The Prenatal Primary Nursing Care Experience of Pregnant Women in Contexts of Vulnerability
A Systematic Review With Thematic Synthesis

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The contexts of vulnerability are diversified and cover a wide range of situations where pregnant women are likely to experience threats or disparities. Nurses should consider the particular circumstances of women in contexts of vulnerability. We used a qualitative thematic synthesis to describe the experience of these women regarding their prenatal primary nursing care. We identified that the women’s experience is shaped by the prenatal care. The fulfillment of their needs and expectations will guide their decision regarding the utilization of their prenatal care. We propose a theoretical model to guide nurses, promoting person-centered delivery of prenatal care. **Key words:** contexts of vulnerability, experience, nursing, pregnant women, prenatal care, systematic review

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During the prenatal period, women receive nursing care through primary care services.\(^1\) Primary care is integrated, accessible, and accountable for addressing a large majority of personal health care needs, enabling the development of a sustained partnership with pregnant women.\(^2\) Prenatal care may contribute to optimizing pregnancy and birth outcomes.\(^3\) Nurses play a key role by improving women’s access to prenatal care, increasing the application of recommendations during pregnancy and the use of prenatal care.\(^1\)

However, pregnant women in certain contexts may underuse such prenatal care.\(^4,\,5\) It is the case for women living in rural areas,\(^1,\,6\) who are younger than 19 years,\(^4,\,7\) benefit from government financial support or have a low income,\(^6,\,8\) are single parents,\(^4,\,7\) are socially isolated,\(^4\) have a low level of education,\(^1,\,6,\,8\) or are immigrants.\(^7\) These contexts put women at risk of adopting less healthy behaviors (ie, prenatal smoking, alcohol, and/or illicit drug use)\(^4\) or experiencing pregnancy complications (ie, multiple birth, hypertensive disorders, antepartum hemorrhage, diabetes, and prenatal psychological distress).\(^4\) All of these contexts combined with determinants of health engender vulnerability according to the World Health Organization (WHO) Commission of Social Determinants of Health (CSDH) conceptual framework.\(^9\) Contexts of vulnerability put women at risk of inequities, such as low access to health care or discrimination.\(^9,\,10\)

Contexts of vulnerability is an evolutive,\(^11,\,12\) and complex concept, given the multitude and variability of situations.\(^11,\,13\) Scheele et al\(^13\) provide a broader definition, stating that a woman in contexts of vulnerability is “a woman who is threatened by physical, psychological, cognitive and/or social risk factors in combination with lack of adequate support and/or adequate coping skills,” putting her at risk of marginalization, exclusion, and inequity.\(^14(p4)\)

The WHO\(^15\) emphasizes the importance of a positive experience during pregnancy. However, contexts of vulnerability can affect women’s experience.\(^16\) Nurses’ attitudes are among the various factors influencing women’s prenatal care experience.\(^17\) For instance, the nurses’ respect of women’s beliefs, the quality of support nurses provide,
whether or not they include the woman in her health care decisions will influence women’s experience.18 The relationship nurses develop with these women will also impact their experience of prenatal care.18,19 Van den Berg et al20 outlined the importance of “being treated as an individual person experiencing a significant life event rather than a common condition.”(p113)

Although many studies have described the experience of women in different contexts of vulnerability, no currently available review synthesizes this experience to provide a global perspective. This would be helpful to nurses working with this clientele, who may be living with a wide range of vulnerability contexts.21 To this end, we aimed to systematically review the literature to describe the prenatal primary nursing care (hereafter prenatal care) experience of pregnant women in contexts of vulnerability (hereafter women).

