the review was designed to include qualitative data and as a result the committee could not specify in advance the data that would be located. Instead they identified the main themes which they expected to emerge from the data. Suggested themes included:

- Face to face vs. remote care (for example Skype, phone, webchat)
- Gaps between visits
- Group vs 1 to 1 care
- Location of visit (for example home, hospital, GP practice)
- Method of referral (for example self-referral, GP, healthcare worker)
- Waiting time for first appointment
- Who does the woman want to see

The evidence review identified data relating to these themes, for example remote contact, frequent contact, building relationships (being known by care provider and continuity of care), prompt and simpler referral, and female care provider preference. There was no evidence identified on the theme location of visit. Other themes that were identified include empowerment; involving family; shared experience (independence from men); access to information (additional information opportunities); clarity of service information (understanding role of care providers); engaging and responsive communication (adequate communication between care providers and interpreter service); free service; and treated as individual. The committee considered the evidence from all identified themes and with their own knowledge and experience, were able to draft the recommendations.

The quality of the evidence

The overall confidence in the review findings ranged from very low to high.

Concerns about the methodological limitations of the primary studies were assessed with the CASP checklist and ranged from serious to minor concerns. The most common issues identified were: no justification for research design and methods of data collection; no discussion about non-participation and data saturation; no report of the period of data collection; insufficient information to determine how informed consent was obtained; insufficient description of data analysis process; insufficient data to support findings; and insufficient description of the credibility of findings.

Concerns about the relevance for the context and populations of interest to this guideline ranged from moderate to no or very minor concerns. The common issues include uncertainty about the period of data collection for 7 studies which makes it unclear how recent the views and experiences contributing to 9 findings are in the studies were in relation to current practice. The 9 findings affected by this issue include: Building relationships; Involving family; Female care provider presence; clarity of service information; Engaging and responsive communication; Frequent contacts; Free service; Prompt and simpler referral and Treated as an individual. Another concern about some of the findings was that they were reported from studies with mainly minority ethnic women population which may limit the transferability of the views and experiences of such population to other populations. The 5 findings affected with this issue include: involving family; female care provider presence; clarity of service information; free service and prompt and simpler referral.

Concerns about coherence was no or very minor for the findings as there were no data that contradicted the findings or were there any ambiguous data.

Concerns about adequacy ranged from moderate to no or very minor concerns. The moderate concerns for 9 findings were due to the few numbers of studies ranging from 1 to 4 contributing to the findings. The affected findings are: Building relationships; Empowerment; Involving family; Female care provider presence; Shared experience; Clarity of service information; Frequent contacts; Free service and Prompt and simpler referral. The remaining findings were reported by minimum of 5 to 10 studies.

Discussion of findings

Some of the committee members noted that most of the studies in this review represent minority ethnic women and that the findings from the evidence (for example, from the theme 'female care provider preference' and 'free service') may not be experienced by the majority of women. They stated that it is possible that most women might have used the opportunity of participating in the studies to voice concerns about the antenatal care service. However, the committee was also of the opinion that although the evidence was mostly collected from minority ethnic women, that the findings of the review are still relevant to all women today.

The committee further acknowledged that because the period of data collection was not reported for some of the studies, the finding from the theme 'prompt and simpler referral' might have been based on studies that were conducted too early to reflect the self-referral system which has become increasingly available throughout the country.

The committee noted evidence from the theme 'access to information', which suggested that pregnant women value receiving information from their care providers. Evidence from the subtheme 'additional information opportunities' suggested that some pregnant women preferred to get more information from other sources, such as the internet, but ultimately still valued the information from antenatal care providers, which they considered as authoritative. The committee observed that evidence from the theme 'building relationships' and the subtheme 'being known by care provider' showed that women value access to their midwives. The committee noted that there is good evidence for ad hoc telephone support from midwives from the subtheme 'remote contact' and the theme 'frequent contact'. The committee therefore suggested that it would be good to utilise other forms of communications rather than relying only on letters. The committee considered the need to use different methods of remote communications that are currently available such as the text messages, phone, e-mail, video calls and instant messaging.

The committee discussed that the individual needs and concerns of pregnant women are important, as supported by the evidence from the theme 'empowerment'. The committee discussed that individual needs and concerns determine the approach towards antenatal care, which was supported by evidence from the theme 'treated as an individual'. For example, more care might be required for women in vulnerable situations, such as if there is a health, social or emotional concern.

The committee agreed that a fundamental part of antenatal care is listening to the woman and responding to her needs and preferences. This was also highlighted by the 2020 Ockenden report. The committee also agreed that as part of informed and shared decision making, whenever offering the woman any kind of intervention, assessment or procedure, the benefits, harms and implications should be discussed and the women should be made aware of her right to decline. This is in line with the 2015 Montgomery ruling. The committee also emphasised that the healthcare professional should respect the woman's decision even if it goes against the views or values of the healthcare professional.

The committee agreed that it is important that when women are advised to seek help or advice, urgent from non-urgent situation are distinguished. The committee agreed on the importance of tailoring the length and number of appointments to the woman's personal

needs and circumstances and cross-referred to the NICE guideline on pregnancy and complex social factors (CG110) which covers specific complex circumstances in more detail.

The committee acknowledged that the availability of interpreters is important as shown in the evidence by the theme 'engaging and responsive communications', and the subthemes 'adequate communication between care providers' and 'interpreter service', however they noted that it is difficult to implement in practice even though this is important for vulnerable populations and those who have hearing problems. The committee agreed it is important to ensure that the interpreter is independent of the woman and not a family member or a friend. Based on their experience, there are various concerns around having a family member or a friend as an interpreter, for example confidentiality issues, putting pressure on a family member or friend, concerns around whether a neutral message is translated. Although, it should also be noted that the evidence from the review from the theme 'involving family' suggests that some women do not mind having family members as interpreters. The committee also discussed that interpretation may also be required by those who use British Sign Language.

The committee discussed the evidence from the subtheme 'continuity of care' and acknowledged that in general women valued continuity and that there is a difference between continuity of care and continuity of carer. Although this review did not investigate the clinical or cost effectiveness of continuity of care or carer the committee agreed it was important and noted it is covered and supported by NHS Better Births. In conjunction with the NHS Better Births and the qualitative evidence the committee agreed that those providing care should aim to provide continuity of carer. This review did not investigate the effectiveness of continuity of carer or what is the best way to deliver continuity of carer.

Despite the aim for continuity of carer, there will likely be various different healthcare professionals involved in the woman's antenatal care, either from the same team or unit or across different providers (for example primary care). The committee discussed the importance of effective and timely communication between healthcare professionals so that information is shared appropriately, concerns are not missed, and the woman does not always have to repeat the same things to various different health care professionals.

The committee agreed that the clarity of pathway of care is an important finding from the theme 'clarity of service information' and the subtheme 'understanding role of care providers' as it stopped some women from attending certain antenatal care appointments in 1 of the studies. It was therefore agreed that there should be a recommendation that involves explaining the content and timing of appointment and why it is important. The committee then suggested that the findings from this review should be referenced in [G] content of antenatal appointments.

The evidence from the theme 'shared experience' showed that women value group appointments. The committee agreed that while the primary mode of delivery of antenatal appointments should be one to one based, these could be supplemented by group model of care.

The committee discussed the evidence from the subtheme 'independence from men', which came from 1 study. Although the evidence was of high quality, the findings were contradictory and the committee agreed that it was a matter of personal preference as to whether the pregnant woman wanted their partner present at group antenatal sessions. Therefore, no recommendation was made based on this theme.

Cost effectiveness and resource use

A systematic review of the economic literature was conducted but no relevant studies were identified which were applicable to this review question.

These recommendations largely reinforce current practice or refer to existing NICE guidance and are unlikely to have any cost impact. The recommendation to offer flexibility in both length and total number of antenatal appointments will lead to more and longer appointments for some women. This to some degree will already be happening in all centres where medically indicated but this recommendation may lead to more appointments for those with social or emotional needs. The number of women is anticipated to be minimal and any increase resource use should be small. Some cost savings and health gains will also be achieved through improved birth outcomes from more intensive antenatal care.

References

Alshawish 2013

Alshawish, Eman, Marsden, Janet, Yeowell, Gill, Wibberley, Christopher, Investigating access to and use of maternity health-care services in the UK by Palestinian women, British Journal of Midwifery, 21, 571-577, 2013

Aquino 2018

Aquino, Maria Raisa Jessica V., Olander, Ellinor K., Bryar, Rosamund M., A focus group study of women's views and experiences of maternity care as delivered collaboratively by midwives and health visitors in England, BMC pregnancy and childbirth, 18, 505, 2018

Beake 2013

Beake, Sarah, Acosta, Luisa, Cooke, Pauline, McCourt, Christine, Caseload midwifery in a multi-ethnic community: the women's experiences, Midwifery, 29, 996-1002, 2013

Binder 2012

Binder, Pauline, Borne, Yan, Johnsdotter, Sara, Essen, Birgitta, Shared language is essential: communication in a multiethnic obstetric care setting, Journal of health communication, 17, 1171-86, 2012

Boyle 2016

Boyle, Sally, Thomas, Hilary, Brooks, Fiona, Women's views on partnership working with midwives during pregnancy and childbirth, Midwifery, 32, 21-9, 2016

Bronfenbrenner 1979

Bronfenbrenner, U. The Ecology of Human Development: Experiments by Nature and Design. Cambridge, Massachusetts: Harvard University Press, 1979

Crowther 2019

Crowther, Susan, Lau, Annie, Migrant Polish women overcoming communication challenges in Scottish maternity services: A qualitative descriptive study, Midwifery, 72, 30-38, 2019

Docherty 2012

Docherty, Angie, Bugge, Carol, Watterson, Andrew, Engagement: an indicator of difference in the perceptions of antenatal care for pregnant women from diverse socioeconomic backgrounds, Health expectations: an international journal of public participation in health care and health policy, 15, 126-38, 2012

Goodwin 2018

Goodwin, Laura, Hunter, Billie, Jones, Aled, The midwife-woman relationship in a South Wales community: Experiences of midwives and migrant Pakistani women in early pregnancy, Health expectations: an international journal of public participation in health care and health policy, 21, 347-357, 2018

Hatherall 2016

Hatherall, Bethan, Morris, Joanne, Jamal, Farah, Sweeney, Lorna, Wiggins, Meg, Kaur, Inderjeet, Renton, Adrian, Harden, Angela, Timing of the initiation of antenatal care: An exploratory qualitative study of women and service providers in East London, Midwifery, 36, 1-7, 2016

Hunter 2018

Hunter, Louise J., Da Motta, Giordana, McCourt, Christine, Wiseman, Octavia, Rayment, Juliet L., Haora, Penny, Wiggins, Meg, Harden, Angela, Better together: A qualitative exploration of women's perceptions and experiences of group antenatal care, Women and birth: journal of the Australian College of Midwives, 2018

Puthussery 2010

Puthussery, Shuby, Twamley, Katherine, Macfarlane, Alison, Harding, Seeromanie, Baron, Maurina, 'You need that loving tender care': maternity care experiences and expectations of ethnic minority women born in the United Kingdom, Journal of health services research & policy, 15, 156-62, 2010

Raine 2010

Raine, Rosalind, Cartwright, Martin, Richens, Yana, Mahamed, Zuhura, Smith, Debbie, A qualitative study of women's experiences of communication in antenatal care: identifying areas for action, Maternal and child health journal, 14, 590-9, 2010

Symon 2019

Symon, Andrew, McFadden, Alison, White, Marianne, Fraser, Katrina, Cummins, Allison, Using the Quality Maternal and Newborn Care Framework to evaluate women's experiences of different models of care: A qualitative study, Midwifery, 73, 26-34, 2019

Thomson 2013

Thomson, Gill, Dykes, Fiona, Singh, Gulab, Cawley, Lucinda, Dey, Paola, A public health perspective of women's experiences of antenatal care: an exploration of insights from a community consultation, Midwifery, 29, 211-6, 2013

Young 2008

Young,E., Maternal expectations: do they match experience?, Community Practitioner, 81, 27-30, 2008

Appendices

Appendix A – Review protocol

Review protocol for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Table 3: Review protocol

Field (based on PRISMA-P)	Content
Review question	What aspects of (referral to and delivery of) antenatal services are valued by women?
Type of review question	Qualitative
Objective of the review	The aim of this review is to establish what aspects of the referral process to, and delivery of, antenatal services are valued by women.
Eligibility criteria – population	All women
Eligibility criteria – Phenomenon of interest	Views and experiences on the process of referral to antenatal services and/or the delivery of these services throughout the course of pregnancy. Themes will be identified from the available literature, but expected themes are: • Face to face vs remote care (for example Skype, phone, webchat) • Gaps between visits • Group vs 1 to 1 care • Location of visit (for example home, hospital, GP practice) • Method of referral (for example self-referral, GP, healthcare worker) • Waiting time for first appointment • Who does the woman want to see
Eligibility criteria – comparator	Not applicable
Outcomes and prioritisation	Not applicable
Eligibility criteria – study design	• Systematic reviews of qualitative studies that specifically address women's views/experiences of the process of referral to antenatal services generally and/or the delivery of these services. • Qualitative studies (for example, studies that use interviews, focus groups, or observations, or surveys with open-ended questions) that specifically address views/experiences of woman on the process of referral to antenatal services generally and/or the delivery of these services. Note: Identified studies will be reviewed in chronological order with most recent first. Studies on views and experiences of women on the information and support they received during antenatal care will be excluded (addressed in RQ1.1).
Other inclusion exclusion criteria	**Exclusion** STUDY DESIGN: • Purely quantitative studies (including surveys that report only quantitative data) • Qualitative studies that specifically address views/experiences of woman, their partner(s) and families on the information provided (or not provided) about specific pregnancy-related topics (for example, screening tests) during the antenatal period

Field (based on PRISMA-P)	Content
	PUBLICATION STATUS: • Conference abstract LANGUAGE: • Non-English **Inclusion** COUNTRY: • Only studies conducted in high-income countries, as defined by the World Bank, with centrally-funded healthcare systems will be included. For a list of these countries, see https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups Note: The use of the World Bank definitions of low-, middle- and high-income countries in this guideline is consistent with its use in the Postnatal care up to 8 weeks after birth (update) NICE guideline CG37.
Proposed sensitivity/sub-group analysis, or meta-regression	Stratification by gravida status, age, ethnicity (for example, BME) and LGBT+ status will be considered if there is available data.
Selection process – duplicate screening/selection/analysis	Review questions selected as high priorities for health economic analysis (and those selected as medium priorities and where health economic analysis could influence recommendations) will be subject to dual weeding and study selection; any discrepancies above 10% of the dual weeded resources will be resolved through discussion between the first and second reviewers or by reference to a third person. All data extraction will quality assured by a senior reviewer. Draft excluded studies and evidence tables will be circulated to the Topic Group for their comments. Resolution of disputes will be by discussion between the senior reviewer, Topic Advisor and Chair.
Data management (software)	NGA STAR software will be used to generate bibliographies/citations, and to conduct study sifting and data extraction. For the qualitative review, GRADE-CERQual will be used to assess the confidence in the findings from a thematic analysis.
Information sources – databases and dates	Sources to be searched: Embase, Medline, Medline In-Process, PsycINFO, CINAHL Limits (for example, date, study design): • Qualitative, patient concerns • Date: 2006 (Date limited to this as this is when the 'new' ANC system/process came into being). • Apply standard animal/non-English language exclusion
Identify if an update	This is a new area in the guideline.
Author contacts	Developer: National Guideline Alliance.
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual.
Search strategy – for one database	For details please see appendix B.
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or H (economic evidence tables).
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or H (economic evidence tables).

Field (based on PRISMA-P)	Content
Methods for assessing bias at outcome/study level	Quality assessment of individual studies will be performed using the following checklists: • CASP checklist for qualitative studies For details please see section 6.2 of Developing NICE guidelines: the manual. Methodological limitations across all available evidence will be evaluated for each theme using the GRADE-CERQual approach: https://www.cerqual.org
Criteria for quantitative synthesis (where suitable)	For details please see section 6.4 of Developing NICE guidelines: the manual
Methods for analysis – combining studies and exploring (in)consistency	For details please see supplement 1: methods
Meta-bias assessment – publication bias, selective reporting bias	Not applicable.
Assessment of confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual.
Rationale/context – Current management	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the guideline. The committee was convened by the National Guideline Alliance and chaired by Kate Harding in line with section 3 of Developing NICE guidelines: the manual. Staff from the National Guideline Alliance undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate, and drafted the guideline in collaboration with the committee. For details please see supplement 1: methods.
Sources of funding/support	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Roles of sponsor	NICE funds the National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England.
PROSPERO registration number	This protocol is not registered with PROSPERO.

CASP: Critical appraisal skills programme; CCTR: Cochrane Controlled Trials Register; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CERQual: Confidence in the Evidence from Reviews of Qualitative Research; CG: clinical guideline; DARE: Database of Abstracts of Reviews of Effects; GRADE-CERQual: Grading of Recommendations Assessment, Development and Evaluation-Confidence in the Evidence from Reviews of Qualitative Research; HTA: Health Technology Assessment; NGA: National Guideline Alliance; NICE: National Institute for Health and Care Excellence; NIHR: National Institute for Health Research.

Appendix B – Literature search strategies

Literature search strategies for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Database(s): Medline & Embase (Multifile)
Last searched on **Embase Classic+Embase** 1947 to 2019 May 10, **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to May 10, 2019, **PsycINFO** 1806 to April Week 5 2019
Date of last search: 13th May 2019
Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily; psyh=PsycINFO

#	Searches
1	(*Pregnancy/ or Prenatal Care/) use ppez
2	(*pregnancy/ or prenatal care/ or maternal care/ or perinatal care/ or perinatal period/) use emczd
3	(*Pregnancy/ or Prenatal Care/ or Perinatal Period/) use psyh
4	(antenatal$ or ante-natal$ or ante natal$ or prenatal$ or pre-natal$ or pre natal$).tw,kw.
5	((maternity or maternal or pregnancy) adj care).tw,kw.
6	1 or 2 or 3 or 4 or 5
7	(Interview/ or Interviews as Topic/ or Qualitative Research/) use ppez
8	(interview/ or qualitative research/) use emczd
9	(Interviews/ or Qualitative Research/) use psyh
10	(experience$ or qualitative or interview$ or themes).tw.
11	(metasynthes$ or meta-synthes$ or metasummar$ or meta-summar$ or metastud$ or meta-stud$ or metathem$ or meta-them$).tw.
12	7 or 8 or 9 or 10 or 11
13	"Referral and Consultation"/ use ppez
14	(patient referral/ or consultation/) use emczd
15	((patient or direct) adj refer$).tw,kw.
16	(refer$ adj (practice$ or pathway$)).tw,kw.
17	(GP$ adj3 refer$).tw,kw.
18	(self-refer$ or selfrefer$).tw,kw.
19	(Teleconsultation/ or Telemedicine/) use ppez
20	(teleconsultation/ or telemedicine/ or telehealth/) use emczd
21	(teleconsultation/ or telemedicine/) use psyh
22	(teleconsult$ or telemedicine$).tw,kw.
23	((video$ or telephone$ or phone$ or web$ or online$ or on-line$ or smartphone$ or computer$) adj3 consult$).tw,kw.
24	((virtual$ or remote$ or face-to-face$) adj consult$).tw,kw.
25	(*"Delivery of Health Care"/ or *Health Services Accessibility/) use ppez
26	(*health care delivery/ or *health care system/) use emczd
27	*health care delivery/ use psyh
28	(model$ adj3 (care or antenatal$ or ante-natal$ or ante natal$ or prenatal$ or pre-natal$ or pre natal$)).tw,kw.
29	(visit adj structure$).tw,kw.
30	(booking adj3 process$).tw,kw.
31	(navigat$ adj3 system$).tw,kw.
32	(group setting or group care).mp.
33	(group$ adj2 (antenatal$ or ante-natal$ or ante natal$ or prenatal$ or pre-natal$ or pre natal$ or pregnan$) adj3 (care or consultation$ or appointment$ or visit$ or clinic$ or program$ or session$ or education$)).tw,kw.
34	(group$ adj (care or consultation$ or appointment$ or visit$ or clinic$ or program$ or session$ or education$) adj5 (antenatal$ or ante-natal$ or ante natal$ or prenatal$ or pre-natal$ or pre natal$ or pregnan$)).tw,kw.
35	(individual adj2 (antenatal$ or ante-natal$ or ante natal$ or prenatal$ or pre-natal$ or pre natal$ or pregnan$) adj3 (care or consultation$ or appointment$ or visit$ or clinic$ or program$ or session$ or education$)).tw,kw.
36	*Continuity of Care/ use ppez
37	*patient care/ use emczd
38	*"continuum of care"/ use psyh
39	((continuum or continuity) adj3 care).tw,kw.
40	(*Health Personnel/ or Physician-Patient Relations/ or Professional-Patient Relations/ or Nurse-Patient Relations/) use ppez
41	(*healthcare personnel/ or doctor patient relation/ or professional-patient relationship/ or nurse patient relationship/) use emczd
42	*Health Personnel/ use psyh
43	*interpersonal communication/ or *communication/
44	13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43
45	("Appointments and Schedules"/ or Office Visits/) use ppez

#	Searches
46	(ambulatory care/ or hospital management/) use emczd
47	((antenatal$ or ante-natal$ or prenatal or pre-natal$) adj care adj (booking$ or visit$ or appointment$)).tw,kw.
48	((antenatal$ or ante-natal$ or ANC or prenatal$ or pre-natal$ or midwi$) adj (booking$ or visit$ or appointment$)).tw,kw.
49	45 or 46 or 47 or 48
50	Time Factors/ use ppez
51	time factor/ use emczd
52	Time/ use psyh
53	((visit$ or standard or traditional) adj3 schedule$).tw.
54	((number or timing or frequency or fewer or less or lower or reduc$ or more or increas$) adj5 (booking$ or visit$ or appointment$)).tw.
55	((timing or frequency or utilis$ or utiliz$) adj3 (antenatal care or ante-natal care or ANC)).tw.
56	50 or 51 or 52 or 53 or 54 or 55
57	49 and 56
58	44 or 57
59	6 and 12 and 58
60	limit 59 to english language
61	limit 60 to yr="2006 -Current"
62	letter/
63	editorial/
64	news/
65	exp historical article/
66	Anecdotes as Topic/
67	comment/
68	case report/
69	(letter or comment*).ti.
70	62 or 63 or 64 or 65 or 66 or 67 or 68 or 69
71	randomized controlled trial/ or random*.ti,ab.
72	70 not 71
73	animals/ not humans/
74	exp Animals, Laboratory/
75	exp Animal Experimentation/
76	exp Models, Animal/
77	exp Rodentia/
78	(rat or rats or mouse or mice).ti.
79	72 or 73 or 74 or 75 or 76 or 77 or 78
80	letter.pt. or letter/
81	note.pt.
82	editorial.pt.
83	case report/ or case study/
84	(letter or comment*).ti.
85	80 or 81 or 82 or 83 or 84
86	randomized controlled trial/ or random*.ti,ab.
87	85 not 86
88	animal/ not human/
89	nonhuman/
90	exp Animal Experiment/
91	exp Experimental Animal/
92	animal model/
93	exp Rodent/
94	(rat or rats or mouse or mice).ti.
95	87 or 88 or 89 or 90 or 91 or 92 or 93 or 94
96	79 use ppez
97	95 use emczd
98	96 or 97
99	61 and 98
100	61 not 99

Database(s): Cochrane Library
Last searched on **Cochrane Database of Systematic Reviews**, Issue 5 of 12, May 2019, **Cochrane Central Register of Controlled Trials**, Issue 5 of 12, May 2019
Date of last search: 13th May 2019

#	Searches
#1	MeSH descriptor: [Pregnancy] this term only
#2	MeSH descriptor: [Prenatal Care] this term only
#3	((antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*)):ti,ab,kw
#4	(((maternity or maternal or pregnancy) NEXT care)):ti,ab,kw
#5	#1 OR #2 OR #3 OR #4
#6	MeSH descriptor: [Referral and Consultation] this term only

#	Searches
#7	(((patient or direct) NEXT refer*)):ti,ab,kw
#8	((refer* NEXT (practice* or pathway*))):ti,ab,kw
#9	(GP* NEAR/3 refer*)
#10	(self-refer* or selfrefer*)
#11	MeSH descriptor: [Remote Consultation] this term only
#12	MeSH descriptor: [Telemedicine] this term only
#13	((teleconsult* or telemedicine*)):ti,ab,kw
#14	(((video* or telephone* or phone* or web* or online* or on-line* or smartphone* or computer*) NEAR/3 consult*)):ti,ab,kw
#15	(((virtual* or remote* or face-to-face*) NEXT consult*)):ti,ab,kw
#16	MeSH descriptor: [Delivery of Health Care] this term only
#17	MeSH descriptor: [Health Services Accessibility] this term only
#18	((model* NEAR/3 (care or antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*))):ti,ab,kw
#19	((visit NEXT structure*)):ti,ab,kw
#20	((booking NEAR/3 process*)):ti,ab,kw
#21	((navigat* NEAR/3 system*)):ti,ab,kw
#22	(("group setting" or "group care")):ti,ab,kw
#23	((group* NEAR/2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) NEAR/3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*))):ti,ab,kw
#24	((group* NEXT (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*) NEAR/5 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*))):ti,ab,kw
#25	((individual NEAR/2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) NEAR/3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*))):ti,ab,kw
#26	MeSH descriptor: [Continuity of Patient Care] this term only
#27	(((continuum or continuity) NEAR/3 care)):ti,ab,kw
#28	MeSH descriptor: [Health Personnel] this term only
#29	MeSH descriptor: [Physician-Patient Relations] this term only
#30	MeSH descriptor: [Professional-Patient Relations] this term only
#31	MeSH descriptor: [Nurse-Patient Relations] this term only
#32	MeSH descriptor: [Communication] this term only
#33	#6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32
#34	MeSH descriptor: [Appointments and Schedules] this term only
#35	MeSH descriptor: [Office Visits] this term only
#36	(((antenatal* or ante-natal* or prenatal or pre-natal*) NEXT care NEXT (booking* or visit* or appointment*))):ti,ab,kw
#37	(((antenatal* or ante-natal* or ANC or prenatal* or pre-natal* or midwi*) NEXT (booking* or visit* or appointment*))):ti,ab,kw
#38	#34 OR #35 OR #36 OR #37
#39	MeSH descriptor: [Time Factors] this term only
#40	(((visit* or standard or traditional) NEAR/3 schedule*)):ti,ab,kw
#41	(((number or timing or frequency or fewer or less or lower or reduc* or more or increas*) NEAR/5 (booking* or visit* or appointment*))):ti,ab,kw
#42	(((timing or frequency or utilis* or utiliz*) NEAR/3 (antenatal care or ante-natal care or ANC))):ti,ab,kw
#43	#39 OR #40 OR #41 OR #42
#44	#38 AND #43
#45	#33 OR #44
#46	MeSH descriptor: [Interviews as Topic] this term only
#47	MeSH descriptor: [Interview] this term only
#48	MeSH descriptor: [Qualitative Research] this term only
#49	((experience* or qualitative or interview* or themes)):ti,ab,kw
#50	((metasynthes* or meta-synthes* or metasummar* or meta-summar* or metastud* or meta-stud* or metathem* or meta-them*)):ti,ab,kw
#51	#46 OR #47 OR #48 OR #49 OR #50
#52	#5 AND #45 AND #51 Publication Year from 2006 to current

Database(s): Cinahl Plus

Date of last search: 13th May 2019

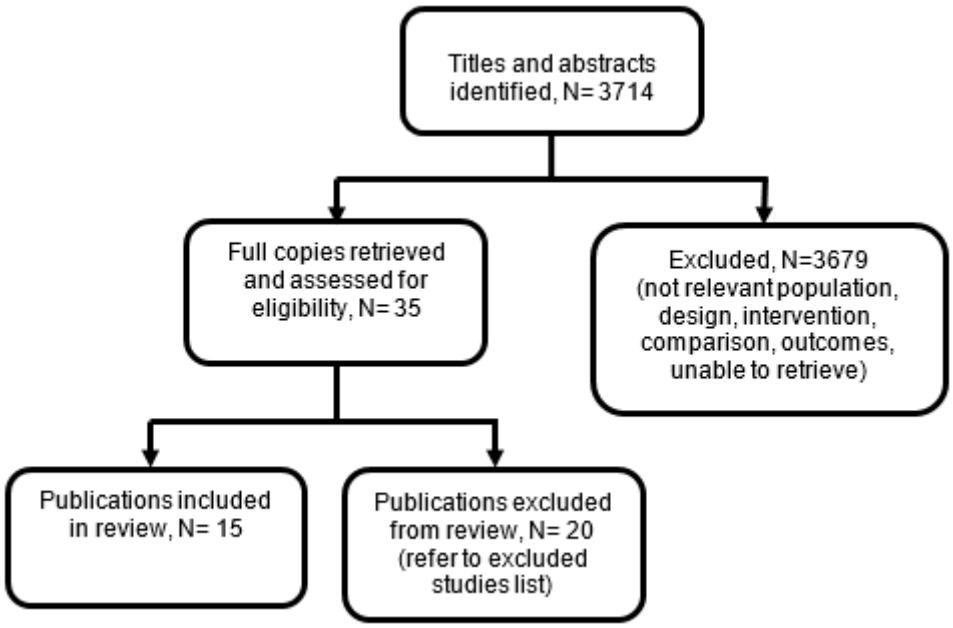
#	Searches
S47	S6 AND S46 Limiters - Publication Year: 2006-2019; English Language; Clinical Queries: Qualitative - Best Balance
S46	S33 OR S45
S45	S39 AND S44
S44	S40 OR S41 OR S42 OR S43
S43	TI ((timing or frequency or utilis* or utiliz*) N3 (antenatal care or ante-natal care or ANC)) OR AB ((timing or frequency or utilis* or utiliz*) N3 (antenatal care or ante-natal care or ANC))
S42	TI ((number or timing or frequency or fewer or less or lower or reduc* or more or increas*) N5 (booking* or visit* or appointment*) OR AB ((number or timing or frequency or fewer or less or lower or reduc* or more or increas*) N5 (booking* or visit* or appointment*)
S41	TI ((visit* or standard or traditional) N3 schedule*) OR AB ((visit* or standard or traditional) N3 schedule*)
S40	(MH "Time Factors")

#	Searches
S39	S34 OR S35 OR S36 OR S37 OR S38
S38	TI ((antenatal* or ante-natal* or ANC or prenatal* or pre-natal* or midwi*) N1 (booking* or visit* or appointment*)) OR AB ((antenatal* or ante-natal* or ANC or prenatal* or pre-natal* or midwi*) N1 (booking* or visit* or appointment*))
S37	TI ((antenatal* or ante-natal* or prenatal or pre-natal*) N1 care N1 (booking* or visit* or appointment*)) OR AB ((antenatal* or ante-natal* or prenatal or pre-natal*) N1 care N1 (booking* or visit* or appointment*))
S36	(MH "Ambulatory Care")
S35	(MH "Office Visits")
S34	(MH "Appointments and Schedules")
S33	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32
S32	(MM "Communication")
S31	(MH "Nurse-Patient Relations")
S30	(MH "Professional-Patient Relations")
S29	(MH "Physician-Patient Relations")
S28	(MM "Health Personnel")
S27	TI ((continuum or continuity) N3 care) OR AB ((continuum or continuity) N3 care)
S26	(MM "Continuity of Patient Care")
S25	TI (individual N2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) N3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*)) OR AB (individual N2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) N3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*))
S24	TI (group* N1 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*) N5 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*)) OR AB (group* N1 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*) N5 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*))
S23	TI (group* N2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) N3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*)) OR AB (group* N2 (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal* or pregnan*) N3 (care or consultation* or appointment* or visit* or clinic* or program* or session* or education*))
S22	TI (navigat* N3 system*) OR AB (navigat* N3 system*)
S21	TI (booking N3 process*) OR AB (booking N3 process*)
S20	TI (visit N1 structure*) OR AB (visit N1 structure*)
S19	TI (model* N3 (care or antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*)) OR AB (model* N3 (care or antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*))
S18	(MM "Health Services Accessibility")
S17	(MM "Health Care Delivery")
S16	TI ((virtual* or remote* or face-to-face*) N1 consult*) OR AB ((virtual* or remote* or face-to-face*) N1 consult*)
S15	TI ((video* or telephone* or phone* or web* or online* or on-line* or smartphone* or computer*) N3 consult*) OR AB ((video* or telephone* or phone* or web* or online* or on-line* or smartphone* or computer*) N3 consult*)
S14	TI (teleconsult* or telemedicine*) OR AB (teleconsult* or telemedicine*)
S13	(MH "Telemedicine")
S12	(MH "Remote Consultation")
S11	TI (self-refer* or selfrefer*) OR AB (self-refer* or selfrefer*)
S10	TI (GP* N3 refer*) OR AB (GP* N3 refer*)
S9	TI (refer* N1 (practice* or pathway*)) OR AB (refer* N1 (practice* or pathway*))
S8	TI ((patient or direct) N1 refer*) OR AB ((patient or direct) N1 refer*)
S7	(MH "Referral and Consultation")
S6	S1 OR S2 OR S3 OR S4 OR S5
S5	TI ((maternity or maternal or pregnancy) N1 care) OR AB ((maternity or maternal or pregnancy) N1 care)
S4	TI (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*) OR AB (antenatal* or ante-natal* or ante natal* or prenatal* or pre-natal* or pre natal*)
S3	(MH "Perinatal Care")
S2	(MH "Prenatal Care")
S1	(MM "Pregnancy")

Appendix C – Clinical evidence study selection

Study selection for: What aspects of (referral to and delivery of) antenatal care are valued by women?

Figure 2: Study selection flow chart



Appendix D – Clinical evidence tables

Evidence tables for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Table 4: Evidence tables

Study Details	Participants and methods	Themes, limitations and other comments
Full citation Alshawish, Eman, Marsden, Janet, Yeowell, Gill, Wibberley, Christopher, Investigating access to and use of maternity health-care services in the UK by Palestinian women, British Journal of Midwifery, 21, 571-577, 2013 **Ref Id** 1018350 **Study type** General qualitative inquiry **Aim of the study** To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women. **Country/ies where the study was carried out** England **Study dates** Not reported.	**Sample size** N=22 women who have children **Inclusion criteria** • Women over 18 years old, Palestinian and living in the UK **Exclusion criteria** None stated **Characteristics** Not reported **Setting** Manchester **Sample selection**	**Themes from study** • Cultural variations • Knowledge of the NHS and the UK health-care system • Health-care services and their utilisation, focusing on maternal and child health-care services • Communication, information provision and needs **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell

Study Details	Participants and methods	Themes, limitations and other comments
Source of funding Not reported	• A sample of women who met the inclusion criteria and who had children in one of the Arabic schools in Manchester was recruited by invitation through the head of school. • Women attending a local mosque were asked to identify other Palestinian women, especially those having children who were older, or who attended other schools. • The women were invited to take part in the study by invitation letter left at the mosque. • Through contacts at the relevant schools and the Didsbury Arabic mosque, the snowball technique was used to identify other Palestinian women living in Manchester. **Data collection** • Twenty-two, in-depth, face-to-face interviews were conducted using a semi-structured interview schedule. • Based on participants' preference, semi-structured interviews were conducted in participants' homes, the researcher's home or in schools. • Demographic data were collected. • The interview was digitally recorded, with the permission of the women. • Depending on the preference of the women, English and/or Arabic language was used. • Duration of the interviews ranged from 45-90 minutes **Data analysis**	**CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Can't tell. Findings discussed within the wider context. Transferability discussed. New area for research not identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Data was transcribed and analysed using framework analysis. • The data was coded and labelled during and after data collection. • Analysis was aided by NVivo 9 • The researcher followed the 5 stages of data analysis in the framework approach: Familiarisation, identifying a thematic framework, indexing, charting and mapping, and interpretation.	
Full citation Aquino, Maria Raisa Jessica V., Olander, Ellinor K., Bryar, Rosamund M., A focus group study of women's views and experiences of maternity care as delivered collaboratively by midwives and health visitors in England, BMC pregnancy and childbirth, 18, 505, 2018 **Ref Id** 1018017 **Study type** General qualitative inquiry **Aim of the study** • To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors	**Sample size** N=12 women **Inclusion criteria** • Mothers aged ≥18 years of age, who have a child less than 18 months old. • Who can read and speak English and provide written consent to participate. **Exclusion criteria** Not reported **Characteristics** Parity: • 0: N=1 • 1-2: N=11 Age (years) range (mean): 30-44 (34.67) Ethnicity:	**Themes from study** • Theme 1: Women's experiences of maternity care from midwives and health visitors • Theme 2: Midwife-health visitor communication • Theme 3: Midwife-health visitor collaboration for tailored care • Theme 4: Women's ideal maternity care pathway Subthemes for theme 4 1. Pregnancy 2. Labour/birth 3. Postpartum care **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?**

Study Details	Participants and methods	Themes, limitations and other comments
• To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. **Country/ies where the study was carried out** England **Study dates** June to August 2017 **Source of funding** • Study was part of a PhD studentship funded by the School of Health Sciences, City, University of London. • The Research Sustainability Fund at the School of Health Sciences, City, University of London paid for Open Access fees. • Additional funding to support the conduct of the study was obtained from the Psychology Postgraduate Affairs Group (PsyPAG).	• White English/British: N=3 • White other Background: N=5 • Asian/ Asian other: N=2 • Mixed ethnicity (White and Black African/French; White and Black Caribbean): N=2 **Setting** Data collection took place in a Children's Centre in London **Sample selection** • Participant were recruited through face-to-face contact with women in Children's Centres, word of mouth, and social media (i.e. Twitter). • 74 Children's Centres and other community-based groups in and around London were approached by email with a follow-up email 1 week later. • 10 centres agreed agreeing to participate. • Due to logistical constraints (e.g. Children's Centre closures, lack of availability of co-moderator), face-to-face recruitment was focused on two Children's Centres. **Data collection**	Yes **CASP - Recruitment strategy appropriate?** Yes **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Cant' tell **CASP - Value of research** Yes. Findings were discussed within wider literature. Transferability was discussed and New area for research identified. **CASP - Overall quality** Minor concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Focus group was used for data collection. • A topic guide was used. • Two members of the research team were present at the focus group discussions. • One acted as moderator and the other as assistant moderator responsible for note-taking. • All focus groups were audio-recorded following written informed consent of all participants. **Data analysis** • Audio-recordings transcribed verbatim by a professional transcription agency and checked for accuracy by 1 of the authors. • Thematic analysis was applied to the data. • A combination of inductive and deductive thematic analysis was used for the study based on critical realism. • NVivo was used for the data analysis by the first author. • Analysis include: familiarisation, or the reading and rereading of transcripts and generation of initial codes to identify noteworthy topics. • This was combined with a deductive approach in which codes were based on the research aims, and used as a template to organise the data into themes. • Another member of the research team reviewed the themes derived from the analysis, and discussed these with the first author. • Another member of the research team read the themes agreed upon by the 2 researchers to ascertain whether the themes were representative of the data and made recommendations for defining and naming the final set of themes.	

Study Details	Participants and methods	Themes, limitations and other comments
	• The data were summarised narratively using notes on flipcharts and transcriptions then compared and contrasted.	
Full citation Beake, Sarah, Acosta, Luisa, Cooke, Pauline, McCourt, Christine, Caseload midwifery in a multi-ethnic community: the women's experiences, Midwifery, 29, 996-1002, 2013 **Ref Id** 1017349 **Study type** Qualitative (Grounded theory) **Aim of the study** To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting. **Country/ies where the study was carried out** England **Study dates** Not reported	**Sample size** N=24 women **Inclusion criteria** • Women who gave birth within the local community area in a two-month period. **Exclusion criteria** • Women who had experienced a stillbirth or neonatal death **Characteristics** • N=12 women who received caseload care and 12 women from adjacent postcode areas receiving conventional maternity care. • N=8 of 12 women in the caseload care group and 10/12 in the usual care group were of minority ethnic background, defined as not white British or European. • The relevant neighbourhoods for the caseload care groups were measured as being among the top 10% of	**Themes from study** • Theme: Knowing and being known 1. Like a friend or kin 2. Feeling safe and relaxed 3. Being able to confide 4. Repeating your history 5. knowing the extended family • Theme : Person-centred cared • Theme : Social support • Theme:Gaining trust and confidence • Theme: Quality and sensitivity of care • Communication **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** yes

Study Details	Participants and methods	Themes, limitations and other comments
Source of funding Not reported	areas of social deprivation in England according to their Index of Multiple Deprivation score. <u>Age range:</u> • 20-29: N=11 • 30-39: N=11 • ≥40: N=5 <u>Parity:</u> 0: N=4 1: N=12 2: N=5 3+: N=3 <u>Ethnicity:</u> White British: N=3 White other European: N=3 Black African: N=3 Black other: N=1 Indian: N=1 Bangladeshi: N=3 Oriental: N=1 Any other: N=6 Not stated: N=1 **Setting** Semi-structured interviews were conducted at a time and venue of choice of the women, mostly in the homes of the women.	**CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes **CASP - Value of research** Can't tell. Findings were discussed within the context of wider literature. Transferability was discussed. New areas for research not identified. **CASP - Overall quality** Minor

Study Details	Participants and methods	Themes, limitations and other comments
	Sample selection • Participants drawn from a list of all women who gave birth within the local community area in a 2-month period. • All women on the list who had received caseload care were invited and all those who agreed to participate were interviewed. • 12 women who had received caseload care were interviewed till data saturation was reached. • A sample of 12 women from adjacent postcode areas receiving conventional maternity care from the same list who matched those interviewed in terms of parity and ethnicity as far as possible were contacted and invited to participate until a comparable sample was achieved. **Data collection** • Individual, semi-structured interviews between 3 to 6 months postnatally were conducted at a time and venue of the woman's own choice, for the most part this was the woman's home. • Two samples of 12 women (caseload and standard care) were interviewed to ensure a sufficient sample for data saturation reached. • The interviews were taped with permission.	

Study Details	Participants and methods	Themes, limitations and other comments
	Data analysis • The taped interviews were transcribed. • Grounded theory principles were used to guide the overall approach and data analysis. • Open coding was used, followed by coding to identify themes emerging from the data. • Transcripts were analysed independently by different members of the research team, who met several times to discuss results, explore the themes and organise them into categories. • During analysis authors noted that links could be drawn with previous work of 1 of the researchers on women's views of caseload midwifery (McCourt and Stevens, 2009) and framework analysis was therefore adopted. • A framework analysis drawing on the previous work was drawn up and the data were analysed in relation to the previous work, while still allowing it to be examined for new or dissonant emergent themes • The 5 key stages typically applied in framework analysis were followed: initial familiarisation with the data by immersion in reading of the transcripts in order to identify recurrent themes and concepts; identifying a thematic framework-identifying all the key issues and themes drawing on prior issues; indexing all the data forming charts for each theme, the charts contain distilled summary of views and experiences rather than verbatim quotations; mapping and interpretation.	
Full citation Binder, Pauline, Borne, Yan, Johnsdotter, Sara, Essen, Birgitta, Shared language is essential: communication in a multiethnic obstetric care setting, Journal of health communication, 17, 1171-86, 2012	**Sample size** N=60 women and 62 obstetric care providers (doctors or midwives) **Inclusion criteria**	**Themes from study** • Language • The interpreter as a tool for communication

Study Details	Participants and methods	Themes, limitations and other comments
Ref Id 1019289 **Study type** General qualitative inquiry **Aim of the study** To gain a deeper understanding of the multiethnic care setting and the roles that ethnicity and language play during the sensitive care encounter between immigrant women and their western obstetric care providers. **Country/ies where the study was carried out** England **Study dates** 2005 to 2006 **Source of funding** Not reported	• Women who had at least one child at the time of data collection • Obstetricians with professional affiliation as a doctor or midwife at 5 hospitals within the Greater London **Exclusion criteria** Not reported **Characteristics** Ethnicity for the 60 women • Somali immigrants: N=39 • Ghanaian: N=11 • White British Women: N=10. Parity range: 1 to 10 **For the African women** Age(years) range: 18-48 years Time spent in the UK ranged from 1 to 20 years **For providers:** Ethnicity • Somali: N=4 • Other African or Caribbean: N=34 • White British: N=21 • Asian: N=3	• Cultural influences on communication **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** No **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Can't tell **CASP - Value of research**

Study Details	Participants and methods	Themes, limitations and other comments
	Setting • London • The focus groups and interviews were carried out in the homes of 36 Somali women. • Setting for the focus groups sessions for the rest of the women was not reported. • The individual interviews were carried out in the maternity wards or homes of the 3 remaining Somali, Ghanaian and White British women. • The providers were interviewed individually or in focus group discussion in the participating hospitals **Sample selection** • Participants were sought throughout Greater London between 2005 and 2006. • The snowball sampling technique was used to recruit some of the Somali participants at the community level and saturation of referrals was reached at 36 women. • The snowball referral was initially arranged by 10 female Somali culture brokers • The 3 remaining Somali women, the Ghanaian women and the White British women were recruited purposively at the hospital by the head midwife or by an on-call obstetrician. • The providers at the various study hospitals were introduced to the project by a posted sign at the maternity ward which invited all interested providers to attend an information meeting given by the research team. • At the meeting, interested providers were invited to interview	Yes. Findings were discussed within the context of wider literature. transferability was discussed and new area for research was identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	Data collection • In-depth individual and focus group interviews using semi-structured, open-ended questions were performed by an obstetrician and an anthropologist. • Interviews were tape-recorded and took 30-90 minutes. • A total of 23 individual interviews and 4 focus group interviews, comprising 2–6 participants were conducted with the Somali women. • A Somali interpreter was used during 10 individual interviews and 3 focus group interviews to directly translate Somali into English. • The Somali culture brokers acted on behalf of the researchers to set up the first contacts and focus groups in the homes of Somali women throughout the study area and assisted the researchers to follow-up on individual interviews around different neighbourhoods. • Seven individual and 1 focus group interview (4 participants) were conducted with Ghanaian women, and 10 individual interviews took place with the White British women. • Fifty-two individual interviews and three focus group interviews (2–5 participants each) were conducted with the providers. • All interviews were performed following individual informed consent. **Data analysis** • The data were analysed using qualitative techniques under a framework of naturalistic enquiry.	

Study Details	Participants and methods	Themes, limitations and other comments
	• Discussions between the researchers took place at different times and settings in order to confirm the intuitive categories generated within the findings. • These discussions were conducted during the interview process and during the analysis period.	
Full citation Boyle, Sally, Thomas, Hilary, Brooks, Fiona, Women's views on partnership working with midwives during pregnancy and childbirth, Midwifery, 32, 21-9, 2016 **Ref Id** 1019693 **Study type** General qualitative inquiry **Aim of the study** To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. **Country/ies where the study was carried out** England **Study dates** Not reported **Source of funding** Not reported	**Sample size** N=16 women **Inclusion criteria** Pregnant women at approximately 10 weeks gestation who were having their initial booking interview. **Exclusion criteria** Not reported **Characteristics** Age range: 21-47 years Parity: 0: N=9 1: N=4 2: N=2 5: n=1 Ethnicity: Caucasians: N=15 Black African: N=1 **Setting** South East of England. All interviews were carried out in the women homes	**Themes from study** • Theme: Organisation of care 1. knowing the system 2. experience of midwife: woman interaction • Theme: Relationships 1. women's perspective 2. interpersonal interactions • Theme: Choice 1. the extent to which women were offered choice 2. influence of decision making **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes

Study Details	Participants and methods	Themes, limitations and other comments
	Sample selection • Women recruited from 2 district general hospitals. • Midwives recruited 16 women during the initial booking interview at approximately ten weeks gestation, to participate in this study using a purposive sampling approach. • The midwife gave the women a letter explaining the study and an information leaflet to take away, which provided full details of the study. • Women who indicated interest in the study were directed to the principal investigator. • Recruitment continued until data saturation was achieved. **Data collection** • Data was collected by means of a diary-interview method. • Guidance was provided in the diary to ask women to include the reason for their visit, whether they had met the midwife before and how they felt after the appointment. • The diary was maintained through the antenatal, intrapartum and postnatal period. • The diary was returned to the researcher prior to the interviews at 34 weeks gestation and 2 to 4 weeks after the baby's birth. • All interviews were conducted in the homes of the women.	**CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes **CASP - Value of research** Yes. Findings discussed within the context of wider literature. Transferability was discussed and new areas for research was identified. **CASP - Overall quality** Minor concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• The semi-structured interviews were digitally recorded following a series of prompts based on the work of Green et al. (1998). • Additional prompts emerged from the diary entries from comments that were considered important to the women. **Data analysis** • A thematic approach was used to interrogate the data for categories to emerge and empirical codes to be identified. • MAXqda software was used to support the analytical process, enabling an electronic codebook to be developed, including coding memos and a record of decisions taken when amending or realigning the data.	
Full citation Crowther, Susan, Lau, Annie, Migrant Polish women overcoming communication challenges in Scottish maternity services: A qualitative descriptive study, Midwifery, 72, 30-38, 2019 **Ref Id** 1018582 **Study type** General qualitative inquiry **Aim of the study**	**Sample size** N=9 women **Inclusion criteria** • Polish migrants who have given birth at the chosen NHS maternity hospital within 12 months at the start of the study (no distinction was made between high and low complex care). • Polish migrants who have limited or no ability to speak and understand English (English proficiency was	**Themes from study** • Theme: Communicating and understanding 1. Language differences 2. Experiencing inconsistency of interpretation services 3. Quality and type of information • Theme: Relationships matter 1. Empowering and responsive caring communication

Study Details	Participants and methods	Themes, limitations and other comments
To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. **Country/ies where the study was carried out** Scotland **Study dates** 2017 to 2018 **Source of funding** Study was supported by the Iolanthe Jean Davies financial award (UK) 2017/2018.	varied, but all had some challenges concerning English comprehension) **Exclusion criteria** • Polish migrant women who do not consent to be interviewed **Characteristics** <u>Age (years) range:</u> 25-39 years <u>Parity</u> • 0:N=0 • 1: N=2 • 2: N=2 • 3: N=3 • 4: N=2 • Time stayed in UK: 5 months-10 years **Setting** An Urban city of Scotland. Semi-structured interview were carried out at venues suitable to the women. **Sample selection**	• Theme: Values and expectations 1. Living with differences 2. Valuing the differences **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** Yes **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes

Study Details	Participants and methods	Themes, limitations and other comments
	• A Polish parish community, run by a Roman Catholic Diocese, was approached and agreed to help advertise the study. • Using a purposive sampling approach, a small sample size of 9 participants was recruited until data saturation was achieved **Data collection** • Following signed informed consent semi-structured interviews at a time and venue suitable to the women were organised. • All interviews were undertaken by 1 investigator experienced in qualitative interviewing. • Interviews were conducted in Polish or in English according to the woman's preference. • Three participants spoke little or no English and requested Polish interpreting during the interviews. • Translations occurred during interviews when needed either by a relative, friend or independent interpreter employed specifically for the study. • The choice of using the professional interpreter or known person was left to the woman and arranged prior to her interview. • Seven participants opted to be interviewed in English as they had adequate proficiency to describe their care. • All interviews were audio-recorded. • Data collection was through the semi structured interviews using an interview guide with prompts • Data collection occurred between July 2017 and November 2017.	**CASP - Value of research** Yes. Findings discussed within the context of wider literature. Transferability discussed and new areas for research identified. **CASP - Overall quality** Minor concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• All women interviewed at time of interviews had been discharged from NHS midwifery care **Data analysis** • The data were analysed using thematic content analysis. • All interviews were transcribed verbatim. • All transcripts were checked with original audio recording and read through by both investigators. • Major clusters of descriptions themes and sub-themes were discussed and analysed among the research team. • Provisional findings were then presented to a faculty research symposium to help ensure plausibility and credibility of the conclusions.	
Full citation Docherty, Angie, Bugge, Carol, Watterson, Andrew, Engagement: an indicator of difference in the perceptions of antenatal care for pregnant women from diverse socioeconomic backgrounds, Health expectations : an international journal of public participation in health care and health policy, 15, 126-38, 2012 **Ref Id** 1017745 **Study type** Qualitative (Case study)	**Sample size** N=21 women at first interview N=17 women at second interview **Inclusion criteria** English speaking primigravidas receiving standard low risk antenatal care, aged >16 years with no known cognitive difficulties from the datazones defined by the Scottish Index of Multiple Deprivation (SIMD). **Exclusion criteria** None stated	**Themes from study** • Language and personalization • Power and relationships • Health literacy • Engagement in the final trimester **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes

Study Details	Participants and methods	Themes, limitations and other comments
Aim of the study To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background. **Country/ies where the study was carried out** Scotland **Study dates** January 2007 to April 2009 **Source of funding** Study was unfunded but there was an employer funding to complete a Doctor of Nursing Degree.	**Characteristics** From least deprived tail: Deprivation decile: 9-10 Age (years) range: 17-40 years From most deprived tail: Deprivation decile: 1-2 Age (years) range: 17-39 years **Setting** One local authority in West Central Scotland **Sample selection** • Potential cases were identified from postcode data at each booking clinic. • Following completion of the clinical appointment, potential cases were provided with study information by the researcher. **Data collection** • Case data were collected from 3 sources: SIMD information; researcher observation of geographical locality and two semi-structured interviews (1 in each of the first and third trimesters). • The interview schedule was piloted. • During the study, there was no attrition from the least deprived group; 4 most deprived cases did not participate in the second interview.	**CASP - Research design appropriate?** No **CASP - Recruitment strategy appropriate?** Yes **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Yes. Findings discussed within the context of wider literature. Transferability discussed and new area for research identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• All interviews were audiotaped and transcribed. **Data analysis** • Data analysis used a 5-stage strategy facilitated by NVivo. • Stage 1 ordered each case according to collated demographic variables. • Stage 2 ordered qualitative data into a priori codes based on key antenatal contacts, • Stage 3 explored this qualitative data within and between case tails. • Stage 4, the inductive stage of analysis reviewed the concepts emerging from the preliminary stages and developed a theoretical proposition on which to base the final substantive analysis. • The substantive 5th stage analysed the relationship between the demographic case variables and the theoretical proposition of engagement. • The substantive analysis was underpinned by 3 themes that emerged from a review of the literature on engagement	
Full citation Goodwin, Laura, Hunter, Billie, Jones, Aled, The midwife-woman relationship in a South Wales community: Experiences of midwives and migrant Pakistani women in early pregnancy, Health expectations : an international journal of public participation in health care and health policy, 21, 347-357, 2018 **Ref Id** 1018546	**Sample size** N=7 migrant Pakistani women and 11 practising midwives **Inclusion criteria** For migrant Pakistani women • Born in Pakistan • Between 3 to 6 months pregnant at the time of recruitment • Receiving maternity care in South Wales for the first time	**Themes from study** • Family relationships • Culture and religion • Understanding different health-care systems **CASP - Clear statement of aims?**