METHODS

We conducted a systematic review with thematic synthesis of qualitative studies, following the Thomas and Harden method.22 This article is presented according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).23

Stage 1: Searching articles

We worked with 2 information specialists to develop search strategies in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EmCare, MEDLINE, and PsyCINFO bibliographic databases. We limited our search to English or French articles published between 1995 and 2020. The strategies included terms related to “pregnancy,” “nursing,” and “experience” (see Supplement Digital Content 1, available at: http://links.lww.com/ANS/A40). Terms related to vulnerability were not included in the search strategies. To ensure that we covered all contexts of vulnerability, they were considered in the inclusion criteria. To be included, articles had to (1) document the primary care registered nurses’ role during prenatal care, including phone care, clinics, and community sites; (2) describe the prenatal nursing care experience of pregnant women in contexts of vulnerability; and (3) use qualitative or mixed methods.

We operationalized the vulnerability context inspired by the CSDH conceptual framework as one in which a woman is likely to experience threats or disparities, because of either individual or environmental contexts. Individual contexts include physical/biological/behavioral (eg, health condition, pregnancy complications, tobacco use), psychological (eg, mental illness), cognitive (eg, cognitive disease), and/or social (eg, low income or unemployment, cultural and linguistic barriers, sexual and gender orientation minority, low level of education or health literacy) factors.10,11,13,24 Environmental contexts include the lack of access to primary care, geographic area (ie, living in rural area), air pollution, or unsafe streets.11,15,24

We excluded studies that were (1) exclusive to fecundation, delivery, or the postnatal period; (2) about miscarriage, abortion, or perinatal loss because these situations may influence women’s experience of prenatal care25; (3) conducted in hospital settings; (4) unclear about nurses’ follow-up in primary care; and (5) using only quantitative methods because this study used a thematic synthesis of qualitative results.

We also examined the reference lists of included articles for other relevant articles (hand searching). One author conducted the first screening using titles and abstracts of the retrieved records. Two authors independently screened the selected full-text articles. A third author helped resolve disagreements, as needed.

Stage 2: Assessing quality

We used the Standards for Reporting Qualitative Research (SRQR),26 a 21-item checklist including items regarding study rationale and context. Two authors independently evaluated each article, indicating
the presence (line and page number) or absence of each SRQR item and then met to compare their results and finalize their assessment of the studies’ methodological quality. We considered articles lacking detail about the justification of qualitative approach/paradigms, contexts, sampling strategies, data collection methods, data analysis, and enhance trustworthiness to be of low quality. As recommended by Thomas and Harden,22 we did not exclude low-quality studies but rather conducted a sensitivity analysis to examine their contribution to the thematic synthesis.

Stage 3: Extracting data

We extracted the following information: authors, year of publication, study purpose and design, country, contexts of vulnerability, and sample size. We also extracted qualitative results to perform the thematic synthesis.

Stage 4: Conducting a thematic synthesis

Two authors independently performed thematic line-by-line coding of the results of each article22 following an iterative process.27 The first author reviewed codes to formulate descriptive themes to describe the prenatal care experience. We grouped descriptive themes into analytical themes by authors, corresponding to our interpretation of “go beyond” the findings. We used researcher triangulation and peer debriefing to ensure the dependability and credibility of results.27

RESULTS

Search results and study characteristics

We retrieved 1585 unique records, 14 of which met our inclusion criteria and were included in the synthesis, as shown in Figure 1. These 14 studies (Table 1), published between 1995 and 2019, used qualitative designs except one,28 which used mixed methods. The studies were conducted in the United States (n = 5), Canada (n = 4), Brazil (n = 3), Ghana (n = 1), and South Africa (n = 1). They addressed a variety of contexts of vulnerability, namely, physical/biological/behavioral (ie, transmitted diseases, deaf condition, pregnancy complications) (n = 6),29-34 social (ie, low income) (n = 6),29,33-35 cultural and linguistic barriers (n = 5),33,35,38-40 sexual and gender orientation minority (n = 1),41 low level of education or health literacy (n = 2),28,40 weak social networks (n = 4),51-53,59 and environmental contexts (ie, living in a rural area) (n = 3).28,40,41 Sample size ranged from 4 to 27 participants.