Study Details	Participants and methods	Themes, limitations and other comments
Study type Qualitative (Ethnographic study) **Aim of the study** To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. **Country/ies where the study was carried out** Wales **Study dates** Not reported **Source of funding** • Laura Goodwin is also funded by the NIHR CLAHRC West Midlands+initiative. • Billie Hunter is the Royal College of Midwives (RCM) Professor of Midwifery, and her post is partly funded by the RCM.	• Aged 16 to 45 For midwives • UK-born • Working in South Wales • Experience of providing maternity care to migrant Pakistani women **Exclusion criteria** For migrant Pakistani women • Serious illness/conditions which may affect the pregnancy **Characteristics** • N=7 migrant Pakistani women and 11 practising midwives For migrant Pakistani women Age (years) range: 17-35 years • Years in UK: 2-15 Migrant Pakistani language interpreter (Sara): Age=47 years; Number of years in UK=10 Mother of 1 participant: Age=56 years; Number of years in UK=13 Characteristics of midwives were not provided for confidentiality reasons. **Setting** A maternity Unit in South Wales	Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Yes **CASP - Value of research** Can't tell. Findings discussed within the context of wider literature. Transferability discussed. New areas for research was not identified. **CASP - Overall quality**

Study Details	Participants and methods	Themes, limitations and other comments
	Sample selection • Pakistani women receiving maternity care in South Wales and 11 midwives with experience of providing maternity care to migrant Pakistani women. • A purposive sampling was used for recruitment. • All eligible migrant Pakistani women were identified by midwives via antenatal clinic booking records, and midwives provided these women with participant information packs at their next appointment. • To recruit midwives, invitations to participate were initially sent out by the Head of Midwifery, with a request to contact the researcher to express interest. • A snowballing approach was then used to recruit other midwives eligible for participation. **Data collection** Several data collection methods were utilized: (i) preliminary fieldwork in the communities under study; (ii) reviews of relevant media (ie newspaper articles, policies); (iii) semi-structured interviews; (iv) non-participant observations of antenatal booking appointments; (v) reflexive field notes (written throughout study design, recruitment data collection and analysis). For interview • Migrant Pakistani women were interviewed at 2 time-points, once after their first antenatal appointment, and after their second/ third antenatal appointment. • A flexible topic guide was used to guide the interviews which lasted between 20-90 minutes. • Language interpreters were offered to all women at all points of engagement with the study. • Anonymised audio extracts of interviews were sent to an independent interpreter for validation.	Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Naturally occurring interviews resulted in data also being included from the mother of 1 of the participants (n = 1) and a migrant Pakistani interpreter (n = 1). • The number of interviews was not predefined but was limited to an extent by the planned duration for data collection; however, recruitment was stopped when no new concepts were emerging from the data. • Interviews with midwives lasted between 20 and 60 minutes. For non-participant observation • total of 15 observations of antenatal booking appointments (20-60 minutes each) took place in antenatal clinics across the local health board over a period of 3-6 months. **Data analysis** • Thematic analysis of the data was used, resulting in a data driven inductive approach. • The first step of the analysis was the data transcript carried out by 1 of the researchers. • Analysis was aided by NVivo, where selections of text were coded to represent instances of a concept. • Codes were reviewed in terms of their relationship to other codes and combined to create more developed themes. • From this analysis, distinctions between the different levels of themes appeared.	

Study Details	Participants and methods	Themes, limitations and other comments
	• Data extracts were regularly shared with members of the project support group to discuss interpretation of the data and to confirm the emerging themes	
Full citation Hatherall, Bethan, Morris, Joanne, Jamal, Farah, Sweeney, Lorna, Wiggins, Meg, Kaur, Inderjeet, Renton, Adrian, Harden, Angela, Timing of the initiation of antenatal care: An exploratory qualitative study of women and service providers in East London, Midwifery, 36, 1-7, 2016 **Ref Id** 1019446 **Study type** General qualitative inquiry **Aim of the study** To explore the factors influencing the timing of the antenatal booking appointment from the perspectives of women with recent experience of pregnancy as well as health service staff. **Country/ies where the study was carried out** England **Study dates** October 2010 to March 2011 **Source of funding**	**Sample size** N=21 pregnant and postnatal women; 30 women from 4 community groups (Bangladeshi, Somali, Lithuanian, and Polish); 26 health service staff members (midwives and bilingual health advocates). **Inclusion criteria** • Women who had their antenatal booking appointment completed before 12 weeks of pregnancy. • Women who had their antenatal booking appointment completed later than 12 weeks of pregnancy. • Bangladeshi, Somali, Lithuanian and Polish women who were residents of Newham but not necessarily having recent personal experience of pregnancy. • Service providers employed by the National Health Service (Midwives and Health Advocates). **Exclusion criteria** None stated. **Characteristics** Interviewed women: • N=21 pregnant and postnatal women; • 75% were born outside the UK in 13 different countries.	**Themes from study** • Perceived purpose and nature of antenatal care • Perceived purpose of health care • Referral to and navigation of the service **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** No **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?**

Study Details	Participants and methods	Themes, limitations and other comments
Study funded by the National Institute for Health Research (NIHR) under its Programme Development Grants Research scheme (RP-DG-1108-10049).	Age range N=14 were aged: 20 to 34 years. n=4 were aged <20 years Parity: • 0: N=16 • 1: N=5 For focus groups: • N=30 women from four community groups (Bangladeshi, Somali, Lithuanian, and Polish) • Residents of Newham at the time of the study. • Did not necessarily have recent personal experience of pregnancy. • N=26 health service staff members (midwives and bilingual health advocates). • N=11 Midwives worked across the maternity service and all had experience of delivering antenatal care and of providing antenatal booking appointments. • N=15 bilingual health advocates had experience of providing interpreting and support to users of antenatal services and together catered for speakers of 10 different Asian, European and African Languages. **Setting** • London Borough of Newham. • Interviews were conducted in places convenient for and chosen by women • Focus groups were conducted with women in community settings	Yes **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Yes. Findings discussed within the context of wider literature. Transferability discussed and new area of research identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Specific location for the focus groups for providers was not stated. **Sample selection** For interview • Women were recruited through a hospital-based maternity service, a hospital-based bilingual health advocacy service and community-based organisations. • The authors recruited the sample to intentionally comprise of at least 10 women who had had their antenatal booking appointment before 12 completed weeks of pregnancy and at least 10 women who had had their antenatal booking appointment later than 12 completed weeks of pregnancy. For focus groups • Recruitment targeted the groups of women for the focus groups • Participants were recruited by a third sector community development organisation called Social Action for Health, using a variety of routes and means including local services, community events and gatherings, leafleting and word of mouth. • For practicality, the focus groups for providers were scheduled to follow a team meeting and a training session at which the bilingual health advocates and midwives, respectively, were already gathered. • At the end of the meeting and training session, the providers present were invited to stay on to participate in the discussions **Data collection** For interviews:	

Study Details	Participants and methods	Themes, limitations and other comments
	• 21 individual interviews and 6 focus group discussions were carried out. • An interview guide provided a broad structure to the interviews which were conducted in places convenient to and chosen by the research participants. • Of the 21 interviews, 2 members of the research team conducted 16 interviews in English and 2 in other languages using interpreters. • Three interviews were conducted entirely in languages other than English by a postgraduate student and a bilingual health advocate who received training and support from the research team. • All interviews were audio-recorded, where necessary translated, and transcribed for analysis. For focus groups • Four of these were conducted with the assistance of interpreters in community settings with groups of 12 Bangladeshi, 13 Somali, 4 Lithuanian and 3 Polish women. • Two focus groups sessions was carried out with 11 Midwives and 15 Health advocates respectively. • All focus group discussions were audio-recorded and transcribed. **Data analysis** • Thematic analysis of the interview and focus group datasets was carried out. • Three members of the research team coded a selection of transcripts in the first instance and compared them for consistency.	

Study Details	Participants and methods	Themes, limitations and other comments
	• The remaining transcripts were divided among the 3 researchers and coding was completed independently. • As a further check on consistency and interpretation, the transcripts of interviews conducted by 1 researcher were coded by another researcher and the codes and analysis notes were shared and discussed. • Thematic analysis of the focus group dataset followed the same steps as for the interviews. • Themes from the interview and focus groups were compared and contrasted and emerging findings discussed by the research team. • Overarching themes were collectively agreed upon by the research team.	
Full citation Hunter, Louise J., Da Motta, Giordana, McCourt, Christine, Wiseman, Octavia, Rayment, Juliet L., Haora, Penny, Wiggins, Meg, Harden, Angela, Better together: A qualitative exploration of women's perceptions and experiences of group antenatal care, Women and birth : journal of the Australian College of Midwives, 2018 **Ref Id** 1017282 **Study type** Qualitative (Phenomenological study) **Aim of the study** • To determine if group antenatal care is acceptable to women in an area of the UK with high levels of socio-economic and	**Sample size** N=26 women in the Pre-implementation Group N=24 women in the Pregnancy Circle **Inclusion criteria** For Pre-implementation group • Women were included if they were living locally, were of reproductive age and aged ≥18 years, and spoke sufficient English. • No specific inclusion criteria in terms of maternity experience For Pregnancy Circle. Women were eligible to receive care in a Pregnancy Circle if they were: • ≥ 16 years • were able to give informed consent	**Themes from study** • Theme: Time for change-the care context • Theme: Mechanism for change 1. A safe space for sharing 2. Learning together 3. Travelling together • Theme: Outcomes of Change 1. Expanding horizons 2. Exercising control 3. A sense of belonging **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?**

Study Details	Participants and methods	Themes, limitations and other comments
cultural diversity, and how the participating women experience the care. • To explore and make sense of the perceptions and experiences of women before and after the introduction of four Pregnancy Circle groups. **Country/ies where the study was carried out** Wales **Study dates** • Pre-implementation focus groups were carried out between December 2014 and January 2015 • Final postnatal interview carried out in April 2017 **Source of funding** • Study was funded the National Institute for Health Research (NIHR)'s Programme Grants for Applied Research Programme (Grant Reference Number RP-PG-1211-20015). • Angela Harden is supported by the National Institute for Health research (NIHR) Collaboration for Leadership in Applied Health Research and Care	• did not meet the criteria for referral to a specialist team for highly vulnerable women operating in the host Trust **Exclusion criteria** • No exclusion criteria for the Pre-implementation Group • For the Pregnancy circle the exclusion criteria was age ≤16, not able to give informed consent and meeting the criteria for referral to a specialist team. **Characteristics** Pre-implementation Group <u>Ethnicity:</u> • White British: N=0 • White other (All Albanian): N=3 • Black Afro-Caribbean: N=2 • South Asian (Mostly Pakistani, Indian and Bangladeshi): N=16 • Mixed/Other (Mostly Latin American/Middle Eastern): N=5 <u>Parity:</u> • 0: N=5 • 1: N=7 • 2-3: N=10 • ≥4: N=4 Pregnancy Circle <u>Age (years) range:</u> 24-41 years	Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes **CASP - Value of research** Yes. Findings discussed within the context of wider literature. Transferability discussed and new areas for research identified. **CASP - Overall quality** Minor concerns

Study Details	Participants and methods	Themes, limitations and other comments
(CLAHRC) North Thames at Bart's Health NHS Trust	Ethnicity: • Asian British: N=1 • British Bangladeshi: N=1 • Bangladeshi/British Bangladeshi: N=3 • White British: N=4 • White European: N=15 • Black African: N=1 • Black British: N=2 • Chinese: N=2 • Middle Eastern: N=1 • Indian British: N=2 • Algeria: N=1 Parity: • 0: N=11 • Multiple: N=12 • Not stated: N=1 Born in UK: • Yes: n=9 • No: n=15 Language • Native English speakers: n=12 • English as 2nd Language/Good: n=12 **Setting** • An inner-city UK National Health Service trust serving an area of high socio-economic, cultural, ethnic and	

Study Details	Participants and methods	Themes, limitations and other comments
	linguistic diversity and high levels of inward and outward mobility. • Pre-implementation focus groups were held in local community centres served in different geographical locations served by the host Trust. • Post-implementation semi-structured interviews was carried out at a time and place of the choosing of the women. **Sample selection** For Pre-implementation group • A combination of opportunistic and snowball sampling was carried out in order to recruit a diverse group of women across the three different geographical areas covered by the study. For Pregnancy Circle • Women of all parities and language abilities were invited to take part. • Women who met the inclusion criteria were given information about Pregnancy Circles by the midwife undertaking their initial antenatal appointment. • They women were approached by a researcher offering further information and inviting them to receive the rest of their care in a Pregnancy Circle shortly after the appointment had finished. • All women attending the Circles were invited to participate in the focus groups which followed some of their Circle sessions and a semi-structured interview following the birth of their baby.	

Study Details	Participants and methods	Themes, limitations and other comments
	Data collection • Three pre Circle-implementation focus groups were held in local community centres in different geographical locations served by the host Trust. • Each group lasted 90 minutes. • Observations were carried out at Pregnancy Circles towards the beginning and end of each set of group sessions. • Twelve observations were carried out in all. • Focus groups were conducted after 7 of the observations lasting 30 minutes. • A total of 20 women each participated in up to 2 focus groups each. • Participants were invited to take part in semi-structured interviews at a time and place of their choosing approximately six weeks after the birth of their babies. • Six women were interviewed (maximum of 60 minutes) • No substantively new themes emerged in the final 2 interviews, indicating that data saturation had been achieved. • Women who had had an adverse neonatal outcome were not approached for an interview unless they specifically requested one. • The semi-structured interviews and focus groups were audio-recorded and contemporaneous notes were taken. • Contemporaneous notes were taken during the observations. • Data collection was undertaken by several members of the research team, who met to reflect on, discuss and agree emerging themes on a number of occasions. **Data analysis**	

Study Details	Participants and methods	Themes, limitations and other comments
	• The notes, audio files and transcripts were stored on a secure university drive • All written data was uploaded onto NVivo, read, re-read and coded independently by 2 authors using codes that arose inductively from the data. • The codes were then collated under themes. • Themes were agreed between the 2 coders and the wider research team using an iterative process of discussion and data checking.	
Full citation Puthussery, Shuby, Twamley, Katherine, Macfarlane, Alison, Harding, Seeromanie, Baron, Maurina, 'You need that loving tender care': maternity care experiences and expectations of ethnic minority women born in the United Kingdom, Journal of health services research & policy, 15, 156-62, 2010 **Ref Id** 1019710 **Study type** Qualitative (Grounded theory) **Aim of the study** To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women. **Country/ies where the study was carried out**	**Sample size** N=34 women **Inclusion criteria** Women born in the UK and their parents were born abroad. **Exclusion criteria** Women who had adverse physical or mental health outcomes **Characteristics** Age (years): • ≤ 20: N=2 • 20-29: N=12 • 30-39: N=18 • ≥ 40: N=2 Ethnicity: • Indian: N=11	**Themes from study** • Equitable care • Sensitive care • Continuity of care • Access to information and communication • Care environment **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** No **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?**

Study Details	Participants and methods	Themes, limitations and other comments
England **Study dates** Not reported **Source of funding** Funded by the Community Fund, now known as the Big Lottery, through a grant to the Maternity Alliance.	• Pakistani: N=4 • Bangladeshi: N=2 • Black Caribbean: N=10 • Black African: N=2 • Irish: N=5 <u>Parity:</u> • Primipara: N=22 • Multipara: N=12 **Setting** London and Birmingham. Most of the interviews were conducted at the home of the mother or in a convenient setting free from interruptions. **Sample selection** • Women were recruited mainly from 6 NHS maternity units in London and 3 units in Birmingham. • At the initial contact, all the respondents were given information about the study, about the length of the interview and the scope of questions. **Data collection** • Qualitative interviews conducted with the women. • The interviews were done at 3 months to 1 year after childbirth.	Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Can't tell. Findings discussed within the context of wider literature. Transferability was discussed. New area of research was not identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• A flexible topic guide was used • Interviews were tape-recorded with permission from the participants. • Average duration of interviews was 60 minutes. • Most of the interviews were conducted where privacy was ensured. **Data analysis** • All the interviews were transcribed. • The texts were then coded and analysed using NVivo • The analysis was based on a grounded approach. • This involved close reading of the interview transcripts and open coding. • The initial codes were then grouped into more abstract levels of codes or themes.	
Full citation Raine, Rosalind, Cartwright, Martin, Richens, Yana, Mahamed, Zuhura, Smith, Debbie, A qualitative study of women's experiences of communication in antenatal care: identifying areas for action, Maternal and child health journal, 14, 590-9, 2010 **Ref Id** 1019107 **Study type** General qualitative inquiry	**Sample size** N=30 women **Inclusion criteria** Pregnant women were eligible for inclusion if they were capable of understanding the nature of the study and of providing consent. **Exclusion criteria** None stated	**Themes from study** • Theme: Communication between GPs and Antenatal Care • GPs operate in 'silo culture' • Consequences of silo culture • Theme 2: Communication within Antenatal Care • Experiences of Constructive Communication 1. An Empathetic Conversational Style 2. Open to Questions

Study Details	Participants and methods	Themes, limitations and other comments
Aim of the study To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users. **Country/ies where the study was carried out** England **Study dates** April to August 2008 **Source of funding** • Funded by the Clinical Research and Development Committee (UCLH Charities). Reference:GCT/2007/MC. • Rosalind Raine is partly funded by a NIHR Public Health Career Scientist Award and by the NIHR UCLH/UCL Comprehensive Biomedical Research Centre.	**Characteristics** <u>Age (mean):</u> 30.2 years <u>Previous Pregnancies</u> • Primiparous: N=12 • Multiparous: N=18 <u>Ethnicity</u> • 6 English Speaking Bengali • 4 Non-English Speaking Bengali • 5 Non-English Speaking Somali • 8 High educated White British • 7 Low educated White British **Setting** One of the largest maternity services in Central London. • Focus groups were conducted in hospital and university meeting rooms. • Semi-structure interviews were conducted at various locations including the homes of the women. **Sample selection** • Recruitment was done from several antenatal settings. • Women were recruited from the hospital, 8 community antenatal clinics situated in socially and ethnically	3. Allowing Time to Talk 4. Text Message Appointment Reminders 5. HCP Take the Initiative • Experiences of Poor Communication 1. Lack of Description of Overall Patter of Antenatal Care 2. Lack of a Clear Understanding of the Purpose of Routine Antenatal Care 3. Lack of Explanation About the Roles of Different HCPs 4. HCPs Failure to Explain Their Concerns About Possible Complications 5. Lack of Due Care and Attention 6. Poor Styles of Communication • Responses of Women 1. Tolerance When Clinical Situations are Communicated Clearly 2. Proactive Communication by Women 3. The Potential to Undermine Women's Commitment to ANC **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?**

Study Details	Participants and methods	Themes, limitations and other comments
	diverse areas and via a community parenting group for Somali women and a Bengali Women's Health Project. • Within the hospital, participants were recruited from the antenatal waiting room (which services low and high risk women), the ultrasound clinic and the glucose tolerance testing clinic. • The purpose of the study was explained in English, standard Bengali, Sylheti (a dialect of Bengali) or Somali as appropriate. **Data collection** • Data was collected from women through focus group or semi-structured interview depending on the choice of individuals after consenting to the study. • Data collection methods were therefore combined to maximise participation amongst hard-to-reach groups. • All participants provided demographic data including their level of educational attainment. • Non-English-speaking focus groups and interviews were conducted in standard Bengali, Sylheti or Somali. • The focus groups and interviews were audio-recorded. Focus group • Participants were therefore assigned to a focus group on the basis of their self-reported ethnicity, their preferred language and, for White women only, their relative social advantage. • Their level of educational achievement was used as an indicator and women with qualifications above GCSE were defined as socially advantaged. • Five focus groups (FG) were established: English-speaking Bengali (ESB), non-English-speaking Bengali (NESB), non-English speaking Somali (NESS), high	Yes **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes **CASP - Value of research** Yes. Findings were discussed within the context of wider literature. Transferability was discussed and new area of research was identified. **CASP - Overall quality** Minor concerns

Study Details	Participants and methods	Themes, limitations and other comments
	educated White British (HEWB) and low educated White British (LEWB). • Focus groups were conducted in hospital and university meeting rooms. • The focus groups were moderated by the female members of the research team in English, Somali and Bengali. • Focus groups lasted approximately 80 minutes. Semi-structured interviews • Semi structured interviews were conducted at various locations to suit the needs of individual participants, including their homes. • Non-English interviews were conducted in Somali or were interpreted into Sylheti. • A standardised topic guide was used. • Semi-structured interviews lasted 20 minutes. **Data analysis** • A thematic analysis to identify themes from a realist perspective was carried out. • The audio recorded data was translated into English where necessary, and transcribed verbatim. • Initially the transcripts from the focus groups were analysed independently by 4 members of the research team leading to the listing of key ideas and a preliminary list of themes. • An iterative process was used whereby themes were discussed and then applied to the data.	

Study Details	Participants and methods	Themes, limitations and other comments
	• A continued emphasis was placed on patterns and disconfirming statements until final agreement on the interpretation of the data was reached.	
Full citation Symon, Andrew, McFadden, Alison, White, Marianne, Fraser, Katrina, Cummins, Allison, Using the Quality Maternal and Newborn Care Framework to evaluate women's experiences of different models of care: A qualitative study, Midwifery, 73, 26-34, 2019 **Ref Id** 1019541 **Study type** General qualitative inquiry **Aim of the study** To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated. **Country/ies where the study was carried out** Scotland **Study dates** Not stated	**Sample size** N=31 women **Inclusion criteria** • Pregnant women in the third trimester and mothers with babies up to five months of age. • Aged ≥16 years **Exclusion criteria** • Women whose babies had died or who were seriously unwell, • Aged<16 • Women who were deemed unable to understand the nature of the study (either through language barrier or cognitive impairment), or who were either emotionally and/or physically seriously unwell. **Characteristics** N=13 pregnant women and 18 new mothers participated in the 7 focus groups. Women had experience of a range of different models of care: • 'High risk' model (antenatal)-(focus groups 3 and 6)	**Themes from study** Sub-themes • Lack of/barriers to information • Anxiety/confusion • System-driven care • Difficulties in achieving tailored care • Limited resources/Time • Seeking information and support • Positive relationships • Tailored care • Effective communication **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** No **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell

Study Details	Participants and methods	Themes, limitations and other comments
Source of funding Supported by NHS Tayside and NHS Fife in the form of 2 part-time secondments.	• Modified Universal provision model and 'High risk' model (postnatal) (focus group 5) • Caseload model (antenatal and postnatal. (focus group 7) • Modified Universal provision model (postnatal). (focus groups 8 and 10) • Modified Universal provision model (antenatal). (Focus group 11) N.B: Modified Universal provision refers to women who received most of their care from community-based midwives, but also saw a consultant obstetrician on 1 or 2 occasions. **Setting** Two health boards in Eastern Scotland **Sample selection** • the research team liaised with local midwives, health visitors and administrative staff to identify potential participants from clinic lists, and displayed advertising posters in prominent locations within the relevant clinics. • Women were recruited purposively. • Potential participants were sent an invitation letter from the local Head of Midwifery and a Participant Information Sheet, which explained the nature and purpose of the study. • The women were invited to contact the study team either directly or by leaving a reply slip at the clinic or giving this to their midwife or health visitor to pass on. **Data collection**	**CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Can't tell **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Yes **CASP - Value of research** Yes. Findings were discussed within the context of wider literature, Transferability discussed and new areas of research identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Seven focus groups (FGs) were conducted with service users lasting between 60-85 minutes. • A focus group topic guide was used by distilling the characteristics of care described in each of the QMNFC 5 components of care. • The authors reframed and reordered some questions as part of their on-going assessment of the most effective way to stimulate productive discussion. • The groups were organised based on particular models of care and on timing (antenatal/postnatal), • However, FG5 involved women from 2 different models, and the Caseloading group (FG7) involved both antenatal and postnatal women. • The focus groups were led by a facilitator and assisted by a note-taker. • The focus groups were audio-recorded and transcribed by a researcher or a professional transcriber. • There was no pre-existing relationship between research team members and any of the women. **Data analysis** • The 6 phases of thematic analysis was used. • The steps include: familiarisation; initial coding; sorting the codes into themes and developing a provisional coding frame; reviewing the themes and the positive and negative sub-themes; shaping the final themes and sub-themes (with reference to the QMNCF). • Four main themes emerged as previously reported in another paper: Organisation Culture / Work Structure; Relationships; Information and support; and Uncertainty. • Each theme comprised positive and negative sub-themes;	

Study Details	Participants and methods	Themes, limitations and other comments
	• The negative sub-themes from the first 3 themes contributed to the fourth theme, which itself included positive and negative sub-themes • In this article the authors reported how the sub-themes were mapped back to the original QMNCF, identifying the relevant characteristics of care and the 5 components of care to which these are related. • Four principal topics of discussion within each focus group were identified. • The research team explored areas of overlap and distinction firstly by the type of model of care experienced, then to see if there were any particular distinctions based on the timing of the focus group (i.e. whether it was before or after the birth). • The process led to the observation of the positivity or negativity of the tone of these sub-themes, leading to an additional comparison between focus groups based on a simple positivity index	
Full citation Thomson, Gill, Dykes, Fiona, Singh, Gulab, Cawley, Lucinda, Dey, Paola, A public health perspective of women's experiences of antenatal care: an exploration of insights from a community consultation, Midwifery, 29, 211-6, 2013 **Ref Id** 1019078 **Study type** Qualitative (Thematic network analysis) **Aim of the study** To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services.	**Sample size** N=92 women and men **Inclusion criteria** Individuals meeting 13 key vulnerability classifications identified by Downe et al., 2009b **Exclusion criteria** None stated **Characteristics** • N=79 women	**Themes from study** • Attendance at antenatal care • Frequency of antenatal appointment • Location of antenatal care • Information risk **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** No

Study Details	Participants and methods	Themes, limitations and other comments
Country/ies where the study was carried out England **Study dates** June and November 2009 **Source of funding** None reported	• N=13 men <u>Age (years) range (mean):</u> 17-74 (35 years) <u>Ethnicity:</u> White: • White British: N=54 • other White/White Mixed: N=5 Asian or Asian British • Indian: N=11 • Pakistani: N=6 • Bangladeshi: N=3 • Other Asian background: N= 1 N=73 (79.3%) had/were currently experiencing at ≥1 priority issues, with 25 (27.2%) experiencing ≥3 **Setting** North West of England. Interviews were conducted in community locations except 1 over the telephone. **Sample selection** • Recruitment was done via organizations and services that engage with the vulnerable groups. • Forty one community, statutory and voluntary organisations/groups were contacted and sent a project briefing sheet. • 13 agreed to participated.	**CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** Yes **CASP - Ethical issues considered?** Yes **CASP - Data analysis rigorous?** Yes **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Can't tell. Findings were discussed within the context of wider literature. Transferability was discussed. New area of research was not identified. **CASP - Overall quality** Moderate concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• Study participants were recruited via posters and/or the main contact within each participating organization/group. **Data collection** • 18 Group interview (focus group) and 6 semi-structured interviews were used. • All group and one individual semi-structured interviews were carried out by members of the research. • N=5 remaining individual interviews were undertaken by 1 member. • All interviews were conducted in community locations except one on the telephone. • The sessions were either digitally recorded and/or detailed records taken. • All digital recordings were transcribed in full. • Data collection methods were designed to explore experiences (direct and indirect) of perinatal services. • Data collection methods combined open-ended questions; scale-lines; tick lists and spider diagrams. • A vignette was used within the data collection sessions involving wider community members (e.g. fathers, grandparents and other family members) to contextualise discussions. **Data analysis** • Descriptive data were analysed using SPSS. • All transcribed data were entered into MAXQDA. • Data collection and analysis were concurrent.	

Study Details	Participants and methods	Themes, limitations and other comments
	• In-depth analysis was undertaken on the findings, with divergent responses across the various community groups highlighted as appropriate. • Data analysis was undertaken using the thematic networks analysis(TNA).	
Full citation Young,E., Maternal expectations: do they match experience?, Community Practitioner, 81, 27-30, 2008 **Ref Id** 175653 **Study type** General qualitative inquiry **Aim of the study** To identify where improvements could be made in preparing parents for their new role by encouraging more realistic expectations and support. **Country/ies where the study was carried out** England **Study dates** Not reported **Source of funding** Not stated	**Sample size** • First focus group: n=5 health visitors, n=1 nursery nurse, and n=1 Community Psychiatric nurse • Semi-structured interviews: n=11 women • Second focus group: n=5 health visitors (different from the first group), n=1 midwife, and n=1 midwifery student **Inclusion criteria** • First focus group: All health visitors and midwives working in the local primary care and healthcare NHS trust areas, as well as 1 nursery nurse and 1 community psychiatric nurse (CPN) were invited. • Semi-structured interviews: Mothers that were first time parents with a baby up to approximately 1 year, and depression was not evident. Participants needed to have experienced pregnancy and early postnatal period were invited. • Second focus group: All health visitors and midwives in the local NHS trust areas, the nursery nurse and CPN were invited. **Exclusion criteria**	**Themes from study** • Antenatal classes • Labour • information • Problems and support **CASP - Clear statement of aims?** Yes **CASP - Qualitative methodology appropriate?** Yes **CASP - Research design appropriate?** Yes **CASP - Recruitment strategy appropriate?** Can't tell **CASP - Data collection appropriate?** Can't tell **CASP - Researcher-participant relationship adequately considered?** No

Study Details	Participants and methods	Themes, limitations and other comments
	• Not stated **Characteristics** For providers: • Health visitors N=10 • Midwife N=1 • Community Psychiatric nurse N=1 • Nursery nurse N=1 • Midwifery student N=1 Women Age (years) range: 24-40 years **Setting** • Location for the focus groups was not reported • The interviews were conducted in the homes of the mothers. **Sample selection** • The providers were invited to participate. For women	**CASP - Ethical issues considered?** Can't tell **CASP - Data analysis rigorous?** Can't tell **CASP - Clear statement of findings?** Can't tell **CASP - Value of research** Can't tell. Findings discussed within the context of wider literature, transferability discussed. New area for research not identified. **CASP - Overall quality** Serious concerns

Study Details	Participants and methods	Themes, limitations and other comments
	• The mothers were accessed through their health visitors, and all of the health visitors in the primary care trust (PCT) area were invited to recruit participants. • Mothers were sent information and consent forms before interviews were arranged. • The researcher did not include women from her own caseload. **Data collection** • Focus groups were tape recorded and then transcribed. • Semi-structured interviews were conducted in the homes of the mothers and lasted up to 60 minutes. • The semi-structured interviews were also tape-recorded and transcribed. • A topic guide with 12 questions was used for the interviews. topics schedule include: antenatal classes; preparation for parenting; expectations of delivery and parenthood; and problems and support. **Data analysis** • Accuracy of the transcripts of the interviews was confirmed with the participants by sending the typed transcripts over to them. • The interview data was analysed by identifying themes that emerged from the interviews and by highlighting important statements made by the interviewees.	

CASP: critical skills appraisal programme; CPN: community psychiatric nurse; FGs: focus groups; NIHR: National Institute for Health Research; NHS: National Health Service; PsyPAG: psychology postgraduate affairs groups; RCM: royal college of midwives; SIMD: Scottish Index of Multiple Deprivation; TNA: thematic network analysis; UK: United Kingdom

Appendix E – Forest plots

Forest plots for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

No forest plots included as this is a qualitative review.

Appendix F – GRADE-CERQual tables

GRADE-CERQual tables for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Table 5: GRADE-CERQual tables

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
One study • Beake 2013 To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting.	**Level 1. Individual** Theme 1: Building relationship *Sub-theme 1a: Being known by care provider* N=24 women Evidence from 1 study reported on this sub-theme. The evidence from the reviewed study (Beake 2013) revealed that women valued being known by their midwives. The women regarded knowing their midwives as more than merely meeting someone but as building a relationship. Although the women also likened the desired relationship with the midwives to those with family members, the study reported that there is need for the midwives to keep appropriate professional boundaries in managing such role. There are several reasons why the women valued being known by their midwives. This include feeling safe and relaxed with midwives who knew them. Moreover, women also reported in the reviewed study (Beake 2013) that they were able to confide in midwives who	Methodological limitations *No or very minor concerns* The quality rating based on CASP checklist was minor concerns for Beake 2013, since the period of data collection was not reported. Relevance *Moderate concerns* Although the findings from this paper are recently published in the UK, the period of data collection was not reported. Hence, it is unclear how recent the data contributing to the findings are. The population is from diverse ethnic groups that may be similar to the general population of women in the UK. Coherence *No or very minor concerns* The finding was produced by consistent evidence. There are no ambiguous data or contradictions to the finding. Adequacy *No or very minor concerns* There was a moderately rich level of data contributing to the finding. There is some depth of evidence and quotations or observations provided to underpin the findings.	**High quality**

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	knew them. This type of relationship was particularly important to the vulnerable women in the study who reported that they were able to discuss certain issues that they could not discuss with anyone else with the midwives. Another reason why the women valued being known by the midwives is so that they do not keep repeating their history every time they meet someone new. This was reported to be particularly helpful to women with complicated obstetric histories. *Beake 2013: "But she was like, I never think she was midwife, I was thinking, believe me, I was so close to her like a sister, even closer than a sister. (CW1). But it's different because I had a relationship with them. V was a great friend…"(CW 6)* *Beake 2013: "So I used to get along with her so good. I used to talk to her about everything that I didn't even speak to my husband or mum about.... You know when you get to know someone, it's easier to talk and stuff" (CW4).*		
Five studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity	**Level 1. Individual** <u>Theme 1: Building relationship</u> <u>*Sub-theme 1b: Continuity of care*</u> N=95 women Evidence from 5 studies reported on this sub-theme: Women desire continuity of care and of carers because it allows them	<u>Methodological limitations</u> *Minor concerns* The quality rating based on CASP checklist was minor concerns for 4 studies (Aquino 2018, Beake 2013; Boyle 2016 and Crowther 2019), and moderate for 1 (Puthussery 2010). Period of data collection was not reported for 3 studies (Beake 2013; Boyle 2016; Puthussery 2010).	**Moderate quality** (Moderate concerns for relevance and minor concerns for methodologi

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
care can best be provided by midwives and health visitors together. • Beake 2013 To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting. • Boyle 2016 To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting. • Crowther 2019 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Puthussery 2010 To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women.	to build trusting relationships with their midwives and makes them feel like being cared for as an individual. For instance, evidence from 1 study (Aquino 2018) showed that women were dissatisfied with the variations in the quality of care and conflicting advice that they received from different antenatal care professionals. This view was expressed in relation to the experiences that the women had with health visitors and midwives. However, whilst the women acknowledged that it would be ideal to have a named midwife and a named health visitor, they were concerned that such continuity of care and carer might not be feasible. Evidence from another study (Beake 2013) also showed that women who were cared for by caseload midwives developed trust and confidence in the midwives. This was associated by the women with the organisation of the care that allowed them to have continuity of care through the caseload midwives. This view was corroborated in the same study by women who did not have such continuity of care through caseload midwives. The women did not only value having the same midwife caring for them throughout the pregnancy, but some of them viewed changing midwives as "mind wrecking" (Beake 2013). Another study (Crowther 2019) reported that building relationship with the midwives overtime was valued by the women. This was illustrated in the study by the dissatisfaction of 1 woman who reported repeating her history to different	Research design was not justified in 1 studies (Puthussery 2010). No discussion around non-participation in 2 studies (Boyle 2016; Puthussery 2010), whilst it was also unclear how participants were approached to particpate in 1 study (Puthussery 2010). Methods of data collections were not justified in 3 studies (Boyle 2016; Crowther 2019; Puthussery 2010). Data saturation was not reported in 2 studies (Aquino 2018; Puthussery 2010). There were insufficient discussion of the credibility of findings in 3 studies (Aquino 2018, Docherty 2012 and Puthussery 2010) and insufficient description of the process of data analysis and data to support findings in 1 study (Puthussery 2010). <u>Relevance</u> *Moderate concerns* This finding was based on studies published between 2010 and 2019 in the UK. However, the period of data collection for 3 studies was not reported. Hence, it is unclear how recent the data contributing to the findings are. However, the population of participants in the 5 studies were from diverse ethnic groups that may be similar to the general population of women in the UK. <u>Coherence</u> *No or very minor concerns* The finding was produced by consistent evidence. There are no ambiguous data or contradictions to the finding. <u>Adequacy</u> *No or very minor concerns* There was a moderately rich level of data contributing to the finding. Given that the evidence was reported by 5 studies there is little or no likelihood of a risk of inadequacy in the data contributing to the finding.	cal limitations)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	midwives several times before she got her needs met in the fourth antenatal care appointment. Evidence from 1 of the studies (Puthussery 2010) further added that the women who received fragmented care reported that the experience made them feel like they were not cared for as an individual but as merely a number. Although continuity of care was valued by women in 1 study (Boyle 2016), the women emphasised the importance of emotional support that they need from the midwives during pregnancy. The study reported that despite achieving continuity of care, some of the women were displeased with the lack of emotional support that they received from the midwives. This is consistent with the evidence from another study (Beake 2013) which reported that women valued the emotional support that they received from the caseload midwives. The study suggested that the emotional support from the midwives is particularly important to women who were born outside Europe, such that it could adequately substitute for the lack of social support for such women when they lack family and community support. *Aquino 2018: "So I met my health visitor, contacted me when I was pregnant and met me […] and we just had an introduction […]. And I thought it was quite helpful actually, because it was quite nice that we've already got to know her then, and then she said that she would be my*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	health visitor and be the person who'll come and see us once the baby got home and she did." FG2, P10 *Boyle 2016: "I sort of hoped that you would see the same midwife…, but because I keep seeing different people they are just all very functional, and I think I expected more of a relationship; …so I think that's the thing I found the most frustrating is, you just never see the same person so it's very difficult to build any kind of rapport with anybody..." (Ava, first pregnancy, community midwife care at the GP's surgery).* *Crowther 2019: "Each time when I was seeing the midwife, it was a different person. I said the same stuffand same history to each midwife. I was diagnosed with Tokophobia in my first pregnancy before in Poland. I said that I need to see someone in hospital for further explanation about the rearrangement as I had tokophobia. They seemed to understand me, but they didn't and nobody follow up my request up until my fourth AN appointment with another midwife who seemed to believe that I had tokophobia. Finally, I was referred to the psychologist. I had been asking them all the time." (Milena)*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	Puthussery 2010: "There was no common ground really. You just had to start all over again ... You know, just that comfort zone. Liaising with, because it wasn't like you had one midwife who knew you, who knew your problems, who knew you from the beginning, it wasn't like that ... And that would have helped." (Indian mother, primipara, 20–29 years, dispensing optician)		
3 studies • Boyle 2016 To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. • Crowther 2019 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Docherty 2012 To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background.	**Level 1. Individual** Theme 2: Empowerment N=46 women The finding shows that women valued being able to contribute to decision making and choices about their antenatal care. The women therefore want to be provided with adequate information or support to aid them in decision making. In this regard, evidence from 1 study (Boyle 2016) reported that most of the women appreciated being guided by the midwives to make decisions largely because they felt that they did not have the knowledge and experience to decide for themselves. However, the study further reported that some of the women did not remember being offered a choice regarding who would provide their antenatal care, whilst other women reported instances where decisions were made for them without an opportunity to discuss alternatives. This was corroborated in another study which suggested that decisions were led by the midwifery staff (Docherty 2012). This	Methodological limitations *Minor concerns* The quality rating based on CASP checklist was minor concerns for 2 studies (Boyle 2016 and Crowther 2019) and moderate concerns for 1 study (Docherty 2012). Period of data collection was not reported for 1 study (Boyle 2016). There was also no discussion about non-participation in 1 study (Boyle 2016). Research design was not justified in 1 study (Docherty 2012), whilst the methods of data collection was not justified in the 3 studies. Data saturation was not reported in 1 study (Docherty 2012), whilst there was an insufficient discussion of the credibility of findings in 1 study (Docherty 2012). Relevance *Minor concerns* This finding was produced by studies published between 2012 and 2019 in the UK. Hence the finding is supported with relatively recent data, even though the period of data collection for 1 of the studies was not reported. Whilst the ethnic profile of the women in 1 study (Docherty 2012) was not reported, the population in the remaining studies is very diverse in respect of ethnic background. Hence, the finding	**Low quality** (Moderate concerns for adequacy and minor concerns form methodological concerns and relevance)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	approach was unpleasant to some women as reported in 1 study (Boyle 2016) where the women stated that they sometimes feel pressured when midwives made decisions for them based on the assumption of what they would want. In respect of information support, consistent evidence from the reviewed studies showed that women felt empowered to contribute to the decision making and informed choices when they are provided with sufficient information to make judgements (Boyle, 2016; Crowther, 2019; Docherty 2012). This autonomy support for decision making was particularly valuable to some ethnic minority women in 1 of the studies (Crowther 2019), where it was reported that they valued the choices and autonomy afforded to them in the NHS maternity services compared to similar service in Poland. However, provision of such information to contribute to decision making does not often occur (Boyle 2016). One of the studies (Boyle 2016) reported that such information was sometimes not provided for the women in a timely manner. Hence, the women reported that they would appreciate if they were provided with written information in advance and supported with discussion with the midwives. Furthermore, the evidence also showed that women would like to make certain decisions at different stages in the	may represent the view of the general population of pregnant women in the UK. <u>Coherence</u> *No or very minor concerns* The finding was based on consistent evidence. There are no ambiguous data or contradictions to the finding. <u>Adequacy</u> *Moderate concerns* There was moderately rich level of data in 2 studies and relatively thin level of data in 1 study (Crowther 2019). Given that the evidence was reported by 3 studies there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	pregnancy continuum, when they would have had sufficient knowledge about the options that they could have. For instance, women in 1 study (Boyle 2016) were concerned that they were asked to make decisions about the place of birth early at the initial antenatal care booking appointment, without any information on which to make such decision. Hence, the women would like to revisit such discussions later in the pregnancy. *Boyle 2016: "I felt that I was fully informed actually and also I felt if there was anything that I wanted to look into a bit more I was quite happy to ask about that and I was never fobbed off, I was always told that that was an option to look into and where to get the information from..."(Ruby, third pregnancy, shared care with Consultant and community midwife)* *Boyle 2016: "But they, I know they always try to sway you in one direction anyway. Like for the breastfeeding, I think, I don't know if I wrote it down but um…the first midwife I saw was like, 'you are going to breast feed obviously?' you know…" (Isabelle, first pregnancy, community midwife care at the GP's surgery).* *Crowther 2019: "The doctor asked me a lot of questions about my experiences with previous tear and how I felt. He told me that there was about 5% chance that I*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	could have another tear this time and asked if I was happy to labour naturally or have a caesarean section. I was very pleased that I could have a choice to choose." (Dorota) *Docherty 2012: "She told me just about basically the different options of like how to have your baby about whether you wanted consultant led or midwife led and explained the difference between the two… so I kind of made a choice that I was just going to go with midwife led."(LD4)*		
One study • Goodwin 2018 To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care.	**Level 2. Family level** Theme 3: Involving family N=9 women The finding shows that some minority ethic women value the involvement of their family members in their antenatal care. Evidence from the reviewed study (Goodwin 2018) showed that mothers-in-law and domestic partners play significant roles in the antenatal care of some minority ethnic women. Despite the value placed on the role of the family members, the women reported that they sometimes struggle to balance the contradictory traditional advice given to them by mothers-in-law with the professional advice from the midwives. Meanwhile, the study further revealed that the presence of family members such as the domestic partners and mothers-in-law at antenatal appointments could be a	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist is moderate concern for the study (Goodwin 2018). Period of data collection is not reported in the study (Goodwin 2018). Method of data collection was not justified in the study and there was no discussion about non-participation in the study (Goodwin 2018). There was no sufficient information to ascertain how informed consent was obtained in the study (Goodwin 2018). Relevance *Moderate concerns* Although the study contributing to the finding was published in 2018, the period of data collection was not reported. The population contributing to the outcome were mainly minority ethnic women from Pakistan. Hence, the experiences reported in the finding may not be representative of the views of the general population or all minority ethnic women in the UK.	**Very low quality** (Moderate concerns for methodological limitations, relevance, and adequacy)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	barrier for midwives to establish relationships with the women, because the family members have the tendency to dominate the appointment. For instance, the male partners of the women were reported in the study to speak for the women even when the latter have sufficient English language skills to adequately communicate. Yet, the women were reported to view the behaviours of their partners positively. The minority ethnic women emphasised that they prefer family members to speak on their behalf because they rely on the greater experience and knowledge of the family members instead of having a direct communication with the midwives. *Goodwin 2018: "I would listen to the midwife. Cos she's obviously the person who's more experienced in that. But then it's tradition….and you kind of respect tradition as well. I don't know – it's a bit difficult. How would you balance it?" Eliza (W).* *Goodwin 2018: "I'd rather have [my mum] talk -she's more experienced with talking to midwives and doctors. And she knows the whole process…I think I'd rather have her talk, than me….If I say something wrong then my mum will be like "no – you say it like this" – that's what I think is important." Eliza (W).*	<u>Coherence</u> *No or very minor concerns* There is no likelihood of incoherence in the data contributing to the outcome since it was reported from a single study. <u>Adequacy</u> *Moderate concerns* There is a moderately rich level of data in the study contributing to the finding. Given that the evidence was reported by 1 study there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
One study • Alshawish 2013 To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women.	**Level 3. Community** <u>Theme 4: Female care provider preference</u> N=22 women This finding showed that some minority ethnic women preferred having female caregivers for their antenatal care sessions. Evidence from the reviewed study (Alshawish 2013) showed that the preference for female caregiver influenced the attendance of some minority ethnic women at the antenatal clinic. Some of the women therefore reported that they did not attend the antenatal care classes because of the presence of men at the sessions.	<u>Methodological limitations</u> *Moderate concerns* The quality rating based on CASP checklist was moderate concerns for the study. Period of data collection was not reported in the study (Alshawish 2013). Data saturation was not reported in the study. There was an insufficient discussion of the credibility of the finding in the study, whilst some of the findings in the study was not supported with sufficient data. <u>Relevance</u> *Moderate concerns* This finding was based on a study published in 2013, but the period of data collection was not reported. Hence, it is not certain how recent the evidence supporting the finding is. The population in the study were mainly minority ethnic women from Palestine. Hence, the evidence may not be an adequate representation of the views of minority ethnic women or the general population of pregnant women in the UK. <u>Coherence</u> *No or very minor concerns* There is no likelihood of incoherence in the data contributing to the outcome since it was reported from a single study. <u>Adequacy</u> *Moderate concerns* There is a thin rich level of data in the study contributing to the finding. Given that the evidence was reported by 1 study there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	**Very low quality** (Moderate concerns for methodological limitations, relevance, and adequacy)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
Three studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. • Hunter 2018 To determine if group antenatal care is acceptable to women in an area of the UK with high levels of socio-economic and cultural diversity, and how the participating women experience the care. • Thomson 2013 To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services.	**Level 3. Community** Theme 5: Shared experience N=141 women This finding shows that pregnant women value the opportunity to share their own experience, and learn from other's experiences that attending individual and group antenatal appointments affords. In this regard, 2 studies (Aquino 2018, Hunter 2018) studies found that women valued the opportunity to socialise in group sessions. While reporting their experiences in the group sessions, women in 1 of the studies (Hunter 2018) valued socialising in the group sessions because they felt it was a safe place for sharing; where there is nothing they could not discuss. The women also appreciated the group sessions because it allowed them to learn together. This is consistent with evidence from another study (Aquino 2018) where women suggested that they would like to learn along with peers in group sessions. However, the women in the study (Aquino 2018) suggested that they would like to attend the group antenatal care appointment sessions that are jointly led by midwives and health visitors towards the end or second half of pregnancy. Moreover, by learning together the women in 1 study (Hunter 2018) were able to empower peers such as those with limited English to understand and find the right words so participate actively. The women	Methodological limitations *Minor concerns* The quality rating based on CASP checklist was minor concerns for 2 studies (Aquino 2018 and Hunter 2018) and moderate for 1 study (Thomson 2013). There was no justification of the research design in 1 study (Thomson 2013) whilst there was no justification for the methods of data collection in 2 studies (Hunter 2018 and Thomson 2013). There was no discussion about non-participation in 2 studies (Hunter 2018 and Thomson 2013). Data saturation was not reported in 2 studies except Hunter (2018), whilst there was no sufficient discussion of the credibility of findings in 2 studies (Aquino 2018 and Thomson 2013). Relevance *No or very minor concerns* The 3 studies were published between 2013 and 2019 in the UK. The ethnicity of the participants in the studies was very diverse and similar to the general population. Hence, the findings could be a representation of the views of women in the general population about the antenatal care in UK. *Coherence* *No or very minor concerns* The finding was produced by consistent evidence. There are no ambiguous data or contradictions to the finding. Adequacy *Moderate concerns* There was a rich level of data in 1 study (Hunter 2018), and a relatively moderate level of data in 1 study (Aquino 2018) and a thin level of data in 1 study (Thomson 2013). Given	**Moderate quality** (Moderate concerns for adequacy and minor concerns for methodological limitations)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	were also able to embolden the shy women among them to contribute to the group discussions. Furthermore, the group session was reported in 1 study (Hunter 2018) to be particularly appreciated by the primiparous women who saw it as an opportunity to learn from multiparous women. However, the group sessions were also valuable to the multiparous women because of the respected status that their experience gave them in the sessions. It was reported in the study (Hunter 2018) that the women also derived strength and reassurances from having contact with other pregnant women, and therefore described their experience as “not being alone”. This is consistent with the finding from another study (Thomson 2013) which revealed that women appreciate the opportunity to socialize with other women at the antenatal clinics. Despite being in a group session, the women (Hunter 2018) felt some of the antenatal care processes were experienced as sufficiently private. Moreover, the women in the group antenatal care sessions reported that they were able to learn new things and that being a part of a group of mixed ethnicities, nationalities, religion and cultures expanded their cultural horizons. The women also reported that they felt a sense of belonging by participating in the group session.	that the evidence was reported by 3 studies there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	Aquino 2018: "P4: I think so, but maybe not too early on, because, I don't know about everyone else but when I was first pregnant especially I was just so wrapped up in the pregnancy I found it really hard to imagine actually having a baby and it felt far away still, so maybe towards the end of the pregnancy when you're like, OK, I do actually have to look beyond." *Hunter 2018: "In the group, we don't hide anything really . . . because from the beginning, the midwives showed us that it's very, very confidential, so that puts all of us at ease to discuss about any matter, any, really. But if it's one to one, you don't know them . . . even though you have some concern, you don't talk about it" (Woman 2, FG 2, Circle 2).* *Hunter 2018: "You know, when you are alone, all the bad things are coming to you and you discuss with someone else . . . and you feel better" (Woman 3, FG 2, Circle 2).* *Hunter 2018: "Woman 2 — Yeah [laughter] I think it's right the way it is" (FG 1, Circle 1 (invited partners once))* *Thomson 2013: "I was up at the hospital for all of mine, but you just sit and you get talking to other mums that are due around*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	the same time, so you don't feel you are sitting there in your isolation, you are not the only one who has got problems, because there is other people around, so there is a social side" (Group Interview 6).		
One study • Hunter 2018 To determine if group antenatal care is acceptable to women in an area of the UK with high levels of socio-economic and cultural diversity, and how the participating women experience the care.	**Level 3. Community** Theme 5: Shared experience *Sub-theme 5a: Independence from men* *N=50 women* Evidence from 1 study contributed to this sub-theme. This finding suggests that some women value the group antenatal care sessions because it afforded them the opportunity to have a sense of freedom from their male domestic partners. It was reported in 1 the reviewed study (Hunter 2018) that the fact that partners were not automatically invited to the group sessions was an influence on whether some women will participate in the programme. Since it was a major concern to decide who will be involved in the sessions, the women who participated in the group antenatal sessions decided that a majority of the sessions will involve only women. However, while some of the women felt a greater sense of their own value because the partners were not involved in some of the group sessions, other women were concerned that their partners were missing out and that their needs were not being met. This is because the women believed that the partners would have had the opportunity to attend every session of a standard antenatal appointment or class.	Methodological limitations *No or very minor concerns* The quality rating based on CASP checklist was low for Hunter 2018. There was no justification for the methods of data collection and there was no discussion about non-participation. Relevance *No or very minor concerns* The study was published between 2013 and 2019 in the UK. The ethnicity of the participants was very diverse and similar to the general population. Hence, the findings could be a representation of the views of women in the general population about the antenatal care in UK. *Coherence* *No or very minor concerns* The finding was produced by consistent evidence. There are no ambiguous data or contradictions to the finding. Adequacy *No or very minor concerns* There was a rich level of data in this study (Hunter 2018). There is sufficient depth of evidence and quotations or observations provided to underpin the findings.	**High quality**