Prenatal primary nursing care experience of pregnant women in contexts of vulnerability

The experience of these women was shaped by the prenatal care provided (theme 1). Women had needs and expectations throughout their pregnancy, influencing their experience (theme 2). Their experience and the fulfillment of their needs and expectations modulated their decision regarding their prenatal care (theme 3). These 3 themes are described with examples of adequate and inadequate prenatal care.

Women’s experience is shaped by the prenatal care

The experience of prenatal care was shaped by 4 subthemes: quality of the relationship with the nurse; consideration of their contexts; quality of the information and support; and accessibility, organization, and continuity of prenatal care. Detailed examples and quotes are provided in Table 2.

Quality of the nurse-woman relationship

Women described a quality relationship with their prenatal care nurse as one where the nurse respected, accepted and listened to them, and treated them with dignity and humanity and without judgment.29,33,35,36,38,40 As described by one woman, if “the nurse will speak respectfully to you, […] you will be happy.”40(p2435)
Lack of humanistic care or disrespect could hamper the relationship.\textsuperscript{33,40} Women perceived disrespect when nurses were not open to hearing what they had to say, provided depersonalized services, did not respect confidentiality, stigmatized them, treated them like a “child,” lost patience with them, or were verbally or physically abusive.\textsuperscript{29,30,32-35,40}

**Consideration of women’s contexts**

Some nurses considered women’s vulnerability contexts and others did not. A woman mentioned that the nurse understood her financial constraints and showed consideration by giving her free vitamin samples.\textsuperscript{29} Other studies provided examples of how not accounting women’s contexts may generate a negative experience.\textsuperscript{30,41} For instance, a queer woman expressed the difficulty navigating a system less inclusive, given a heteronormative approach:

> I felt a little disempowered and had to struggle a little bit with that, and tell myself that it was okay to ask questions or to say no or to... You know, I felt a little bit at the mercy of the medical system.\textsuperscript{41(p3851)}

**Quality of information and support**

According to women, information should be sufficient,\textsuperscript{29,30,34,39} unbiased, and consistent\textsuperscript{32} and should cover prenatal care,
Table 1. Study Characteristics

| First Author (Publication Year) | Study Purpose | Study Design | Country | Contexts of Vulnerability | Sample Size, n |
|--------------------------------|---------------|--------------|---------|--------------------------|----------------|
| Berry (1999)                   | Describe and explain the meanings, expressions, and experiences of generic and professional care during pregnancy of Mexican American women in their home and prenatal clinic contexts. | Exploratory descriptive | United States | Mexican American pregnant women | 16 |
| Blackford (2000)               | Describe how prenatal nurse educators are well prepared to meet the learning needs of mothers with disabilities. | Exploratory descriptive | Canada | Pregnant women with chronic conditions/disabilities and low income | 8 |
| Burns (2019)                   | Gain a more comprehensive understanding of Mi’kmaq women’s experiences accessing prenatal care. | Feminist participatory action research | Canada | Mi’kmaq pregnant women socially isolated in rural context | 4 |
| Cricco-Lizza (2006)            | Describe low-income Black non-Hispanic women’s perspectives about the promotion of infant feeding methods by nurses and physicians. | Ethnographic | United States | Black non-Hispanic pregnant women with low income | 11 |
| De Andrade Costa (2018)        | Identify the perceptions of deaf women regarding nursing care during pregnancy, childbirth, and postpartum. | Exploratory descriptive | Brazil | Deaf pregnant women | 9 |
| Fernandes Demarchi (2017)      | Investigate pregnant women’s and primiparous mothers’ perceptions of maternity. | Exploratory descriptive | Brazil | Primiparous pregnant women with low income | 11 |
| Hubbard (2018)                 | Explore the experiences of deaf women receiving perinatal care and suggest implications for nursing practice within the QSEN framework. | Descriptive qualitative | United States | Deaf pregnant women | 5 |