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	Hunter 2018: "Woman 1 — I think if the husbands would be here every time that we meet for two hours, they would get bored and we wouldn't be able to talk about everything, it would be uncomfortable." *Hunter 2018: "Woman 3—And some of us would not be able to talk about our things."*		
8 studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. • Boyle 2016 To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. • Crowther 2019	**Level 4. Policy** Theme 6. Access to information N=213 women This finding revealed that women value getting adequate information on the pregnancy and their antenatal care from the care providers in order to address concerns and for reassurances. For instance, evidence from 1 study (Puthussery 2010) suggested that women valued getting information from the midwives because they were satisfied with the level of information that they got during the antenatal care appointment. Evidence from another study (Aquino 2018) further revealed that women would like to meet their health visitors during antenatal care to establish an individualised and supportive relationship with them. The women wanted to establish such relationship during pregnancy with the health visitors so that they could process the information given to them and ask questions about their concerns such as in respect of parent groups and immunisation. Owing to the	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist is minor concern for 3 studies (Aquino 2018, Boyle 2016 and Crowther 2019), moderate concerns for 4 studies (Docherty 2012, Puthussery 2010, Symon 2019 and Thomson 2013), and serious concern for 1 study (Young 2008). Period of data collection was not reported in 4 studies (Boyle 2016, Puthussery 2010, Symon 2019 and Young 2008). Research design was not justified in 5 studies (Boyle 2016, Docherty 2012, Puthussery 2010, Symon 2019 and Thomson 2013). There was no discussion about non-participation in 5 studies (Boyle 2016, Puthussery 2010, Symon 2019, Thomson 2013 and Young 2008), whilst it was unclear how participants were approached in 1 study (Puthussery 2010). Methods of data collection were not justified in 6 studies except 2 (Aquino 2018 and Boyle 2016) while data saturation was reported in only 2 studies (Boyle 2016 and Crowther 2019). There was insufficient description of the credibility of findings in 3 studies (Aquino 2018, Docherty 2012 and Thomson 2013), whilst there was insufficient description of the data analysis process and data to support findings in 2 studies (Puthussery 2010 and Young 2008). There was no sufficient information to ascertain how informed consent was obtained in 2 studies (Symon 2019	**High quality**

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Docherty 2012 To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background. • Puthussery 2010 To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women. • Symon 2019 To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated. • Thomson 2013	need for information, the women in 1 of the studies (Puthussery 2010) reported that they considered the antenatal or parentcraft classes conducted by the NHS maternity units as an important source of information on pregnancy. Hence, the women in the study attended these classes and spoke positively about the information that they got from them. The study further reported that the parentcraft classes were overbooked and some women found getting access to them difficult. The study further reported that due to inconsistent information, some of the women confused the parentcraft classes with antenatal appointment. This is consistent with the evidence from 1 study (Thomson, 2013) which showed that the women perceived the antenatal care as an invaluable source of information on risks to maternal and infant health. For minority ethnic women, evidence from 1 of the studies (Crowther 2019) suggested that minority ethnic women sometimes struggle to reconcile their experiences in the UK with previous experiences that they have had outside of the UK. The study (Crowther 2019) however reported that the women often attempt to fully comprehend the UK NHS maternity system, thereby suggesting that the women would value the provision of information to understand the antenatal care system. *Aquino 2018: "P3: Yes, I definitely agree that to have the session that I had at home,*	and Young 2008). There was insufficient information about reflexivity in 1 study (Young 2008). Relevance *No or very minor concerns* The studies were published between 2008 and 2019 in the UK. However, period of data collection was not reported in 4 studies. Hence, it is not clear how recent some of the data supporting the finding are. Although the ethnicity of the study population in 2 studies (Symon 2019; Young 2008) were not reported, the ethnicity of the participants in the remaining studies was very diverse and similar to the general population. This diversity could also be supported with the fact that the context of study population in Symon (2019) was stated as not greatly diverse as other UK communities. Therefore, the finding could be an adequate representation of the experiences of the antenatal care by women in general UK population. Coherence *No or very minor concerns* There are no data that contradict the review finding or are ambiguous. Adequacy *No or very minor concerns* There were moderately rich level of data in 7 studies and relatively thin level of data in 1 study (Young 2008). Given that the finding was reported from 8 studies, there is little or no risk of inadequacy on the data supporting the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services. • Young 2008 To identify where improvements could be made in preparing parents for their new role by encouraging more realistic expectations and support.	*to have had that prior to birth would have been much more helpful, because it [New Birth Visit] was literally leaflet after leaflet after leaflet, and then I keep meaning to go through it and you know, it takes a while to get round, […] some downtime so even prior, just before the birth, I would have found it more beneficial, just information overload I think at a really quite manic time." FG 1.* *Crowther 2019: "At the very first initial appointment at the GP practice, I got the whole book, it was in Polish and all sorts of leaflets were translated in Polish but during the antenatal clinic I haven't got any leaflets translated into Polish apart from polio vaccination information." (Renata).* *Docherty 2012: "Sometimes there is quite a lot of jargon and when I go to my appointments you know when I'm being measured and stuff like that and they're checking for the foetal position and stuff they're not really back to me, I ve got to come back and check my notes." (MD 9).* *Symon 2019: "I'm really lucky, my best friend is a midwife, so they weren't explaining things to me so I just phoned her and asked…"(Janie, FG5: 171).* *Thomson 2013: "It is important to access to get information for both me and my baby's health and for advice as my baby*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	was not planned so had not read anything, or prepared at all"(Group Interview 4). *Young 2008 "I felt unprepared for how tired and drained you feel constantly" (C8).*		
7 studies • Boyle 2016 To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. • Crowther 2019 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Docherty 2012 To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background. • Puthussery 2010	**Level 4. Policy** Theme 6. Access to information *Sub-theme 6a: Additional information opportunities* N=201 women Evidence from 7 studies reported on this sub-theme. This finding revealed that most women often want to have the opportunities to get more information on their pregnancy and antenatal care than they usually receive from the antenatal sessions. In this regard, some of the women in a study (Puthussery 2010) were dissatisfied with the lack of time to get additional information from the antenatal care providers when they requested for more information that they felt they needed. Evidence from 1 study (Docherty 2012) further suggested that some women wanted to receive additional information from their antenatal care providers towards the later stages of pregnancy when they have greater awareness of their needs. Another study (Young 2008) reported that women wanted more information to enable	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist is minor concern for 2 studies (Boyle 2016 and Crowther 2019), moderate concerns for 4 studies (Docherty 2012, Puthussery 2010, Symon 2019 and Thomson 2013), and serious concern for 1 study (Young 2008). Period of data collection was not reported in 4 studies (Boyle 2016, Puthussery 2010, Symon 2019 and Young 2008). Research design was not justified in 5 studies (Boyle 2016, Docherty 2012, Puthussery 2010, Symon 2019 and Thomson 2013). There was no discussion about non-participation in 5 studies (Boyle 2016, Puthussery 2010, Symon 2019, Thomson 2013 and Young 2008), whilst it was unclear how participants were approached in 1 study (Puthussery 2010). Methods of data collection were not justified in 6 studies except 1 (Boyle 2016) while data saturation was reported in only 2 studies (Boyle 2016 and Crowther 2019). There was insufficient description of the credibility of findings in 2 studies (Docherty 2012 and Thomson 2013), whilst there was insufficient description of the data analysis process and data to support findings in 2 studies (Puthussery 2010 and Young 2008). There was insufficient information to ascertain how informed consent was obtained in 2 studies (Symon 2019 and Young 2008). There was insufficient information about reflexivity in 1 study (Young 2008). Relevance	**High quality**

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women. • Symon 2019 To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated. • Thomson 2013 To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services. • Young 2008 To identify where improvements could be made in preparing parents for their new role by encouraging more realistic expectations and support.	them to be better prepared for the emotional impact of motherhood, relationship changes and the role of the father. Women therefore tend to seek additional information from diverse sources. For instance, In this regard, evidence from 1 study (Symon 2019) showed that women sought additional information from friends who are midwives and through the "Google". This is consistent with the evidence from another study (Boyle 2016) which reported that they got their information from the internet and using child-birth forums or "Google". The study further reported that due to the need for more information, some of the women preferred the birth centre for their antenatal care so they could get longer appointment time that allows for their questions to be answered satisfactorily, than being seen by the community midwives at the GP surgery or health clinic. The women described their experience with short appointment time where their questions were not adequately answered as mechanistic and leaving them feeling not well prepared for motherhood. Women in another study (Puthussery 2010) also reported seeking additional information through sources like the television programmes, the internet, books and the National Childbirth Trust; which is a UK based voluntary organization that provides information and support for pregnancy. Minority ethnic women in 1 study (Crowther 2019) were also reported to value other forms of communicating information, which	*No or very minor concerns* The studies were published between 2008 and 2019 in the UK. However, period of data collection was not reported in 4 studies. Hence, it is not clear how recent some of the data supporting the finding are. Although the ethnicity of the study population in 2 studies (Symon 2019; Young 2008) was not reported, the ethnicity of the participants in the remaining studies was very diverse and similar to the general population. This diversity could also be supported with the fact that the context of study population in Symon (2019) was stated as not greatly diverse as other UK communities. Therefore, the finding could be an adequate representation of the experiences of the antenatal care by women in general UK population. <u>Coherence</u> *No or very minor concerns* There are no data that contradict the review finding or are ambiguous. <u>Adequacy</u> *No or very minor concerns* There were moderately rich level of data in 6 studies and relatively thin level of data in 1 study (Young 2008). Given that the finding was reported from 7 studies, there is little or no risk of inadequacy on the data supporting the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	were often unavailable to them. This include information leaflets that are translated into the languages of the minority ethnic women. Owing to the frustration of not getting these additional useful sources of information from the antenatal care providers, the minority ethnic women in the study resorted to technology to get the answers that they needed. Despite the desire for these additional sources of information, the women in 1 study (Puthussery 2010) still valued the information that they considered as authoritative from the antenatal care providers. This is corroborated by women in another study (Thomson 2013) who reported that they wanted to have open discussions with their antenatal care providers to appease their concerns, rather than just written information. *Symon 2019: "I googled like if there was any kind of breastfeeding support groups around, because that's my biggest worry…like who can I call …if it's not working out because it's something I'm quite passionate about and I wanted it to work, but I found it hard to find the information, but then I haven't asked my midwife, so that would probably make sense, but I don't know if there's groups or anything."(Bernie; FG11: 76)* *Thomson 2013: "Not enough information provided….they give you leaflets and tell you some risks…..but I would have liked to have talked to someone. It is different*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	reading it than talking to someone and sometimes you don't understand the leaflets….so talking is better" (Group Interview 17).		
Three studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. • Goodwin 2018 To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. • Raine 2010	**Level 4. Policy** <u>Theme 7. Clarity of service information</u> N= 51 women Moderate quality of evidence from 3 studies reported on this theme. The finding revealed that women would like to know what is going to happen at every stage of the pregnancy and want more information to help them navigate the antenatal care service better. In this regard, 1 study (Raine 2010) reported that the women were frustrated that the antenatal care providers did not provide them with an overall picture of the care that they could expect to receive as they progressed through their pregnancy. The women were also concerned that there was no clear explanation of the appropriate times to discuss particular aspects of care. Some of the women also emphasised that the purpose of each antenatal appointment was often unclear and the apparent duplication of visits frustrated them. Due to this lack of clear guide to the care, some women reported a reluctance to attend appointments which appeared to serve little purpose or meet their needs, while other women chose not to attend the clinic for routine ultrasound scan, because there	<u>Methodological limitations</u> *Minor concerns* The quality rating based on CASP checklist was minor concerns for 2 studies and moderate concerns for 1 study (Goodwin 2018). Period of data collection was not reported for 1 study (Goodwin 2018). There was no discussion about non-participation in 1 study (Goodwin 2018). Methods of data collection was not justified in 1 study (Goodwin 2018). Data saturation was not discussed in 2 studies (Aquino 2018 and Raine 2010). There was insufficient discussion of the credibility of findings in 1 study (Aquino 2018), whilst there was no sufficient information to ascertain how informed consent was obtained in 1 study (Goodwin 2018). <u>Relevance</u> *Moderate concerns* The studies were published between 2010 and 2018, but the period of data collection was not reported in 1 study (Goodwin 2018). Meanwhile, the ethnicity of the participants in the studies was largely minority ethnic women. Hence, the finding may not be an adequate representation of the experience of the general population of women in the UK about antenatal care. <u>Coherence</u> *No or very minor concerns*	**Low quality** (Moderate concerns for relevance and adequacy, and minor concerns for methodological limitations)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users.	appeared to be misunderstandings about its value and safety. Moreover, the minority ethnic women in another study (Goodwin 2018) reported that confusion regarding pre-booked appointments and poor knowledge of the UK healthcare system was preventing them from attending their antenatal appointment and sometimes led to late attendance. *Aquino 2018: "[…] for me it would have been nice to meet them during their [midwives'] session and have them deliver something for 20 min or maybe on their role, what they do, da, da, da, da, that might be quite nice. FG 2, P5* *Raine 2010: ''they repeat the same thing…so it just seems pointless waiting all that time…to see the doctor whereas you know what they're going to say because the nurse has already said it'' (I6, ESB).* *Raine 2010: ''you never, from the outset, have a vision of what will be happening to you at certain stages'' (I2, HEWB).* *Raine 2010: "'I tend to always miss my first scans…[I] join the process late'' (FG3, NESS, 1.* *Raine 2010: "I missed an appointment…the early scan is not to be gone to, Somalis…they said it is not good*	The evidence from the studies were direct and descriptive and not ambiguous to interpret. There were also no data that contradicted the review finding or were ambiguous. <u>Adequacy</u> *Moderate concerns* There were moderate level rich data in the 3 studies. Given that the finding was reported from 3 studies, there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	to go, if you go there will be problems, they will drop the baby from you'' [a metaphor for a miscarriage] (FG3, NESS, 2).		
Two studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. • Goodwin 2018 To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care.	**Level 4. Policy** Theme 7. Clarity of service information *Sub-theme 7a: understanding role of care providers* N=31 women Evidence from 2 studies reported on this sub-theme. Some minority ethnic women are interested in knowing the role remit of their antenatal care service providers. Evidence revealed that some minority ethnic women including those who recently migrated into UK wanted to have greater clarity about the qualifications of the antenatal care providers and their professional responsibilities (Aquino 2018 and Godwin 2018). While reporting thein experience, some of the women in 1 of the studies (Goodwin 2018) reported that this lack of clarity continued until their fourth antenatal appointments. *Goodwin 2018: I don't have any idea about midwife – I mean – what they do, how much qualified they are. Seriously – at this stage I really don't know. Hana (W).*	Methodological limitations *Minor concerns* The quality rating based on CASP checklist was minor concerns for Aquino 2018 and moderate concerns for Goodwin 2018. Period of data collection was not reported for 1 study (Goodwin 2018). There was no discussion about non-participation in 1 study (Goodwin 2018). Methods of data collection was not justified in 1 study (Goodwin 2018). Data saturation was not discussed in 1 study (Aquino 2018). There was insufficient discussion of the credibility of findings in 1 study (Aquino 2018), whilst there was no sufficient information to ascertain how informed consent was obtained in 1 study (Goodwin 2018). Relevance *Moderate concerns* The studies were published between 2010 and 2018, but the period of data collection was not reported in 1 study (Goodwin 2018). Meanwhile, the ethnicity of the participants in the studies was largely minority ethnic women. Hence, the finding may not be an adequate representation of the experience of the general population of women in the UK about antenatal care. Coherence *No or very minor concerns* The evidence from the studies were direct and descriptive and not ambiguous to interpret. There were also no data that contradicted the review finding or were ambiguous.	**Low quality** (Moderate concerns for relevance and adequacy, and minor concerns for methodological limitations)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
		Adequacy *Moderate concerns* There were moderate level rich data in the 2 studies. Given that the finding was reported from 2 studies, there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	
Ten studies • Alshawish 2013 To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women. • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together. • Beake 2013 To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand	**Level 4. Policy** Theme 8: Engaging and responsive communication N=293 women This finding revealed that women feel supported and respected based on the ways that their antenatal care providers communicate with them. For instance, evidence from 1 study (Aquino 2018) reported that women perceived their midwives and health visitors as very helpful and supportive based on their manner of communication. However, the evidence also showed that lack of engagement from the healthcare professionals, particularly during routine questions was discouraging to the women. This is consistent with the reports in 3 other studies (Puthussery 2010; Raine 2010; Symon 2019) which reported that women found interactions with their midwives which tended to be discourteous, abrupt or lacking in compassion as discouraging.	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist was minor concerns for 4 studies (Aquino 2018, Beake 2013, Crowther 2019 and Raine 2010), and moderate concerns for 6 studies (Alshawish 2013, Binder 2012, Docherty 2012, Hatherall 2016, Puthussery 2010, and Symon 2019). Period of data collection was not reported for 4 studies (Alshawish 2013, Beake 2013, Puthussery 2010 and Symon 2019). Research design was not justified in 5 studies (Binder 2012, Docherty 2012, Hatherall 2016, Puthussery 2010 and Symon 2019). No discussion around non-participation in 5 studies (Alshawish 2013, Binder 2012, Hatherall 2016, Puthussery 2010 and Symon 2019), whilst it was not clear how participants were approached in 1 study (Puthussery 2010). Data saturation was not reported in 8 studies except in 2 (Beake 2013, Crowther 2019 and Hatherall 2016). Methods of data collection were not justifies in 6 studies (Binder 2012, Crowther 2019, Docherty 2012, Hatherall 2016, Puthussery 2010, and Symon 2019), whilst there was no sufficient description of the data collectors in 1 study (Binder 2012). There was an insufficient discussion of the credibility of findings in 5 studies (Alshawish 2013, Aquino 2018, Binder 2012, Docherty 2012 and Hatherall 2016). There was also insufficient description of the data analysis process in 2	**Low quality** (Moderate concerns for methodological limitations and relevance)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
women's usual maternity experience within the setting. • Binder 2012 To gain a deeper understanding of the multi-ethnic care setting and the roles that ethnicity and language play during the sensitive care encounter between immigrant women and their western obstetric care providers. • Crowther 2019 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Docherty 2012 To determine whether pregnant women's perceptions of current antenatal provision differed according to their socioeconomic deprivation background. • Hatherall 2016 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services.	Moreover, 1 study (Beake 2013) reported that women found having an effective communication with the midwives as important to their antenatal care experience. This experience was associated with the ability of the women to confide in the midwives and feeling responded to. This was corroborated by the evidence from another study (Symon 2019) which showed that some women feel that they could have an engaging and effective communication with the midwives that they have good relationships with. This is also consistent with the report in another study (Docherty 2012) which suggested that some women valued communication approach that is shared with their midwives. Evidence from 1 of the studies (Binder 2012) also reported that women valued a respectful encounter with their caregivers. This was described in another study (Crowther 2019) as responsive. In this regard, the study (Crowther 2019) showed that the women found responsive communication as empowering and described it as helping them to feel safe and respected. The women also reported that they felt understood when they received responsive and caring communication approach from their midwives. This responsive communication was also valued by women in another study (Raine 2010) which reported that the attitude of the midwives that suggested	studies (Binder 2012; Puthussery 2010), whilst 4 studies did not support findings with sufficient data (Alshawish 2013, Binder 2012, Hatherall 2016 and Puthussery 2010). There was also insufficient information to ascertain informed consent was obtained in 1 study (Symon 2019). <u>Relevance</u> *Moderate concerns* Although the ethnicity of the study populations was not reported for 2 studies (Docherty 2012; Symon 2019), it was stated that the context for study population in Symon 2019 is mostly not ethnically diverse as other settings in UK. Given the well diverse ethnicity in the remaining 8 studies the finding may represent the views and perception of the ethnically diverse general population of women in the UK about antenatal care. The 10 studies were published between 2010 and 2019 in the UK. However, for 4 studies the period of data collection was not reported. Therefore, it is not certain how recent some of the data contributing to the studies are. <u>Coherence</u> *No or very minor concerns* The evidence is consistent from the studies. There are no ambiguous data or contradictions to the finding. <u>Adequacy</u> *No or very minor concerns* There were moderately rich level of data from 8 studies, with a thin level of data in 2 studies (Beake 2013; Hatherall	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
• Puthussery 2010 To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women. • Raine 2010 To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users. • Symon 2019 To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated.	openness to questions was believed to be capable of facilitating the provision of reassurances that women needed. The study (Raine 2010) further reported that women valued constructive communication with their midwives. This includes an empathic and engaging conversational style that the women described as reassuring and that could enhance rapport with the midwives. The study also reported that women found it refreshing when their midwives were willing to take the initiative to ensure that they receive prompt and appropriated healthcare. The women also appreciated midwives who did not make them feel rushed during antenatal appointments. This was corroborated by evidence from another study (Docherty 2012) which reported that the women valued a friendly and relaxed approach to antenatal care by their midwives.	2016). Hence, there is an adequacy of data supporting the finding.	
One study • Raine 2010 To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users.	**Level 4. Policy** Theme 8: Engaging and responsive communication *Sub-theme 8a: Adequate communication between care providers* *N=30 women* Evidence from 1 study reported on this sub-them. This finding revealed that women feel cared for when the antenatal	Methodological limitations *No or very minor concerns* The quality rating based on CASP checklist was minor concerns Raine 2010 as information about data saturation was not reported. Relevance	**High quality**

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	care providers adequately share information about them for antenatal care purposes. Evidence from 1 study (Raine 2010) showed that women found fragmented communication between the components of the antenatal care frustrating and confusing. For instance, the study reported that the women were frustrated with failure of the General Practitioner (GP) to exchange clinical information with other health care professionals and their inability to guide the women through the antenatal care system. Although the women acknowledged the pivotal role of the GPs, the women suggested that the disconnection between the GPs and other components of the antenatal service is a problem that should be addressed. *Raine 2010: ''she listens to all the problems…and not like, you've only got 10 min'' (FG5, ESB).*	*Minor concerns* There was diverse ethnicity in the population of Raine 2010 and so the finding may represent the views and perception of the ethnically diverse general population of women in the UK about antenatal care. Coherence *No or very minor concerns* The evidence is consistent from the studies. There are no ambiguous data or contradictions to the finding. Adequacy *No or very minor concerns* There was a moderately rich level of data from this study as there is some depth of evidence and quotations or observations provided to underpin the findings.	
Four studies • Alshawish 2013 To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women. • Binder 2012 To gain a deeper understanding of the multi-ethnic care setting and the roles that ethnicity and	**Level 4. Policy** Theme 8: Engaging and responsive communication *Sub-theme 8b: Interpreter service* *N=142 women, 62 healthcare professionals* Evidence from 4 studies reported on this sub-theme. This finding showed minority ethnic women want a reliable and consistent interpreter service. The reviewed evidence revealed that for some minority ethnic women, language barrier is	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist was minor concerns for Crowther 2019 and moderate concerns for the remaining 3 studies (Alshawish 2013, Binder 2012, Hatherall 2016). Period of data collection was not reported for 1 study (Alshawish 2013). Research design was not justified in 2 studies (Binder 2012, Hatherall 2016). No discussion around non-participation in 3 studies (Alshawish 2013, Binder 2012, and Hatherall 2016). Data saturation was not reported in Alshawish 2013. Methods of data collection were not justified in 3 studies (Binder 2012,	**Moderate quality** (Moderate concerns for methodological limitations and minor concerns for relevance)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
language play during the sensitive care encounter between immigrant women and their western obstetric care providers. • Crowther 2019 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services. • Hatherall 2016 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services.	a significant challenge to communicate with their antenatal care providers in an engaging style. To engage properly with the antenatal care providers, the minority ethnic women who were unable to speak English needed the interpreter service. The evidence from 3 of the studies (Alshawish 2013, Binder 2012 and Crowther 2019) showed that the interpreter service was not often available or reliable, leading to some women using their family members and friends as interpreters. However, 1 of the studies (Binder 2012) reported that the decision to use family members and friends was sometimes due to personal preferences of the women even though the interpreter service may be available. Meanwhile, some of the women in the study emphasised that they preferred having female interpreters for their antenatal care appointments. The study (Binder 2012) further reported that the strategy to use the family members or friends was not consistently reliable especially when bad news had to be relayed during routine consultations. Moreover, evidence from 1 of the studies (Crowther 2019) showed that despite the language barrier, some minority ethnic women reported how antenatal care staff helped to mitigate their challenge by speaking slowly and simply. The study further reported that some of the women valued their experiences when they were provided with the choices concerning the interpreting and translation services by the	Crowther 2019, and Hatherall 2016), whilst there was no sufficient description of the data collectors in 1 study (Binder 2012). There was an insufficient discussion of the credibility of findings in 3 studies (Alshawish 2013, Binder 2012, and Hatherall 2016). There was also insufficient description of the data analysis process in Binder 2012, and 3 studies did not support findings with sufficient data (Alshawish 2013, Binder 2012, and Hatherall 2016). <u>Relevance</u> *Minor concerns* There was diverse ethnicity in the population for the 4 studies, and so the finding may represent the views and perception of the ethnically diverse general population of women in the UK about antenatal care. <u>Coherence</u> *No or very minor concerns* The evidence is consistent from the studies. There are no ambiguous data or contradictions to the finding. <u>Adequacy</u> *No or very minor concerns* There were moderately rich level of data from 3 studies, with a thin level of data in Hatherall 2016. Hence, there is an adequacy of data supporting the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	antenatal care providers. However, the women wanted to have such choices to be provided sensitively. Meanwhile, evidence from another study (Hatherall 2016) suggested that women would like to know about the interpreter services before antenatal care booking appointment. According to the study, not all the women knew prior to their antenatal booking appointment that the interpreter service was available. Therefore, some minority ethnic women who were unable to speak English, experienced challenges of registering and making antenatal appointment with a GP to obtain a referral for an antenatal booking appointment. The women also reported experiencing additional difficulty of having to arrange for trusted family members and friends to accompany them to the antenatal care appointment to translate. *Alshawish 2013: "The problem we asked about an interpreter but unfortunately I didn't see her during my pregnancy 9 months [sic]."(Participant number 21).* *Binder 2012: ''Interpreters are there on hand, but my children speak very well English so they used to translate for me'' (Somali woman, informant 29).* *Crowther 2019: "I've told them that I do understand some parts of English, but not all and that's why they were alert and they*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	were speaking slowly and simply so I can manage to understand a bit more." (Milena)		
Two studies • Raine 2010 To identify key features of communication across antenatal (prenatal) care that are evaluated positively or negatively by service users. • Symon 2019 To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated.	**Level 4. Policy** Theme 8: Engaging and responsive communication *Sub-theme 8c: Remote contact* *N=61 women* Evidence from 2 studies reported on this sub-theme. This finding revealed that women value having remote contact with the midwives, in addition to the usual care antenatal appointments. In this regard, evidence from 1 study (Raine 2010) reported that women appreciated the use of text message reminder that is sent to their mobile phones for antenatal care appointments by the midwives. This is supported by evidence from another study (Symon 2019) which reported that women value their interaction with the midwives because they could be contacted on the phone. This approach to communication was described by the women as reassuring and responsive. *Symon 2019: "They always ring you back as well, so I think I left a message once and they rang me back the next day, just to answer a few questions that I had because I knew I wasn't seeing them for about six weeks."(Mo, FG11: 46).* *Symon 2019: "I feel like I'm annoying them all the time, I'm phoning them constantly, because this is my first time*	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist was minor concerns for Raine 2010 and moderate concerns for Symon 2019. Period of data collection was not reported and research design was not justified for Symon 2019. No discussion around non-participation, no report of data saturation, and no justification of data collections methods in Symon 2019. There was also insufficient information to ascertain informed consent was obtained in Symon 2019. Relevance *Moderate concerns* Although the ethnicity of the study populations was not reported for Symon 2019, it was stated that the context for study population is mostly not ethnically diverse as other settings in UK. Given the well diverse ethnicity in the other study the finding may represent the views and perception of the ethnically diverse general population of women in the UK about antenatal care. Coherence *No or very minor concerns* The evidence is consistent from the studies. There are no ambiguous data or contradictions to the finding. Adequacy	**Low quality** (Moderate concerns for methodological limitations and relevance)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	…and they were like 'Don't worry, it's fine, you don't need to worry about it', but I feel I've been constantly on the phone panicking about some- thing, but they're really good though, they've always phoned back..."(Anita, FG11: 47).	*No or very minor concerns* There were moderately rich level of data from the studies. Hence, there is an adequacy of data supporting the finding.	
Four studies • Boyle 2016 To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. • Goodwin 2018 To examine midwife–woman relationships for migrant women by exploring relationships between first-generation migrant women and midwives in the South Wales region of the UK, focusing on identifying the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. • Thomson 2013 To offer a critical discussion from a public health perspective	**Level 4. Policy** <u>Theme 9. Frequent contacts</u> N=115 women This finding showed that women want to have more contacts with their antenatal care service providers whenever they need it for support. Consistent evidence from 3 studies (Boyle, 2016, Goodwin 2018 and Young 2008) revealed that some women specifically want more frequent contacts during the first half of pregnancy. This was particularly noted among the multigravida women in 1 study (Boyle 2016). The study reported that the rigid schedule of appointments for multigravida women does not meet the needs of the women for psychological support and information. Some minority ethnic women in 1 of the studies (Goodwin 2018) also reported that they wanted to have more ad-hoc contacts with their midwives during the early period of pregnancy for support and cited the lack of flexibility for them to initiate the antenatal care contacts with the midwives as a potential problem for their on-going relationship with the midwives. However, women with low risk pregnancies in another study (Thomson 2013) reported that they would also like to have additional	<u>Methodological limitations</u> *Serious concerns* The quality rating based on CASP checklist is minor concerns for 1 study (Boyle 2016), moderate concerns for 2 studies (Goodwin 2018 and Thomson 2013), and serious concern for 1 study (Young 2008). Period of data collection is not reported in 3 studies except 1 (Thomson 2013). Research design was not justified in 1 study (Thomson 2013) and no discussion about non-participation in the 4 studies. Methods of data collection was not justified in 4 studies and data saturation was not reported in 2 studies (Thomson 2013 and Young 2008). There was no sufficient description of the credibility of findings in 1 study (Thomson 2013). There was insufficient information to ascertain how informed consent was obtained in 2 studies (Goodwin 2018 and Young 2008). In 1 study (Young 2008) there was insufficient information to determine reflexivity, whilst there was also insufficient description of the data analysis process and some findings were not supported with data. <u>Relevance</u> *Moderate concerns* The 4 studies were published between 2008 and 2018 in the UK. The period of data collections was not reported in 3 studies. Hence, it is unclear how recent the views contributing to findings are. Although, the ethnicity of the populations in 1 study (Young 2008) the total population in the remaining studies was diverse in respect of the ethnic composition. However, the vulnerability of the women in 1 of	**Very low quality** (Serious concerns for methodological concerns, and moderate concerns for relevance and adequacy)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
of service user's experiences of antenatal care services. • Young 2008 To identify where improvements could be made in preparing parents for their new role by encouraging more realistic expectations and support.	contacts with the antenatal care service providers. The women in the study did not specify any particular period of the pregnancy for their desired increased antenatal care contact. The women emphasised that the anxiety and stress that they experience during pregnancy means that they should be able to access help and support from the maternity services whenever they need it. The women therefore considered more flexible access as important to ensure early identification of risks and complications and for appropriate individually determined support to be provided. Meanwhile, evidence from 1 of the studies (Boyle 2016) further revealed that some women lacked adequate knowledge of how to contact the midwives in between appointments as there was no clear communication strategy informing them about what they should do if they needed to see a midwife in between visits. *Boyle 2016: "It's just the three week thing and having that six week gap you know, I would have liked to have another appointment. The only thing I would say is that um, I don't know why or whether there is any possibility of having more frequent appointments. It would be good if they said come back in three weeks unless you think you need to come back earlier". (Grace, third pregnancy, community midwife care at the GP's surgery)*	the studies (Thomson 2013) could have influenced the views reported in the finding. Hence, it is unclear how representative of the view of general population of women the finding could be. <u>Coherence</u> *No or very minor concerns* There were no ambiguous data or any contradictions to the finding. <u>Adequacy</u> *Moderate concerns* There was a rich level of data in 2 studies (Boyle 2016 and Thomson 2013) with moderately thin levels of data in 2 studies (Goodwin 2018 and Young 2008). Given that the finding was reported from 4 studies, there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	Goodwin 2018: "We can't contact our midwife, or visit them frequently….[Pakistani women] would be more happy if they had care or attention in the beginning. Because that period is more sensitive and more need to care…I think it will make good relationship between you and your midwife." Hana (W) *Thomson 2013: "I think you should have a point of access to see someone when you are worried, to have that flexibility with the service rather than at set points" (Group Interview 5).* *Thomson 2013: "If ill they do look after you, but when flying through, they step back and I don't like that, as there could be points where I was slipping" (Group Interview7).*		
Two studies • Alshawish 2013 To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women. • Crowther 2019 To explore Polish migrant women's experiences of language and communication	**Level 4. Policy** <u>Theme 10: Free service</u> N=31 women This review finding revealed that some minority ethnic women greatly value the universal free access that women have in the UK to antenatal services which contrasted with the services in other countries. *Alshawish 2013: I have [a] positive attitude toward [the] British system, no countries like the UK deliver free health*	<u>Methodological limitations</u> *Minor concerns* The quality rating based on CASP checklist was minor concerns for 1 study (Crowther 2019) and moderate for 1 study (Alshawish 2013). Period of data collection was not reported in 1 study (Alshawish 2013). The method of data collection was not justified in 1 study (Crowther 2019). For the study by Alshawish (2013), there was no discussion about non-participation, data saturation was not discussed, some findings were not supported with data and there was insufficient discussion of credibility of findings. <u>Relevance</u>	**Low quality** (Moderate concerns for relevance and adequacy, and minor concerns for methodological limitations)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
concerns when accessing UK maternity services.	*care services [to a] high standard level for all people. Actually they cut taxes directly from our salary, but they are free services and we must keep the NHS [free from] privatisation.' (Participant number 2).* *Crowther 2019: It's very good that you have access to all the painkillers or any-thing you want …if you need a C S there is no problem in hospital they will do it. But in my country you if want to have a c section you have to prove that you really need it; if you want painkiller or epidural, you have to pay for it. (Ewa)*	*Moderate concerns* The 2 studies were published between 2013 and 2019 in the UK. However, for 1 of the studies (Alshawish 2013) the period of the data collection was not reported. Hence, it could not be determined if the evidence supporting this finding is recent. Moreover, the finding was produced from studies mainly among minority ethnic women. Therefore, the finding may not be a representative of the general population of pregnant women in the UK. <u>Coherence</u> *No or very minor concerns* The data contributing to the finding were descriptive and direct. There are no ambiguous data or contradictions to the finding of the review. <u>Adequacy</u> *Moderate concerns* There are relatively thin level of data for this finding in both studies. Given that the finding was reported from 2 studies, there is a likelihood of serious risk of inadequacy on the data contributing to the finding.	
Two studies • Alshawish 2013 To investigate the access to and use of health services, particularly maternal and child health care, in the UK by Palestinian women.	**Level 4. Policy** <u>Theme 11: Prompt and simpler referral</u> N=75 This finding revealed that minority ethnic women want a faster and less cumbersome process of referral so that they could have adequate care especially during the early period of pregnancy.	<u>Methodological limitations</u> *Moderate concerns* The quality rating based on CASP checklist was moderate concerns for the studies. Period of data collection was not reported in 1 study (Alshawish 2013) and there was no justification of the research design in 1 study (Hatherall 2016). No discussion about non-participation in both studies. Data saturation was not reported in the 2 studies. Methods of data collection was not justified in 1 study	**Very low quality** (Moderate concerns for methodological limitations, relevance, and adequacy)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
• Hatherall 2016 To explore Polish migrant women's experiences of language and communication concerns when accessing UK maternity services.	Evidence from 2 studies (Alshawish 2013 and Hatherall 2016) suggested there was a low awareness of self-referral among the minority ethnic women who mostly sought referral for their antenatal care through the GP. Some of the women in 1 study (Hatherall 2016) were new to their communities and were therefore unaware of the local GP practices or have permanent address so they could register with the GP in time to secure referral for their antenatal care. Some of the women in both studies (Alshawish 2013 and Hatherall 2016) who were already registered with GP practices also reported delays in getting referred to the midwives. There were also reports of instances of delay in 1 study (Hatherall 2016) which was experienced by some of the women who were asked to return to their GPs for referral for the antenatal booking appointment after directly accessing other health services either to confirm their pregnancy or for problems early in their pregnancy. *Alshawish 2013: "The system is very slow, I need at least 1 week to know the result of my test from the GP, that confirmed my pregnancy, then I need another 2 months to contact the midwife, the most critical period is the first 3 months which finished without any care. For normal women that's fine, but for me because I have thalassaemia it is a big problem."*	(Hatherall 2016). There was insufficient discussion of the credibility of the 2 studies and some of the findings in both studies were not supported with sufficient data. Relevance *Moderate concerns* The finding was largely the view of migrant and ethnic minority women. For 1 study (Alshawish 2013) the period of the data collection was not reported. Hence it could not be determined how recent the data supporting the finding are and the experience may not represent the view of women in the general population of UK about antenatal care. Coherence *No or very minor concerns* The data from the studies were direct and descriptive and easy to interpret. There are no data that contradicted the review finding or that are ambiguous. Adequacy *Moderate concerns* There was a rich level of data in 1 study (Hatherall 2016) but there was a relatively thin level of data in the study by Alshawish (2013). Given that the finding was reported from 2 studies, there is a likelihood of serious risk of inadequacy in the data contributing to the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	(Participant number 21). *Hatherall 2016: "It does take a long time because they don't take women without a GP at the hospital, so to get to the hospital she needed to get a GP, register with a GP, get an appointment and for her to be referred to the hospital it takes time. GP requires proof of address, some bill or something. And she did not have that address because they moved just recently so she was waiting for proof to come". (Interviewee 18, via an interpreter).* *Hatherall 2016: "My referral came late and that's why I had a late [booking] appointment. [ ] I did try phoning them but all they would say is that your referral form is not here yet. So I said that a lot of time has passed and my referral is still not here. This happened a few times. Then they said they would have another look". (Interviewee 11).*		
Eight studies • Aquino 2018 To explore women's experiences of maternity care as collaboratively provided by midwives and health visitors. To explore perspectives of women on how their maternity care can best be provided by midwives and health visitors together.	**Level 4. Policy** Theme 12. Treated as an individual N=276 women This finding revealed that women want to be treated as an individual and not as a number in the antenatal care system. In this regard, evidence from 1 of the studies (Aquino 2018) showed that women want their midwives and health visitors to be aware of their health status and relevant medical information to avoid narrating their needs repeatedly. Evidence from 2 studies	Methodological limitations *Moderate concerns* The quality rating based on CASP checklist is minor concerns for 5 studies (Aquino 2018, Beake 2013, Boyle, 2016, Hunter 2018 and Raine 2010) and moderate for 3 studies (Puthussery 2010, Symon 2019 and Thomson 2013). Period of data collection was not reported in 4 studies (Beake 2013, Boyle 2016, Puthussery 2010 and Symon 2019). There was no justification of the research design in 3 studies (Puthussery 2010, Symon 2019 and Thomson 2013). There was no discussion about non-participation in 5 studies (Boyle 2016, Puthussery 2010, Hunter 2018, Symon 2019 and Thomson 2013)), whilst it	**Low quality** (Moderate concerns for methodological limitations and relevance)

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
• Beake 2013 To evaluate caseload midwifery in a relatively deprived and ethnically diverse inner-city area and to explore and understand women's usual maternity experience within the setting. • Boyle 2016 To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth. • Hunter 2018 To determine if group antenatal care is acceptable to women in an area of the UK with high levels of socio-economic and cultural diversity, and how the participating women experience the care. • Puthussery 2010 To explore the maternity care experiences and expectations of United Kingdom (UK)-born ethnic minority women. • Raine 2010 To identify key features of communication across antenatal	(Hunter 2018 and Raine 2010) also showed that women want their antenatal care providers to pay more attention to their needs as individuals and to appreciate the women's perspective regarding pregnancy. Evidence from another study reported (Beake 2013) that women appreciated feeling like having someone there for them, because their antenatal care was personalised. According to the women in the study, a personalised antenatal care was described as unrushed and flexible. This is consistent with the evidence from another study (Symon 2019) which suggested that women want their antenatal care to be flexible and fit with their individual and family needs. Some of the women in the study described how their caseload midwives made their antenatal care appointment more accessible, by making it geographically closer to accommodate their individual needs. This evidence is also corroborated by the views of women in another study (Thomson 2013) which showed that women want more accessible antenatal care service that could afford them the opportunity to develop relationships with their healthcare providers. In this regard, some of the women in the study were dissatisfied with issues of accessibility, waiting times and restricted clinic appointments. In addition, the women also emphasised that they would prefer that the information on risks associated with pregnancy to be tailored to individual needs instead of using a universal approach.	was unclear how participants were approached in 1 study (Puthussery 2010). Methods of data collection were not justified in 5 studies (Boyle 2016, Hunter 2018, Puthussery 2010, Symon 2019 and Thomson 2013), whilst data saturation was not reported in 5 studies (Aquino 2018, Puthussery 2010, Raine 2010, Symon 2019 and Thomson 2013). There was no sufficient discussion of the credibility of findings in 2 studies (Aquino 2018 and Thomson 2013), whilst there was also no sufficient description of the data analysis process and data supporting findings in 1 study (Puthussery 2010). There was insufficient information to ascertain how informed consent was obtained in 1 study (Symon 2019). <u>Relevance</u> *Moderate concerns* Whilst the ethnicity of the population in 1 study (Symon 2019) was not reported, the authors indicated that the context for study population is not as diverse as other settings in the UK. Overall, the ethnicity of the population in the remaining studies was diverse. Hence, the finding could be an adequate representation of the views of women in the general population of UK. However, the period of data collection was not reported for 4 studies, even though the studies were published between 2010 and 2019. Hence it is unclear how recent the data contributing to the finding are. <u>Coherence</u> *No or very minor concerns* The data from the studies were direct and descriptive and easy to interpret. There was no data that contradicted the review finding or are ambiguous. <u>Adequacy</u>	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
(prenatal) care that are evaluated positively or negatively by service users. • Symon 2019 To identify the most salient aspects of different models of care and how these are experienced by using the Quality Maternal and Newborn Care Frame- work (QMNCF) as a 'lens' through which different aspects of care could be evaluated. • Thomson 2013 To offer a critical discussion from a public health perspective of service user's experiences of antenatal care services.	Moreover, evidence from 1 of the studies (Boyle 2016) showed that women wanted the midwives to discuss more important issues with them than spending more time on completing medical records and physiological measurements. The experiences of the women in the study suggested that they do not want to be treated like being on a production line, but want their emotional needs to be met during the interaction with the midwife. This is consistent with the evidence from another study (Puthussery 2010) which showed that women expected their caregivers to empathize with their individual needs during pregnancy. Furthermore, evidence from 1 of the studies (Thomson 2013) suggested that women who have mental health concerns related to extreme anxiety or fear of the pregnancy may prefer a more personalised antenatal care appointment instead of attending the antenatal care appointment in a clinical environment. According to the study, due to the 'stress' and' pressure' of attending a clinical environment and having clinical tests which could potentially expose concerns for their baby's health, the women did not attend all their antenatal care appointments. The study further suggested that teenage mothers may not be motivated to access universal antenatal care appointments, because they tend to consider the antenatal care to be for the adults partly due to the experiences of	*No or very minor concerns* There were moderately rich level of data in the 8 studies. Hence, there is an adequacy of data supporting the finding.	

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	being judged by the older mothers. The teenage mothers therefore reported difficulties in organising appropriate appointment times. *Beake 2013: "V referred me to the doctors she said if there's a problem just give me a ring"(CW1)* *Beake 2013: "Anything had I just called her. Sometimes she was in labour [sic] you know. We usually send text messages because that was easier for her you know just in case she was with another woman or something .So I just sent her a text message and when she was free she would call me(CW4) and she would just sit on the carpet in the bedroom, with her notes here you know. It was wonderful, I mean it was brilliant because she was just there for me" (CW12)* *Beake 2013: "That antenatal clinic it just felt you were a flock of sheep and you were just you know do this, do that, and put in line and obviously they know what they are doing but I don't know what's going to happen so and I didn't know when they do a sweep I didn't know what that was." (SW 9)* *Beake 2013: "I think I am lucky…it makes such a difference if they can just come to your home and see you at home you know in your own environment…. I think it's more personal." (CW9).*		

Study and study aim	Theme	GRADE-CERQual components assessments	Overall confidence (Quality)
	Raine 2010: ''I was a bit surprised that on my notes it said that I was a smoker. I stopped smoking ages ago but nobody's asked me about that and…I thought that they would follow up'' (FG6, LEWB, 1) *Raine 2010: ''Then [the midwife] had written in my book that I was 31 weeks pregnant, and she started grilling me as to why I hadn't attended the 28 week blood tests, and I'm like, well, I'm not 30 weeks, and she was 'but it says here', and I was like, well, yeah, you just wrote that''(FG6, LEWB, 2).* *Symon 2019: "Yeah I think maybe if you're a second time mum they just kind of expect you to know what you're doing, but my first pregnancy, my daughter was born eight weeks early, so my second pregnancy was completely..... they just expected me to know, like I got less midwife appointments with my midwife because it was my second pregnancy…after I got to 20 weeks they just kind of left me to get on with it."(Janie, FG5: 21).*		

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

A single economic search was undertaken for all topics included in the scope of this guideline. No economic studies were identified which were applicable to this review question. See supplementary material 2 for details.

Appendix H – Economic evidence tables

Economic evidence tables for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

No economic evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Clinical studies

Table 6: Excluded studies

Study	Reason for exclusion
Balaam, Marie-Clare, Akerjordet, Kristin, Lyberg, Anne, Kaiser, Barbara, Schoening, Eva, Fredriksen, Anne-Mari, Ensel, Angelica, Gouni, Olga, Severinsson, Elisabeth, A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth, Journal of advanced nursing, 69, 1919-30, 2013	Systematic review. References checked, no additional relevant studies identified.
Briscoe, L; Lavender, T, Exploring maternity care for asylum seekers and refugees, British Journal of Midwifery, 17, 17-24, 2009	Study population outside the scope of guideline.
Cherguit, Jasmina, Burns, Jan, Pettle, Sharon, Tasker, Fiona, Lesbian co-mothers' experiences of maternity healthcare services, Journal of advanced nursing, 69, 1269-78, 2013	Participants were not biological/pregnant mothers. No relevant data found.
Downe, S., Finlayson, K., Walsh, D., Lavender, T., 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries, BJOG : an international journal of obstetrics and gynaecology, 116, 518-29, 2009	Systematic review. References checked, no additional relevant UK studies identified.
Ebert, Lyn, Bellchambers, Helen, Ferguson, Alison, Browne, Jenny, Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care, Women and Birth, 27, 132-137, 2014	Study in Australia, not conducted in UK.
Fisher, Joanne, Hinchliff, Sharron, Immigrant women's perceptions of their maternity care: a review of the literature part 1, The practising midwife, 16, 20-2, 2013	Review, non-systematic.
Fisher, Joanne, Hinchliff, Sharron, Immigrant women's perceptions of their maternity care: a review of the literature. Part 2, The practising midwife, 16, 32-4, 2013	Review, non-systematic.
Hawley, Glenda, Janamian, Tina, Jackson, Claire, Wilkinson, Shelley A., In a maternity shared-care environment, what do we know about the paper hand-held and electronic health record: a systematic literature review, BMC pregnancy and childbirth, 14, 52, 2014	Systematic review. References checked, no additional relevant studies identified.
Heberlein, Emily C., Picklesimer, Amy H., Billings, Deborah L., Covington-Kolb, Sarah, Farber, Naomi, Frongillo, Edward A., Qualitative Comparison of Women's Perspectives on the Functions and Benefits of Group and Individual Prenatal Care, Journal of midwifery & women's health, 61, 224-34, 2016	Study in USA, not conducted in UK.

Hoang, Ha, Le, Quynh, Ogden, Kathryn, Women's maternity care needs and related service models in rural areas: A comprehensive systematic review of qualitative evidence, Women and birth : journal of the Australian College of Midwives, 27, 233-41, 2014	Systematic Review. References checked, one study (Pitchfort 2009) found but excluded.
Jomeen, Julie, Redshaw, Maggie, Ahmed, Aronson Ball Barber Bowes Bowler Cross-Sudworth Edwards Ellberg Gray Homans Jomeen Katbamna Knight Kurinczuk Lyons McCourt Morse O'Cathain Ockleford Raleigh Redshaw Redshaw Redshaw Redshaw Singh Smith Sookhoo Whitehead, Ethnic minority women's experience of maternity services in England, Ethnicity & health, 18, 280-296, 2013	Study focused on intrapartum and postpartum care. Outside scope of guideline.
McLeish, Jenny, Redshaw, Maggie, Maternity experiences of mothers with multiple disadvantages in England: A qualitative study, Women and birth : journal of the Australian College of Midwives, 32, 178-184, 2019	Study population outside the scope of guideline.
Nabb,J., Pregnant asylum-seekers: perceptions of maternity service provision, Evidence Based Midwifery, 4, 89-95, 2006	Study population outside the scope of guideline.
Novick, Gina, Women's experience of prenatal care: an integrative review, Journal of midwifery & women's health, 54, 226-37, 2009	Review, non-systematic.
Origlia, Paola, Jevitt, Cecilia, Sayn-Wittgenstein, Friederike Zu, Cignacco, Eva, Experiences of Antenatal Care Among Women Who Are Socioeconomically Deprived in High-Income Industrialized Countries: An Integrative Review, Journal of midwifery & women's health, 2017	Review, non-systematic.
Pangas, Jacqueline, Ogunsiji, Olayide, Elmir, Rakime, Raman, Shanti, Liamputtong, Pranee, Burns, Elaine, Dahlen, Hannah G., Schmied, Virginia, Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review, International journal of nursing studies, 90, 31-45, 2019	Systematic review. References checked, no additional relevant studies identified.
Perriman, Noelyn, Davis, Deborah Lee, Ferguson, Sally, What women value in the midwifery continuity of care model: A systematic review with meta-synthesis, Midwifery, 62, 220-229, 2018	Systematic review. References checked, no additional relevant UK study identified.
Phillimore, Jenny, Migrant maternity in an era of superdiversity: New migrants' access to, and experience of, antenatal care in the West Midlands, UK, Social science & medicine (1982), 148, 152-9, 2016	Majority of study population are outside the scope of guideline, experiences could not be separated.
Pitchforth, E; van Teijlingen, E; Watson, V; Tucker, J; Kiger, A; Ireland, J; Farmer, J; Rennie, A-M; Gibb, S ; Thomson, E; Ryan, M , â□œChoiceâ□□ and place of delivery: a qualitative study of women in remote and rural Scotland, Quality & safety in health care, 18, 42-48, 2009	Study not meet the inclusion criteria. Focused on intrapartum care

Small, Rhonda, Roth, Carolyn, Raval, Manjri, Shafiei, Touran, Korfker, Dineke, Heaman, Maureen, McCourt, Christine, Gagnon, Anita, Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries, BMC pregnancy and childbirth, 14, 152, 2014	Systematic Review: references checked, no additional relevant UK study identified.

Economic studies

A single economic search was undertaken for all topics included in the scope of this guideline. No economic studies were identified which were applicable to this review question. See supplementary material 2 for details.

Appendix L – Research recommendations

Research recommendations for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

No research recommendations were made for this review question.

Appendix M – Quotes supporting themes

Quotes supporting themes for review question: What aspects of (referral to and delivery of) antenatal care are valued by women?