(continues)
Table 1. Study Characteristics (Continued)

| First Author (Publication Year) | Study Purpose | Study Design | Country | Contexts of Vulnerability | Sample Size, n |
|---------------------------------|---------------|--------------|---------|--------------------------|----------------|
| Omar (1995)                     | Describe pregnant women’s perceptions regarding their expectations of and satisfaction with prenatal care. | Exploratory | United States | At-risk pregnant women with low income | 22 |
| Pretorius (2004)                | Explore and describe the perceptions of the pregnant women regarding ANHSU. | Mixed methods | South Africa | Pregnant women in rural context | 14 |
| Sanders (2008)                  | Explore the meaning of pregnancy after diagnosis with HIV infection. | Phenomenological | United States | Pregnant women with HIV infection | 9 |
| Searle (2017)                   | Examine structural marginalization within perinatal care relationships that provides insights into the impact of dominant models of care on queer birthing women. | Feminist interpretative phenomenological | Canada | Queer pregnant women in a rural context | 13 |
| Teixeira (2013)                 | Examine the perceptions of primiparae on the guidance received in prenatal care regarding breastfeeding. | Descriptive qualitative | Brazil | Primiparous pregnant women with low income | 10 |
| Whitty-Rogers (2016)           | Explore and gain insight into the experiences of Mi’kmaq women with GDM in 2 First Nations communities and explore how these experiences have been shaped by a variety of SDOH and existing health policies. | Participatory action research | Canada | Mi’kmaq pregnant women with gestational diabetes and low income | 9 |
| Yakong (2010)                   | Describe rural women’s perspectives of their experiences seeking reproductive care from nurses. | Ethnographic | Ghana | Pregnant women in rural context with linguistic barriers | 27 |