Table 7: Table of quotes for referral and delivery of antenatal care

Author and study year	Theme or sub-theme	Quotes
Alshawish 2013	Theme: Female care provider preference: Some minority ethnic women preferred the presence of female antenatal care providers	'I never attended the antenatal class, because no one takes care of [my] other two kids. Where [can I leave] them?' (Participant number 10)
Alshawish 2013	Sub-theme: Interpreter service: Minority ethnic women want to have a reliable and consistent interpreter service	'Sometimes I wait 4–5 days to have an appointment with the GP, because I want an Arabic doctor to see me. My English language is poor and I feel more comfortable when I deal with an Arabic doctor. He can understand me.'(Participant number 2) 'I am usually able to understand, [but] if I found my midwife and GP speaking very quickly or that something was unclear I ask them to repeat and always they are happy to do so.' (Participant number 9)
		'The problem we asked about an interpreter but unfortunately I didn't see her during my pregnancy 9 months [sic].' (Participant number 21) 'My children speak and understand English well, like native people. Usually my children are explaining the problem and my concern to the GP and in the emergency department.' (Participant number 21)
Alshawish 2013	Theme: Free service: Some minority ethnic women value the free NHS antenatal care service	I have [a] positive attitude toward [the] British system, no countries like the UK deliver free health care services [to a] high standard level for all people. Actually they cut taxes directly from our salary, but they are free services and we must keep the NHS [free from] privatisation.' (Participant number 2)
Alshawish 2013	Theme: Prompt and Simpler referral: Some minority ethnic women want a faster and less cumbersome referral process	'The system is very slow, I need at least 1 week to know the result of my test from the GP, that confirmed my pregnancy, then I need another 2 months to contact the midwife, the most critical period is the first 3 months which finished without any care. For normal women that's fine, but for me because I have thalassaemia it is a big problem.' (Participant number 21)
Aquino 2018	Sub-theme: Continuity of care and carer: women want to have continuity of care and of carers	In addition, women in this study reported valuing continuity of care, and of carer. Women shared experiences of seeing various health professionals throughout their pregnancy and after the birth, reflecting a lack of continuity of carer. This was associated with variations in the level and quality of care that the women receive as well as conflicting advice...However, participants acknowledged that whilst it would be ideal to

Author and study year	Theme or sub-theme	Quotes
		have a single healthcare professional providing maternity care (i.e., one named midwife and one named health visitor) this might not be feasible.
Aquino 2018	Theme: Shared Experience: Women want to socialise with other women during antenatal care	P5: Yeah, I didn't really know what they [health visitors] do really. P7: I thought this was a general check that they do and I could imagine that for, they're also maybe checking for everyone so that they can catch on families where things are difficult, but they are there to help, maybe. I thought that was part of their role, just to make, inform a little bit about, there's a pathway of vaccinations to some general bits, but also to check if the baby is fine, where maybe families are difficult, that's what I sort of thought was their role as well, just to check on everyone but if there's some trouble that they could pick it up and help. FG 2
Aquino 2018	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	So I met my health visitor, contacted me when I was pregnant and met me […] and we just had an introduction […]. And I thought it was quite helpful actually, because it was quite nice that we've already got to know her then, and then she said that she would be my health visitor and be the person who'll come and see us once the baby got home and she did. FG2, P10
		P1: […] if they could introduce themselves to you before you have the baby, but … P3: Yes, I definitely agree that to have the session that I had at home, to have had that prior to birth would have been much more helpful, because it [New Birth Visit] was literally leaflet after leaflet after leaflet, and then I keep meaning to go through it and you know, it takes a while to get round, […] some downtime so even prior, just before the birth, I would have found it more beneficial, just information overload I think at a really quite manic time.FG 1
Aquino 2018	Sub-theme: Understanding role of providers: Some minority ethnic women want to know the role and responsibility of the care providers	[…] for me it would have been nice to meet them during their [midwives'] session and have them deliver something for 20 min or maybe on their role, what they do, da, da, da, da, that might be quite nice. FG 2, P5
Aquino 2018	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	I really liked our health visitor, she was really interested, she was very, she seemed professional at what she was doing, caring, like you said, I felt like she really sort of saw you as an individual not just like tick the box type of thing, and so that was really nice. Focus group (FG) 2, P7
		So she [a health visitor] just went through loads of forms and just circled stuff, you know, that I had to remember and then that was it really and then she went, but yeah, it was, it was a bit of a waste of time, really. […] There wasn't much point to the visit. FG 1, P2

Author and study year	Theme or sub-theme	Quotes
		Mine were definitely completely fragmented, because on the days that […], but perhaps that was to do with the miscommunication initially with the addresses, but I would get a call from the health visitor on the day the midwife was coming, saying she was coming and I'd have to say no, I've already seen the midwife today, so there was definitely no communication between the teams in my experience.
Aquino 2018	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	This theme represents maternity care areas where midwife-health visitor collaboration could be beneficial. Participants focussed on information that they received from midwives and health visitors, and the co-ordination of their care. Women expressed concerns regarding the inconsistent information they received and suggested that centralised. All participants agreed it was important for midwives and health visitors to be aware of their health status and relevant medical information, to counter unnecessarily narrating their needs repeatedly. This aligns with women's suggestions on how maternity care should be co-ordinated; in particular, through midwife-health visitor led antenatal group classes, and joint midwife-health visitor appointments. They considered group classes apt for learning about pregnancy and parenting from midwives and health visitors, along with other parents-to-be....
Aquino 2019	Theme: Shared Experience: Women want to socialise with other women during antenatal care	P4: I think so, but maybe not too early on, because, I don't know about everyone else but when I was first pregnant especially I was just so wrapped up in the pregnancy I found it really hard to imagine actually having a baby and it felt far away still, so maybe towards the end of the pregnancy when you're like, OK, I do actually have to look beyond. P1: And also I think towards the end of your pregnancy, you, like you were saying, you had a bit more time, some, not everyone, but some people have, will have a bit of, will stop work a bit before the baby's due, and actually I think it would be quite nice if they did do a session in the children's centre.
Beake 2013	Sub-theme: Being known by providers: women want to be known by their antenatal care providers	But she was like, I never think she was midwife, I was thinking, believe me, I was so close to her like a sister, even closer than a sister. (CW1) But I feel she was like a mum. Believe me, believe me it's like a mum. When I had my baby she was like this, you know, she kiss me and she was very kind.(CW5) But it's different because I had a relationship with them. V was a great friend... (CW 6)
		But it's different because I had a relationship with them. V was a great friend… (CW 6) (Text 1). Sometimes they are more into it than the family. They are helpful and my family can sometimes give you trouble (CW 11)

Author and study year	Theme or sub-theme	Quotes
		You know when you get to know someone, it's easier to talk to them and stuff.(CW4) And in hospital I don't know many people you would go through, how many people would be at the birth.... I was comfortable with her, she was comfortable with me and I think that's the crucial thing in a birth-that you have to be comfortable. (CW12)
		So I used to get along with her so good. I used to talk to her about everything that I didn't even speak to my husband or mum about.... You know when you get to know someone, it's easier to talk and stuff(CW4). I spoke to her about my family problem, about my problem. She just made me feel like I was welcome to her heart, it's like her heart just opened the doors for me (CW 8)
		It's better to have one, because every time you meet the different one, you have to tell everything, the whole story. (CW10) There is no consistency there? They don't know the full story, whereas if you have one or two they sort of get to know you, they know your history, your medical history and everything else. Otherwise you have got to keep retelling the whole thing to everybody. (CW9)
		And then you have to explain everything again, what you did with the other one and you don't feel the same. Because everything they do individually they are different, and I think we should stick to one, unless there's actually a big problem (SW3) (text 2) Because when she knows you and she doesn't need to ask you the same questions every time. (SW5) (Text 2) It was only I think twice I had the same midwives, every time there was someone new which can sometimes be a bit unnerving… sometimes it works well because if you don't like the midwife but other times you almost have to repeat everything again and again… it can be a bit disconcerting at times (SW8)
		Yes, she told us before if it happens to become pregnant again to call her if you want to. And when I found out, I did call her and she said it would be nice to be our midwife again. And it was nice to have her for both of them. We already knew her and it was nice.(CW3) Because with the first one, I was with M and the second one, and was happy with her, because she knew me. And it was all everything was perfect .(CW10)
		She's famous, yes she's famous because my sister-in-law told me she had a baby with S... Yes, so all the family know her! (CW 5)
Beake 2013	Sub-theme: Continuity of care and carer: women want to have	you get used to know that person and you trust her and all that (CW 3) The first time I didn't have gas, I mean I had it there but I did not use it… it was that smell I couldn't but with S you

Author and study year	Theme or sub-theme	Quotes
	continuity of care and of carers	know because I trusted her you know, because I had had her for nearly eight months…I used to know she was not wrong so I used to listen to her and get advice(CW4) I felt safe and confident that she knew exactly what she was doing (CW 6). (Text 2).
		Because every day when you see the same midwife your confidence is growing up, not going to be strange, you can tell easy I think (SW 1). Once you get used to someone you get comfortable, you start trusting them because being pregnant is a time you are emotionally… it's a time you need a good midwife to be there, somebody you can trust, you know, somebody you can actually call a friend as well, so actually changing midwives sometimes is mind wrecking(SW3).
		She was very supportive. Sometimes I was scared about something you know and she would talk to me and explain everything. (CW3) The support of having V and A is just totally invaluable, and it helped me so much and I would look forward to those days when they came so much. Any little questions that I had or any anxieties or worries or just knowing that somebody's there, especially with me, with my depression and the fact that post-natal depression is not uncommon when you have had depression. (CW6) She even came after one month after the birth. She was really kind and helped me. One month later she still came and really support and help me.(CW11)
		Because in Africa there's so much help. What I mean so much help is that you may have large families, where if you give birth straight away you have people around you.(SW3) In my country you do have mummy, you have sister and brother, you have brother's wife, it's all in the same area. And in my country, when a woman gives birth for 10 days she's just relax. Not here. And here next day you have to go collect your children from school.(SW1)
Beake 2013	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	V referred me to the doctors she said if there's a problem just give me a ring(CW1) Anything had I just called her. Sometimes she was in labour [sic] you know. We usually send text messages because that was easier for her you know just in case she was with another woman or something. So I just sent her a text message and when she was free she would call me(CW4) and she would just sit on the carpet in the bedroom, with her notes here you know. It was wonderful, I mean it was brilliant because she was just there for me(CW12)
Beake 2013	Theme: Treated as individual: Women	I wasn't well at the time, so it was very good she came. Normally midwives come about 10 days only(CW11)

Author and study year	Theme or sub-theme	Quotes
	want to be treated more than a number in the antenatal care system.	if you pick up a phone you can talk to them directly sometimes rather than I would have to call the hospital and speak to them (SW 8)
		With the bad midwives you just felt like you were something, you weren't even a person, you were just a pregnant thing that walks in and they do their job and then go home. It didn't feel very one to one friendly, 'how are you feeling?' (SW 9).
		They were just brilliant. They were also, where they were so great was they were just so enthusiastic about anything that I wanted to do, like homeopathy and lots of alternative therapies. (CW 6). She called me and she said I am L, I am your midwife, and she said do you like to come visiting at home or would you like to go to the hospital for appointments? (CW7). I think I am lucky…it makes such a difference if they can just come to your home and see you at home you know in your own environment…. I think it's more personal. (CW9).
		I got the impression that they were looking after may be 3 ladies at the same time(SW10)
		That antenatal clinic it just felt you were a flock of sheep and you were just you know do this, do that, and put in line and obviously they know what they are doing but I don't know what's going to happen so and I didn't know when they do a sweep I didn't know what that was. (SW 9) (Text 2)
Binder 2012	Sub-theme: Interpreter service: Minority ethnic women want to have a reliable and consistent interpreter service	''the problem we Somalis have here as a refugee or as foreigners or as immigrants is the language . . . Everyone will be fed-up with you if you can't understand what they are saying – if you can't talk to them . . . sometimes they will just ignore you'' (Somali woman, informant 1).
		''They think that we would understand them and would treat them well, with no discrimination'' and ''Especially when you speak the same language. It puts a smile on their face and they relax . . . and talk to you and share more than maybe they would have done if we had spoken English'' (Ghanaian midwife, informant 86).
		''But I don't always know what the interpreters are saying; how can I trust them? It's really a challenging assumption . . .'' (White British doctor, informant 37).
		''The clinic has an appointment system, but like any appointment system, you know, if you have somebody who takes longer, the system will be overrun'' (White British midwife, informant 59).

Author and study year	Theme or sub-theme	Quotes
		Using an interpreter could be complex if it is a real emergency . . . You need to have more time. If you want to use an interpreter everything takes twice or three times as long because not only do you have to talk to the interpreter, but the interpreter then has to talk to the woman. So, that is already twice as long. Then she has to talk to the interpreter and the interpreter then has to talk to you. So, that's three times. (White British midwife, informant 106)
		''claim better English skills than what they actually have'' (Asian doctor, informant 57), I recall three women who had had interpreters and all felt that they had got good care, felt that they had understood what was going on, and felt that they had some control, some choice and some involvement. They felt alright before they even had their baby. But then there have been several others who never had an interpreter and had no idea of what the doctors asked. (White British midwife, informant 38)
		''Interpreters are there on hand, but my children speak very well English so they used to translate for me'' (Somali woman, informant 29). One woman's daughter was required to explain to her mother about an ultrasound image that showed a handicapped, headless fetus. She described, ''. . . my daughter started to cry . . .Yes, she was the one who got shocked, not me. I got shocked myself but not the same way as my daughter'' (Somali woman, informant 14).
		The other issue that you can have if you use interpreters is that if you have only a small group representing an atypical language, then the local interpreter may also be a part of that local culture and you are asking very personal questions where their culture can interfere with the translation of the woman's needs. (White British doctor, informant 116)
		''it does not matter if he was Somali or British or anything else as long as I had a kind midwife or doctor'' (Somali woman, informant 27).
		''She (midwife) was a good woman, she was a White lady and very good. So it is not about race or something like that'' (Ghanaian woman, informant 45).
		''it doesn't matter. It doesn't really bother me, to be honest. Actually, the best midwives are black. I would rather meet an African midwife than a White one'' (White British woman, informant 85).
		''It's like talking to your brother or sister . . . it's the same language, that's why I like it'' (Somali woman, informant 10). (Text 3).
		You see, if a Somali woman perceives herself as treated badly . . . she won't get into a big argument. She will just

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		smile gently and go away and won't come back. So, Somali women can avoid the whole of their antenatal care and appear for the first time in labour. (White British doctor, informant 88)
		''In our culture you don't really ask 'why?' Also, if you go to a hospital in Ghana, you don't ask questions as a patient because the doctor always knows best.'' And, ''so, it's just to go ahead and do whatever, to accept whatever . . .No questions asked'' (Ghanaian midwife, informant 87).
Boyle 2016	Sub-theme: Continuity of care and carer: women want to have continuity of care and of carers	'...really that they are there to support me in my choices and what I want to do, accepting that, you know, that they're the medical people so if there's something then I totally accept what they're saying or what they want to do...it was very much 'we want you to have the experience that you want to have, and we'll help you to do that, and we'll do it together', so there was a lot of, I guess, 'how do you feel? What do you want to do? Have you thought about this? Have you thought about that?' (Evie, first pregnancy, attended a birth centre for her antenatal care).
		'I think she's met it in terms of the mechanics of it but may be a bit lacking in the, the emotional sort of thing… maybe it's my unrealistic expectation of what a midwife is supposed to do, you know, they might think, 'I'm not an agony aunt, I'm not a counsellor'…. (Jessica, first pregnancy, community midwife care at the GP's surgery)
		'I sort of hoped that you would see the same midwife…, but because I keep seeing different people they are just all very functional, and I think I expected more of a relationship; …so I think that's the thing I found the most frustrating is, you just never see the same person so it's very difficult to build any kind of rapport with anybody...' (Ava, first pregnancy, community midwife care at the GP's surgery).
Boyle 2016	Sub-theme: Empowerment: Women want to be empowered to contribute to decision making and choices	'I don't think that I was actually offered a choice. I don't know that I was actually sort of told, well you can see this person, or you can see that person. I think I was probably asked are you happy to have shared care with the GP'. (Ruby, third pregnancy, shared care with Consultant and community midwife).
		'I like the, even though I've said it's quite a medical focus through the midwives, I still prefer the midwives than the GP's. I think there's something about seeing a GP which makes it feel like a medical condition, whereas, I think it happens to be the GP's surgery where I have the appointments but its midwife led definitely and makes it feel pregnancy related rather than illness related'. (Lily, second pregnancy, community midwife care at the GP's surgery).

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		'…they said, 'well, which hospital do you want to go to?' and I said, 'well, I'm not from the area so how would I make a decision about which hospital? How do I find out information about it?' 'Well they're all good or bad, they're much of a muchness really'. (Megan, first baby, community midwife care at the GP's surgery)
		'...the pressure to also come into the clinic to see somebody rather than them come for home visits, yes she was putting a lot of pressure, I just thought on the one hand you're saying to new mothers make sure you get lots of rest, take it easy and then you want me to come into the clinic'. (Emily, second pregnancy, attended a birth centre for her antenatal care) 'That's another thing actually that I found really frustrating, um that you are just told that it's going to be between eight and six, that is no help at all, because you can't, you want to be at least, up and washed, you know, even if you are not dressed, you know...'(Daisy, first pregnancy, community midwife care at the GP's surgery)
		'...things you're told is that they're the medical people and you basically must listen, um to what they're saying and they decide certain things and that really was determined I guess the way we behave and you know again what happened at my labour as well. They're the professionals and even though I kept asking they decided. Um, so that is generally the impression that most people get is you don't have much choice, they decide on your behalf'. (Emily, second pregnancy, attended a birth centre for her antenatal care).
		'I know the midwives are there to, you know, to help you through it and I know they're there to guide you. And I will take every single bit of help and guidance that they give'. (Amelia, second pregnancy, community midwife care at the GP's surgery).
		'But they, I know they always try to sway you in one direction anyway. Like for the breastfeeding, I think, I don't know if I wrote it down but um…the first midwife I saw was like, 'you are going to breast feed obviously?' you know…' (Isabelle, first pregnancy, community midwife care at the GP's surgery).
		'I felt that I was fully informed actually and also I felt if there was anything that I wanted to look into a bit more I was quite happy to ask about that and I was never fobbed off, I was always told that that was an option to look into and where to get the information from...'(Ruby, third pregnancy, shared care with Consultant and community midwife)
Boyle 2016	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more	'I should probably ask the midwife because getting all your information from Google is probably not the best, but there are certain websites like midwife centre where you do get midwife consultants…' (Grace, third pregnancy, community midwife care at the GP's

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	information on the pregnancy and antenatal care	surgery) 'I go in armed with quite a lot of questions. C and I will talk about things and we will make notes… I suppose now I am keen over the next couple of weeks to maybe really pump the midwives for as much information on labour and any bits of advice they can give me really'. (Sophie, first pregnancy, attended a birth centre for her antenatal care). 'I think talking; the real benefit I would get out of the midwife as opposed to the medical support would be just talking about birth. Because that's ultimately what you're building towards and I felt like that's the only thing we didn't really, talk about particularly.' (Lily, second pregnancy, community midwife care at the GP's surgery).
Boyle 2016	Theme: Frequent contacts: Women want to have ad-hoc contacts with the midwives between antenatal care appointments	'It's just the three-week thing and having that six week gap you know; I would have liked to have another appointment. The only thing I would say is that um, I don't know why or whether there is any possibility of having more frequent appointments. It would be good if they said come back in three weeks unless you think you need to come back earlier'. (Grace, third pregnancy, community midwife care at the GP's surgery)
		'I could have accessed the central number and left a message for her, but I didn't really feel that I should, I didn't feel that it was an emergency if I could see my GP'. (Ava, first pregnancy, community midwife care at GP surgery).
		'I've phoned her upon a couple of occasions when I know she's been working at the birth centre, just to ask questions and she has been very, very informative and helpful, but you know she encouraged me at those times to phone her...' (Sophie, first pregnancy, attended a birth centre for her antenatal care).
Boyle 2016	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	'…all the way through it has felt very much like a very medical exercise so it's like, we've got to get your history, we have a number of very basic checks we've got to do, we've got to check your blood pressure, your urine, we've got to check any swelling etc., like tick, tick, tick, so very functional, very medical in that respect, not anything that was different from that, anything more emotional… ' (Lily, second pregnancy, community midwife care at GP surgery).
		'I felt a bit like I'm on a production line'. Go in, yes your blood results are fine, keep taking tablets, hear the baby's heartbeat, blood check, blood pressure check and right you're gone, she just wants to see you, get you out of the room and go on to the next patient, in the quickest possible way…' (Ella, first pregnancy, shared care between Consultant and community midwife).
Crowther 2019	Sub-theme: Continuity of care and carer: women want to have	Each time when I was seeing the midwife, it was a different per- son. I said the same stuff and same history to each midwife. I was diagnosed with Tokophobia in my

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	continuity of care and of carers	first pregnancy before in Poland. I said that I need to see someone in hospital for further explanation about the rearrangement as I had tokophobia. They seemed to understand me, but they didn't and nobody follow up my request up until my fourth AN appointment with another midwife who seemed to believe that I had tokophobia. Finally, I was referred to the psychologist. I had been asking them all the time. (Milena)
Crowther 2019	Sub-theme: Empowerment: Women want to be empowered to contribute to decision making and choices	The doctor asked me a lot of questions about my experiences with previous tear and how I felt. He told me that there was about 5% chance that I could have another tear this time and asked if I was happy to labour naturally or have a caesarean section. I was very pleased that I could have a choice to choose. (Dorota)
Crowther 2019	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	The thing I didn't like during the pregnancy is that…the meeting with the midwife is like…it's not helpful at all, because you go to the clinic, you go to the midwife and the only thing they doing is asking you question, how are you, how are you feeling? How is your baby…doing? Obviously, I can say I feel the baby is moving, stuff like that but you have only two scans which is not helpful. [Midwives] are helpful, but I don't think it is enough. It's like checking and chatting and then that's it, and then you can go! I found it quite strange to be honest (Dominika)
		I was quite surprised that I didn't have any examination by the gynaecologist that I was actually pregnant, I was just asked when my last period was. In Poland, all the visits are being led by a doctor. I asked directly at one visit if I would be seeing a doctor at all during my pregnancy. (Marzena)
		In my second pregnancy, I had bleeding earlier on. I am a Christian and I believe that every child is not just a pack of cells. When the doctor said that if the baby dies then the baby dies and there is nothing to do about it. I was shocked and they weren't keen to do anything at this stage; a test or scan or anything. I was really angry, fortunately nothing happened and my pregnancy was fine at the end. In Poland they provide a better care at the beginning of the pregnancy and you really feel looked after and try to do everything to keep your child. But when the baby is born care is much better [in the UK] than in Poland. (Ola).
Crowther 2019	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care	I was worried about my early labour and the midwife mentioned that I got the steroids and the labour could stop. I was worried about my waters because they'd gone. I asked her to explain to me because I never heard that word before. She explained that the waters would be there and there would be enough waters for my baby and my body would produce the waters to fill it up and my tummy won't be empty, and he won't be without waters. It was explained to me in really simple detail. She asked if I wanted to explain it in more details and I said no as I was able to under- stand. (Dominika)

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		At the very first initial appointment at the GP practice, I got the whole book, it was in Polish and all sorts of leaflets were translated in Polish but during the antenatal clinic I haven't got any leaflets translated into Polish apart from polio vaccination information. (Renata)
		When I go to the doctor, I usually don't know how this problem is called in English, so I try to prepare it in advance, I google some words then either memorise them or make a note of them. (Marzena)
Crowther 2019	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	I've high blood pressure so when I was in labour, I was supported by lots of staff. They told me that unfortunately the level of oxygen in our baby's seemed low and it is possible that after few attempts, I might have a caesarean section. All the staff were very kind and encouraged me; I felt safe and listened to. Eventually, I was able to push my baby out. (Paulina)
Crowther 2019	Sub-theme: Interpreter service: Minority ethnic women want to have a reliable and consistent interpreter service	I've told them that I do understand some parts of English, but not all and that's why they were alert and they were speaking slowly and simply so I can manage to understand a bit more. (Milena)
		It never occurred to me that I could ask for the translator. I always thought that it would create more problems and their perception towards me would be worse. I believe that in this country, not knowing and not being able to speak the language will create a problem and is not welcomed (Milena)
		I was quite embarrassed of not speaking, I was literally praying that no one was approaching me. Frankly it wasn't comfortable, I would rather nod my head showing that I do understand, but I couldn't [understand]. (Dorota)
		It definitely affects my ability of giving an answer. I don't know how to answer or I'm running out of words, sometimes when I'm trying to say something [I need] I get stressed, nervous and forget some words, mix it up, then I get locked and can't say anything after. (Iwona)
		I use an interpreter over the phone during all my antenatal clinics appointment with the midwife at the GP practice. Every single word and question the midwife was saying, the lady over the phone was translating back to me. Each time it was a different person, the voice is different. I didn't mind whoever she is as long as it is a Polish translator and understand what's going on. I didn't have the [interpreting] service when I attended my [hospital] appointments as no one told me that I could ask for the interpretation service; so, I brought my son as my interpreter. (Renata)
		There was an option, the midwife asked me at the beginning if I need any translator. I said 'no' as I'm quite

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		happy with my understanding and my situation. She also asked me if I need Polish leaflets. I didn't, yet still I have an option to choose Polish leaflets. ….. everything was explained and I liked the way they showed me with examples (Dominika)
		Because I did not know that I could have a translator service over the phone when I was in labour, I arranged my friend as the interpreter when I was in labour because it was more comfortable for me having a person as my friend and my husband instead of using the telephone service. (Renata)
Crowther 2019	Theme: Free service: Some minority ethnic women value the free NHS antenatal care service	It's very good that you have access to all the painkillers or any- thing you want …if you need a C S there is no problem in hospital they will do it. But in my country you if want to have a c section you have to prove that you really need it; if you want painkiller or epidural, you have to pay for it. (Ewa)
Docherty 2012	Sub-theme: Empowerment: Women want to be empowered to contribute to decision making and choices	She told me just about basically the different options of like how to have your baby about whether you wanted consultant led or midwife led and explained the difference between the two… so I kind of made a choice that I was just going to go with midwife led. (LD4)
Docherty 2012	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	Sometimes there is quite a lot of jargon and when I go to my appointments you know when I'm being measured and stuff like that and they're checking for the foetal position and stuff they're not really back to me, I've got to come back and check my notes. (MD 9)
Docherty 2012	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care	I thought maybe they would talk to you more about things like for example in my notes I've got like a labour plan and stuff like that and I wonder what stage they would start to talk about this.(LD4)
		Yea well that is why for some people it would have been useful, but I know myself like what to do if I've got constipation or heartburn or stuff like that so for me it probably wasn't that useful. (LD 4)
Docherty 2012	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	The midwife had said to me if you're ever, if there's anything you re ever worried about they gave me those two numbers and it was like they really meant it. (LD3)
		Being up at the hospital they were really, really busy you know so I don t know yea it was good. I mean I didn't come out any different from when I went in I suppose. (LD8)
		I got my booklet, my notes and we went through any matters. (MD11)
		I didn't really know what was happening about antenatal classes and things like that, what to actually do about that. I can remember them being

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		mentioned at some point but I'm not sure if it's something I should arrange. (MD13)
		I'm quite a strong enough person to say no this isn't what I want to do if I didn't want to do it so.(LD5)
		she was very normal, very down to earth, very practical, she was actually pregnant herself and that was like the first thing she said you know I'm actually pregnant… She was very natural. (LD6)
		You can have a wee quick look through it if you re wanting. You're not thinking what are they writing about me and I'm not seeing it. (LD1)
		I wish there was a helpline you could just phone, you're not bothering anybody with really stupid questions. (LD8) Although the midwives have said that, don t hesitate to phone even if you think it is a silly thing but I don t know whether I would. (LD9)
		Perhaps anything medical the consultant needs to you know take the time with me rather than [the midwife]. (LD7)
		The ladies have been really nice. Everyone I've spoken to has been really nice. (LD8) The woman that we spoke to, she was going on about you know about protein in your urine or whatever and all this stuff and I just didn't have a clue what you're talking about. It is all very, I know they must do it all the time. (LD8)
		I know probably they do have certain things that they've got to say to you… I mean I'd read about it in the leaflets and things like that and I felt they didn't need to go on about it quite so much. (LD4) Each time with the midwives before it kind of works into it that we are health professionals. It's really incredibly basic. (LD7)
		I was not sure what was happening and did not want to seem stupid. (MD5)
Docherty 2013	Sub-theme: Empowerment: Women want to be empowered to contribute to decision making and choices	She just explained the whole process and she offered me the options of the CMU [community midwifery unit] or the Consultant led unit and explained them in detail and just again we talked through any of my anxieties. (MD11)
		The midwives said to me but you re low risk, you don t need that and you can have a birthing pool and all this. (MD6)
Goodwin 2018	Theme: involvement of family: Women value the support from family member during antenatal care	Susan (M): You're not quite knowing what the lady herself is thinking. They're inclined to – the mother-in-law, if she comes, to sort of dominate the consultation. Researcher: Do you find that affects your relationship with the client then? Susan (M): Well it does, really.

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		Because you never really get to know them like you do, other ladies. You know…they're keeping them back, I think, a little bit really.
		I mean the ones who have newly come over – all they're hearing is what the mothers-in- law or the family tell them…and they're taking that as gospel…And you've got a real battle to say "just because grandma said it doesn't mean to say it's right!" Heather (M)
		I would listen to the midwife. Cos she's obviously the person who's more experienced in that. But then it's tradition….and you kind of respect tradition as well. I don't know – it's a bit difficult. How would you balance it? Eliza (W)
		You never get a relationship going how you'd like it to be [if there is another person present] …It's not the same. Even if you've met them once on their own – you kinda get a better idea about who they are. Mary (M)
		In their culture the man is the head of the house. So he makes decisions, he does the talking. Gail (M)
		Woman seems a little nervous – looking to partner for answers when midwife asks questions (despite good English fluency). Partner answers most questions for woman. Partner explains about medical condition of woman. Midwife tries to engage woman by directing questions at her – woman turns to partner and waits for him to answer. Midwife has started to speak to partner more now –directing questions at him instead of woman. Fieldnote 1
		I think it's a caring thing. Because they care about their wives and their children. That's why they [speak] for their wives or girlfriends…he speaks for me and he cares about me so I'm happy about it. Liyana (W)
		I'd rather have [my mum] talk -she's more experienced with talking to midwives and doctors. And she knows the whole process…I think I'd rather have her talk, than me…. If I say something wrong, then my mum will be like "no – you say it like this" – that's what I think is important. Eliza (W)
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Goodwin 2018	Theme: Clarity of service information: Women want to know what is going to	Woman is late by 40 minutes – midwife now pressured to do an hour booking in 20mins. Midwife obviously a bit stressed about this but puts on cool, calm face when woman enters. Woman doesn't seem concerned that she is late – no apology. Fieldnote 2

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	happen at every stage of pregnancy	[In Pakistan] they just go there, straight away. Take a number and sit. And when they call them – they go and tell the doctor what's going on. And that's why people don't know about appointments [here], you know, to make them. Sara (Interpreter)
		What I dislike is people who come in and they've got a list of demands. "You need to write me a letter for housing. You need to do this – you need to do that" That's all they want! Care isn't always a priority for them…they'll only come when they want something. Gail (M)
Goodwin 2018	Sub-theme: Understanding role of providers: Some minority ethnic women want to know the role and responsibility of the care providers	I don't have any idea about midwife – I mean – what they do, how much qualified they are. Seriously – at this stage I really don't know. Hana (W)
		That's one of the banes of my clinic. I give them appointments and they just turn up when they like. [They] know they're late and they've missed their time – but they still do it! Mary (M)
		Woman is late by 40 minutes – midwife now pressured to do an hour booking in 20mins. Midwife obviously a bit stressed about this but puts on cool, calm face when woman enters. Woman doesn't seem concerned that she is late – no apology. Fieldnote 2
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Goodwin 2018	Theme: Frequent contacts: Women want to have ad-hoc contacts with the midwives between antenatal care appointments	We can't contact our midwife, or visit them frequently…. [Pakistani women] would be happier if they had care or attention in the beginning. Because that period is more sensitive and more need to care…I think it will make good relationship between you and your midwife. Hana (W)
Hatherall 2016	Theme: Prompt and Simpler referral: Some minority ethnic women want a faster and less cumbersome referral process	"It does take a long time because they don't take women without a GP at the hospital, so to get to the hospital she needed to get a GP, register with a GP, get an appointment and for her to be referred to the hospital it takes time. GP requires proof of address, some bill or something. And she did not have that address because they moved just recently so she was waiting for proof to come". (Interviewee 18, via an interpreter)

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		"My referral came late and that's why I had a late [booking] appointment. [] I did try phoning them but all they would say is that your referral form is not here yet. So I said that a lot of time has passed and my referral is still not here. This happened a few times. Then they said they would have another look". (Interviewee 11)
Hunter 2018	Theme: Shared Experience: Women want to socialise with other women during antenatal care	When it comes to, 'I want to discuss something in private' then it's got to be private, I don't want other people to eavesdrop. (Pre FG 2).
		You . . . might have a group that have got mixed races from mixed backgrounds which might not want to discuss things in front of other people (Pre FG 1).
		In the group, we don't hide anything really . . . because from the beginning, the midwives showed us that it's very, very confidential, so that puts all of us at ease to discuss about any matter, any, really. But if it's one to one, you don't know them . . . even though you have some concern, you don't talk about it (Woman 2, FG 2, Circle 2).
		At the beginning of every session we have like this little whiteboard where we can write anything that . . . we wanted to discuss . . . so it was great because it was not only led by the midwives, it was kind of led by us (Postnatal interview 1, Circle 3)
		[Other women] also ask questions which you haven't actually thought about, somebody asks and you are like, 'Oh yeah, this is nice, this is useful information,' because usually when you are one to one you are confused . . . you don't know what to ask (Woman 1, FG2, Circle 2)
		'brought out of their shells' (Postnatal interview 1, Circle 1)
		I felt very prepared, I knew everything, the outcome of everything and what I could do in what scenario (Postnatal interview 1, Circle 1).
		So you are not just told the figures. At the GP, they just told us the number whereas here you can question them a bit more and compare them with other people (Woman 2, FG 1, Circle 1) I think it was quite nice to be so independent . . . so it's not only them telling you, 'Oh, the urine test is okay,' no, you are doing it and you see that it is fine and I think that also makes you feel . . . um, I don't know, made me feel good about it (Postnatal interview 1, Circle 3).
		we talk, we've got real people who have had experiences (Woman 4, FG 1, Circle 4).
		I have said stuff that I know [the midwife] could never say, but I can

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		get away with saying it because I am not an employee following a guideline (Woman 2, FG 1, Circle 4). They also had a pastoral role within the groups: [X] has two kids before us and she gives a lot of good things on this . . . basically she is say . . . our mother [laughter] for beginner mothers, us (Woman 3, FG 2, Circle 2).
		Everyone was coming with questions, even though they had done it before. Just because sometimes you forget, you know there is loads of things, or you might have a symptom you didn't have last time (Postnatal interview 1, Circle 4).
		The midwives took you on board and travelled with you in your journey (Postnatal interview 1, Circle 1).
		[The Midwife] knew us so well . . . and because we built that relationship with her, it was much easier to ask her a question and her to be able to answer, really knowing the answer . . . not guessing, because she's got to know us (Postnatal interview 3, Circle 4).
		You know, when you are alone, all the bad things are coming to you and you discuss with someone else . . . and you feel better (Woman 3, FG 2, Circle 2). We do it all together with support from the midwives and everybody else (Woman 2, FG 2, Circle 1).
		Later on in the pregnancy when they were doing, you know, measurements and the heartbeat and stuff, that always felt a lot more separate than I thought it would (Postnatal interview 2, Circle 4). So it hasn't been weird at all you know, hearing other people's babies' heartbeats [laughter]. It sort of feels like you are plotting everyone's growth and [sigh] it's just . . . you are not just bonding with the mothers, you are bonding with everyone's babies as well, you can hear them grow you know, their hearts beating' (Woman 3, FG 1, Circle 1).
		I wasn't really aware of many of the options . . . I didn't know what a water birth was, I actually thought it was a little bit hippy, I didn't know it was like a completely normal thing to do (Woman 1, FG 1, Circle 4). I didn't feel comfortable with breastfeeding at all, it wasn't normal to me, I found it something I was a bit self-conscious about as well, but [the Pregnancy Circle Midwives] taught me to be open minded and I went to the sessions in the evening to get the techniques and I listened to what they were saying about natural . . . like let your instincts take over, and then I ended up breastfeeding for three months (Postnatal interview 1, Circle 1).

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		[Y] is Jewish, and . . . she was saying that she . . . organises food . . . for the ladies who have had babies and they don't have to cook for the first three weeks . . . and one of the other mums was like 'Oh, that's a really good idea...I could look to do that in my community' (Midwife interview, Circle 4).I think at the end of the day we were all Mums or Mums-to-be like, everything else kind of stays away . . . in a way it was more enriched, there was a lot of enrichment in the group that we were all so different, from different places you know (Postnatal interview 1, Circle 3).
		My husband is supposed to work every Saturday . . . so I told him, 'Tell your chef, tell your manager that today you must take off "til two o'clock, I must attend to my meeting (Woman 2, Focus Group 1, Circle 2).
		[Doctor] said we have to go to the hospital. I said, 'Hospital? For me it's my decision, it's going to be for a scan and consultation appointment. Midwife, I am staying [at the Pregnancy Circle] (Woman 2, FG 1, Circle 2).
		I don't really know anyone here that is pregnant or is going to have baby or that you know, that are in the same situation (Woman 4, Focus group 1, Circle 3).
		I find that the WhatsApp group that we have has helped all of us a lot because any concerns that are raised, we don't even need to call the midwife (Woman 3, FG 1, Circle 1).
		Everyone is really supportive of each other and there is a lot of advice going around between us Mums, what is really great . . . you know being there at 4 o'clock or 5 o'clock in the morning and feeling that you are not there by yourself (Postnatal interview 1, Circle 3).
Hunter 2018	Sub-theme: Independence from men: Some women want to have freedom from male domestic partners through the antenatal care	I was like, maybe if I join this group, my husband is not going to see me anymore.' (FG 1, Circle 3).
		They want their own husbands; they don't want someone else's! [laughter]. (Pre FG 2).
		Woman 1 — I think if the husbands would be here every time that we meet for two hours, they would get bored and we wouldn't be able to talk about everything, it would be uncomfortable. Woman 3—And some of us would not be able to talk about our things. Woman 2 — Yeah [laughter] I think it's right the way it is (FG 1, Circle 1 (invited partners once))

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		I realised there was no need, really, for him to come . . . it was about me (Postnatal interview 1, Circle 3)
		I realised there was no need, really, for him to come . . . it was about me (Postnatal interview 1, Circle 3)- Another lady said it empowered her to think that actually, 'Yeah, I don't actually need him to be here, I can do this' (Midwife interview Circle 4, partners not invited).
Hunter 2018	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	I just like that we are all the same even though we are different (Pre-implementation focus group (pre FG) 2).
		'[Health Professionals] would do everything themselves and they would tell me, "Everything is okay." (Woman 3, Focus group (FG) 1, Circle 1) '[midwives] have to learn that . . . they have to help, they can't just 'No, you have to do this, this, this and do this' (Pre FG 1).
Puthussery 2010	Sub-theme: Continuity of care and carer: women want to have continuity of care and of carers	One thing I always say is I would've preferred it if I had a, like a consistent person to see. ... because you get so many, it was quite confusing ... during my pregnancy, I must have seen about ten, fifteen midwives. Even during my labour there was like loads (Indian mother, primipara, 20–29 years, human resources advisor)
Puthussery 2010	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	To be honest, OK, information-wise, in terms of when it was asked, it was given ... The general sort of, at one point it did feel like, here's your book, now go away and read it, it did feel like that at one point. (Indian mother, primipara, 20–29 years, dispensing optician) It's like they're just talking over you and you're not there... It just makes you feel really nervous and distracted... But once you let them know that they needed to directly explain things to you then you're all right <laughs> (Black Caribbean mother, primipara, 20–29 years, sales assistant)
		And I remember there was one thing the midwife said, 'Oh, we think you might have diabetes, pregnancy diabetes', and when I left the surgery I was in tears, she really frightened me, you know? But when I went for the tests they said everything was fine. You know, she really made me panic, like the way she was explaining it to me, basically, by how she said it to me. (Black Caribbean mother, multipara, over 40 years, mental health worker)
Puthussery 2010	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care	To be honest, OK, information-wise, in terms of when it was asked, it was given ... The general sort of, at one point it did feel like, here's your book, now go away and read it, it did feel like that at one point. (Indian mother, primipara, 20–29 years, dispensing optician) It's like they're just talking over you and you're not there... It just makes you feel really nervous and distracted... But once you let them know that they needed to directly explain things to you then you're all right <laughs> (Black Caribbean mother, primipara, 20–29 years, sales assistant)

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Puthussery 2010	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	I said 'I'm really not well'. And they said 'you look fine. Everything's normal'. I said please, there is something going on. And it was just unbelievable how they didn't take it so seriously and within ... my baby was born at 4.30 so within such short time it all happened. (Bangladeshi mother, primipara, 20–29 years, accounts clerk)
Puthussery 2010	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	When they're dealing with women who are going through the most painful and amazing experience of their life, they need that kind of sense of support and understanding from somebody who's going to be taking care of them throughout the whole process. The midwives need to change their attitudes and try to re-focus on their jobs and believe and be more passionate about it, not just do it as a job really. (African mother, primipara, 20–29 years, occupation not recorded, degree level education)
		Having no sleep, having no rest and thinking maybe the hospital staff will give the mother a rest by taking the baby away, for a couple of hours would be amazing, but there's none of that, there was no help, and I actually asked for the help... I think it was the second night I just broke down in tears, because I was so exhausted, in so much agony... And I asked for help and they said look, we don't do that. I was a bit surprised that, that help wasn't available. (Bangladeshi mother, primipara, 20–29 years, accounts clerk)
Puthussery 2011	Sub-theme: Continuity of care and carer: women want to have continuity of care and of carers	There was no common ground really. You just had to start all over again ... You know, just that comfort zone. Liaising with, because it wasn't like you had one midwife who knew you, who knew your problems, who knew you from the beginning, it wasn't like that ... And that would have helped. (Indian mother, primipara, 20–29 years, dispensing optician)
		I mean it wasn't a bad relationship but no continuity, it's just the fact that you are with different people at every appointment ... you don't really build up a relationship with any of them, you're just another patient and another number really ... That would be my main criticism of the way it's run. (Irish mother, primapara, 30–39 years, clerk)
Raine 2010	Theme: Clarity of service information: Women want to know what is going to happen at every stage of pregnancy	''you never, from the outset, have a vision of what will be happening to you at certain stages'' (I2, HEWB) ''I asked her about my birth plan, and she just said, 'oh, it's too early for that, we'll discuss that later on'" (FG6, LEWB, 1)
		''knowing a bit more detail about what's going to come up during those sessions, then you're more focused on

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		the kind of dialogue that you need to have. Otherwise it would be easy to forget to ask a question, or to think well that maybe applies a bit later and I don't need to find out now, but actually maybe you do'' (FG2, HEWB, 1) ''It would really help to have a list of numbers saying, you know, this is who you phone for X, this is who you phone for Y…because otherwise you feel lost'' (FG2, HEWB, 2)
		''you'd been [to] the hospital last week…you have midwife this week, you knew really, she wasn't really going to tell you a lot, and you weren't going to get a lot out of it'' (FG6, LEWB, 1) ''they repeat the same thing…so it just seems pointless waiting all that time…to see the doctor whereas you know what they're going to say because the nurse has already said it'' (I6, ESB)
		''There would be this part of me that thinks, can I really be bothered to go?…at a time of life when you're quite vulnerable…you want to see someone who is going to reassure you…if you don't get that then I don't see point in going'' (FG6, LEWB, 1) ''when I've rung [the HCP] it's just like you're getting fobbed off, and you don't want to ring back after that.'' (I5, LEWB)
Raine 2010	Theme: Clarity of service information: Women want to know what is going to happen at every stage of pregnancy	''I tend to always miss my first scans…[I] join the process late'' (FG3, NESS, 1) ''I missed an appointment…the early scan is not to be gone to, Somalis…they said it is not good to go, if you go there will be problems, they will drop the baby from you'' [a metaphor for a miscarriage] (FG3, NESS, 2)
Raine 2010	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	''If they talk nicely then you feel peace…. I feel very relaxed'' (FG4, NESB, 1) ''our first scan, she was saying, 'look at this, and it's all lovely', and she seemed really excited, and they make you feel that…you're being looked after'' (I4, HEWB) Referring to the reaction of staff at the Assisted Conception Unit when the woman had a positive pregnancy test: ''they're delighted when they get a positive result and you get hugs from the nurses…and your consultant comes in and sends his congratulations, and all that is very reaffirming'' (FG1, HEWB, 4) ''[it's] the way [the midwife] talks to me and we can laugh and joke and…I feel…really comfortable'' (I14, LEWB)
		''[the consultant] was lovely…she was approachable, she was like, 'is there anything else? Oh, do you want to hear the baby's heartbeat?'' (FG6, LEWB, 2) ''I can ask [the midwife] questions even though it could be just growing pains, it's just [it will] put my mind at ease and let me know'' (I14, LEWB)

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		‘‘she listens to all the problems…and not like, you’ve only got 10 min’’ (FG5, ESB, 1)
		[the midwife] said…that she’d phone me, and she did actually phone me…and we agreed the appointment time’’ (FG6, HEWB, 1) ‘‘the midwife told me that I was small for gestational age so she arranged for me to have a scan at the hospital. I knew that midwife was helping me because she phoned me and asked how…the scan went, what they said to me and that was good because you know that she’s aware of what’s happening’’ (I8, NESS)
		‘‘[the HCP] was so rude, so dismissive, so patronizing and almost annoyed I was even there…just wanted me out of the room as quickly as possible’’ (I2, HEWB) ‘‘the internal check-up, if you say…that you’re hurting, ‘I just have to do it’…it’s the aggressive way they would answer’’ (I9, ESB) ‘‘I tried to tell them. I felt like they’re not hearing me’’ (I9, ESB) ‘‘tick tock, time is getting on…let’s get you out of here so we can go home’’ (FG6, LEWB, 2) ‘‘Most Bengali women, they can’t speak English, and…I see that [Bengali women are] treated bit different…[midwives] are quite polite and speaking to the English ladies…but I can see it’s different treatment [towards Bengali women]’’ (I9, ESB)
		‘‘There were so many occasions when I had to chase or phone up’’ (FG2, HEWB, 2) Referring to the lack of explanation offered about the procedure for glucose tolerance testing (GTT): ‘‘no one tells [women] that they have to knock on the door, no one tells them they have to time their own hour and go back…and if there’s a massive queue…people would probably just wait and then it could be 2 h…and then they’ve screwed all the results up.’’ (I2, HEWB)
		‘‘[the sonographer] said, I’m not going to talk to you now, I need to do what I need to do…and then I’ll go through it with you afterwards…and so because she’d said that, it was all right when she was doing all her stuff…. I wasn’t sat there thinking ‘oh, God, is it all right?’’’ (FG6, LEWB, 1) ‘‘They said, at the moment there’s no doctors on the ward and we’ve got six ladies waiting…they were very sympathetic and saying…we’re really sorry but you might have to wait a couple of hours to have your scan. I said that’s fine’’ (I4, HEWB)—waiting for an unscheduled ultrasound following a ‘little scare’

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Raine 2010	Sub-theme: Adequate communication between providers: Women feel adequately cared for when care providers share information about them for antenatal care.	‘‘the GP didn’t really know how the hospitals and midwives worked. It catapults you into the hospital system and that’s it as far as the GP is concerned’’ (FG2, HEWB 2). ‘‘[at] my first appointment with the GP, I said can you give me the right number to get through?…and the GP said I’m really sorry, I don’t know them’’ (FG2, HEWB, 2)
		‘‘one day there wasn’t any movement from the baby…[my GP] told me to go to the hospital straight away…scan people (at the hospital) asked whether the GP checked using a monitor…[my GP] said we don’t have this you have to go to hospital’’ (FG4, NESB, 2) ‘‘[My GP] said, do you have a urine sample? I hit the roof. I’ve already sent off two urine samples. Nothing was logged in the system. I started crying ‘cos I was so angry…she (the GP) said ‘oh, midwives don’t work with me, we don’t work under the same company’’’ (FG5, ESB, 2) ‘‘I wanted to get referred back to a consultant this time [i.e. for this woman’s second pregnancy], and the GP wasn’t sure about how that would work, and she seemed to kind of say, once you’re in the system, it’s out of our hands’’ (FG2, HEWB, 2)
Raine 2010	Sub-theme: Remote contact: Women value having remote contacts with the midwives	‘‘it’s brilliant because you get that text message and you go, oh yeah, you have an appointment’’ (FG6, LEWB, 2) ‘‘this appointment I totally forgot…and then I got the text message, and I was like, yeah’’ (I6, ESB)
Raine 2010	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	‘‘I was a bit surprised that on my notes it said that I was a smoker. I stopped smoking ages ago but nobody’s asked me about that and…I thought that they would follow up’’ (FG6, LEWB, 1)
		‘‘Then [the midwife] had written in my book that I was 31 weeks pregnant, and she started grilling me as to why I hadn’t attended the 28 week blood tests, and I’m like, well, I’m not 30 weeks, and she was ‘but it says here’, and I was like, well, yeah, you just wrote that’’(FG6, LEWB, 2)
		‘‘that feeling that the health professionals are being quite blase´ about it. Because they’ve seen so many pregnancies that are absolutely fine…and actually it doesn’t feel like that when you’re the one who is pregnant’’ (FG2, HEWB, 2)
Symon 2019	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	“I’m really lucky, my best friend is a midwife, so they weren’t explaining things to me so I just phoned her and asked…”(Janie, FG5: 171) “I googled like if there was any kind of breastfeeding support groups around, because that’s my biggest worry…like who can I call …if it’s not working out because it’s something I’m quite passionate about and I wanted it to work, but I found it hard to find the information, but then I haven’t asked my

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		midwife, so that would probably make sense, but I don't know if there's groups or anything."(Bernie; FG11: 76)
Symon 2019	Theme: Engaging and responsive communication: Women feel respected and supported based on how antenatal care providers communicate with them	"I kind of feel that anything that I suggested or asked for information in, it was basically like, 'Well, you should already know this, you've already been here like twice kind of thing'…"(Orla, FG 8: 19)
		"[She] was just the complete opposite …I just thought I couldn't ask her anything and when I came in for my checks she wouldn't speak to me at all …." (Anna, FG8: 23, 25) "Really? She wouldn't speak to you? …weird." (Alyshea, FG8: 26) "Not really. You would say 'Hi', and she wouldn't say hi back, and she would check baby's heart beat and she would be like, 'Are you happy with that?' and I would be like, 'Well, you are the midwife'."
		"I don't think they focus on you at all, it's more about 'Let's check the baby'…"(Shadiya, FG10: 131)
Symon 2019	Sub-theme: Remote contact: Women value having remote contacts with the midwives	"They always ring you back as well, so I think I left a message once and they rang me back the next day, just to answer a few questions that I had because I knew I wasn't seeing them for about six weeks."(Mo, FG11: 46) "I feel like I'm annoying them all the time, I'm phoning them constantly, because this is my first time …and they were like 'Don't worry, it's fine, you don't need to worry about it', but I feel I've been constantly on the phone panicking about some- thing, but they're really good though, they've always phoned back..."(Anita, FG11: 47)
Symon 2019	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	"I was consultant-led mainly, so I didn't really get much of a chance to build up a relationship with the community midwife or even the ones at (the community maternity unit). It was al- ways a different midwife." (Elaine, FG8: 36) Facilitator: "So do you think the antenatal care is flexible, it fits in with your family needs? Or is it on a set day?" (FG8: 43) "It's always on a set day isn't it? The midwives just have clinics?"(Orla, FG8: 44)
		"Yeah I think maybe if you're a second time mum they just kind of expect you to know what you're doing, but my first pregnancy, my daughter was born eight weeks early, so my second pregnancy was completely..... they just expected me to know, like I got less midwife appointments with my midwife because it was my second pregnancy…after I got to 20 weeks they just kind of left me to get on with it."(Janie, FG5: 21)
		"I found that really difficult as I am a high school teacher so it was only a Monday morning two-hour period so I have to go every…well not every Monday but being a high school teacher it meant I was missing the same classes each time which was quite inconvenient. It would have been better if I could miss different classes, so it was a bit frustrating…"(Anna, FG8: 48)
		"I had to go to [the unit] a few times which was difficult be- cause I'm working in [town]…but the midwife was

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		always accommodating making my appointments [geographically] closer …so that was always good, yeah, but she was pretty easy to work around."(Laura, FG7: 104) It also extended to referral pathways: "I just rang and spoke to the midwife and she just said 'Right, okay, I think you've got this thing, it's quite normal, I'll just refer you to the physio', and [the] physio sent a letter within three days with an appointment, and that's an amazing referral pathway…"(Trudi, FG7: 68)
Thomson 2013	Theme: Shared Experience: Women want to socialise with other women during antenatal care	I was up at the hospital for all of mine, but you just sit and you get talking to other mums that are due around the same time, so you don't feel you are sitting there in your isolation, you are not the only one who has got problems, because there is other people around, so there is a social side (Group Interview 6).
Thomson 2013	Theme: Access to information: Women value getting adequate information on the pregnancy and antenatal care	It is important to access to get information for both me and my baby's health and for advice as my baby was not planned so had not read anything, or prepared at all (Group Interview 4).
		its (antenatal appointments) very important. Because on my dad's side of the family we found out there was Down's syndrome and cystic fibrosis. My niece has two cystic fibrosis children. So it is extremely important (Group Interview 11).
Thomson 2013	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care	They give me leaflets and stuff and told me what to do and to rest and stuff. Because I can't just rest can I, I have got a baby to look after, it is not easy (Group Interview12).
		In my first pregnancy [the midwives were] going on and on at me to give up smoking, saying it is a really bad thing.... Yeah I know that….you told me that….the more you go on at me about it, the more I want a fag (Group Interview 11).
		Not enough information provided…. they give you leaflets and tell you some risks…. but I would have liked to have talked to someone. It is different reading it than talking to someone and sometimes you don't understand the leaflets….so talking is better (Group Interview 17).
Thomson 2013	Theme: Frequent contacts: Women want to have ad-hoc contacts with the midwives between antenatal care appointments	I was really lucky with my third baby because I was losing water and I had really good care when I was in and out of hospital...the staff were really fantastic. They would check on the heart beat and monitoring so I was really lucky (Group Interview 3).
		They don't always have the people there for you unless you are high risk (Group Interview 6).
		If ill they do look after you, but when flying through, they step back and I don't like that, as there could be points where I was slipping (Group Interview7).
		'in my case, I felt there was too much care', Group Interview 2

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		I think you should have a point of access to see someone when you are worried, to have that flexibility with the service rather than at set points (Group Interview 5).
Thomson 2013	Theme: Treated as individual: Women want to be treated more than a number in the antenatal care system.	I did not go to the GP [General Practitioner] until I was 24–5 weeks…. I was 16 and trying to hide the fact. I still wanted to be 16 as well. I didn't want to go out drinking, but I wanted to go to my friend's house and be normal and go to town. I often found that when I went to a health clinic they were always a lot older than me (Group Interview1).
		'cover her belly up' (Group Interview 15).
		Antenatal classes are not very good and it was too far away, it was 10 miles (Group Interview 2).
		there were plenty of them to go to…..going every week and sitting in a room where there is 30 odd women waiting for hours, just for 5min for them to say you are fine, check your blood pressure, you are fine (Group Interview 16).
		I had built a relationship with her, I felt looked after and I had confidence in who was providing my care (Individual Interview 1).
		I went from an easy pregnancy to having anaemia and at that time that I was not educated as to what that could cause. It might have been nicer to have some material as to why the importance of iron is needed (Group Interview 3).
		There are so many issues about treating everybody the same– we are not all the same (Group Interview 16).
Young 2008	Sub-theme: Additional information opportunities: Women want to have the opportunity to get more information on the pregnancy and antenatal care	It was a big shock (C5). It was overwhelming, the responsibility of it all (C2). It was chaos (C8). I felt unprepared for how tired and drained you feel constantly (C8). You think 'I am the only person going through this', not everyone is honest about how hard it is and the tremendous strain it puts on your relationship (C11)