Abbreviations: ANHSU, antenatal health service utilization; GDM, gestational diabetes mellitus; HIV, human immunodeficiency virus; SDOH, social determinants of health; QSEN, quality of safety education for nurses; Queer, member of the lesbian, gay, bisexual, queer, pansexual and two spirit (LGBQP2S) communities.41
| Subthemes                  | Examples                                                                 | Quotes                                                                 |
|---------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Quality nurse-woman       | Quality relationship: I talked to the nurse and she was honest with me ... | “I really had a good relationship with our nurse.”^33(p194)            |
| relationship              | but nice about it and gave me some ideas.                                |
| Nurse does not respect    | [Pregnant woman] found out that this nurse in office actually spread it,  | “[Pregnant woman] probably could have gotten her in trouble, she [the nurse] spread it to everybody. Everybody was looking at [pregnant woman] so strange.”^32(p52) |
| the confidentiality       | [pregnant woman] was looking at [pregnant woman] so strange.             |
| Nurse stigmatizes women   | Pregnant women with HIV condition expressed: I feel like I’m a piece of | [... ] That hurts. Just the way they look at you. [... ] They are professional people. You come to them for help. They should not tear you down like that.”^32(p51) |
| Nurse infantilizes women  | [The nurse] said why is it that I did not come to the clinic till six months to tell her that I am pregnant. Was she the one who impregnated me?^40(p2435) |
| Nurse loses patience with | The frustration related to extra time took to speak to pregnant women with deaf condition causes nurses to tend to be impatient and to use exaggerated facial expressions or lip movement. ^51(p132) |
| women                     |                                                                         |
| Nurse is verbally or      | They bully and mistreat us.”^28(p78)                                     |
| physically abusive with   | “Nurses yell at you.”^40(p2435)                                          |
| women                     |                                                                         |
| Consideration of the      | Priscilla, a mother with diabetes, and Coreen, who has systemic lupus    | “Clinic walls were decorated with posters and pictures containing information about contraceptives and immunizations, these forms of information dissemination had little impact because the majority of women were not educated and had limited literacy.”^40(p2436) |
| women’s contexts          | erythematous, reported that they were given no alternative suggestions for addressing these concerns such as increased exercise, hydration, nutrition or rest. ^29(p901) |
| Physical/biological/      | “When I call, they speak English. I ask for a Spanish person, and they say wait; then they hang up the telephone.”^38(p208) |
| behavioral (living with a |                                                                          |
| disease/condition)        |                                                                          |
| Cultural and linguistic   |                                                                          |
| barriers                  |                                                                          |
| Low income                | The women knew that when they received a diagnosis of gestational diabetes mellitus, they had to follow a healthy diet, but for some, it presented a challenge because they did not have easy access to grocery stores and/or because they did not have the financial resources to buy food, let alone healthy food. ^35(p191) |
| Low level of education or |                                                                          |
| health literacy           |                                                                          |
| Weak social networks      | A pregnant woman identified that inadequate communication with her partner is caused by a lack of education by nurses: “If he would have had the proper training or instructions he would have been able to [help], but he wasn’t aware of what to look for.”^29(p902) |
| Sexual and gender         | “I’m queer, I have a female body partner, and you told me not to have sex before the pap test. ‘What do you mean by that? Why?’ And they were like, ‘Oh, no, it’s just sperm.’ And I was like, ‘Well, then use a different word. Use different languages. Use different languages because my partner just wouldn’t have sex with me.”^41(p3583) |
| orientation minority      | (continues)                                                              |
| Subthemes | Examples | Quotes |
|-----------|----------|--------|
| Quality of information and support | Adequate information | "At the clinic the nurse gave the lecture once a month."[^37] <br> "All the information I got is real good . . . And you know she [the nurse] gave me pictures of how to do it and stuff like that."[^35] <br> "I don’t know . . . I didn’t really get a gist of like . . . What exactly was going on. Or what they were saying. [She] indicated that she was not properly educated during her prenatal check-up appointments."[^42] <br> "I have never been oriented in my prenatal, only when I came [to the hospital that] I knew I should breastfeed until six months."[^37] <br> Anna mentioned that "the nurses here supported me to get prenatal care." She values the nurses at the Health Centre, as indicated by how the support made her feel [... ] really good knowing that [she] wasn’t alone trying to figure it all out on [her] own, cause when [she] first became a mother [she] was only 16."[^39] |
| Inadequate information | "I don’t know . . . I didn’t really get a gist of like . . . What exactly was going on. Or what they were saying. [She] indicated that she was not properly educated during her prenatal check-up appointments."[^42] <br> "I have never been oriented in my prenatal, only when I came [to the hospital that] I knew I should breastfeed until six months."[^37] <br> "I didn’t really get a gist of like . . . What exactly was going on. Or what they were saying. [She] indicated that she was not properly educated during her prenatal check-up appointments."[^42] <br> "I have never been oriented in my prenatal, only when I came [to the hospital that] I knew I should breastfeed until six months."[^37] |
| Adequate support | Anna mentioned that “the nurses here supported me to get prenatal care.” She values the nurses at the Health Centre, as indicated by how the support made her feel [... ] really good knowing that [she] wasn’t alone trying to figure it all out on [her] own, cause when [she] first became a mother [she] was only 16."[^39] |
| Inadequate support | "I have never been oriented in my prenatal, only when I came [to the hospital that] I knew I should breastfeed until six months."[^37] |
| Accessibility, organization, and continuity of prenatal care | Accessibility of care | "I see a nurse every time I have my prenatal visits."[^5] <br> "She [the interpreter] knows my signing style so it’s better to just have the same interpreter."[^31] |
| Same nurse or interpreter throughout the prenatal care | "I see a nurse every time I have my prenatal visits."[^5] <br> "She [the interpreter] knows my signing style so it’s better to just have the same interpreter."[^31] |
| Limited services | "I have never had contact with the [Estratégia de Saúde da Família] nurse."[^30] <br> "It took a long time before they got me in, 4, 5, 6 weeks."[^34] <br> "I have never had contact with the [Estratégia de Saúde da Família] nurse."[^30] |
| Long wait times | "I have never had contact with the [Estratégia de Saúde da Família] nurse."[^30] <br> "It took a long time before they got me in, 4, 5, 6 weeks."[^34] <br> "I have never had contact with the [Estratégia de Saúde da Família] nurse."[^30] |
| Legal and bureaucratic constraints | For immigrant contexts by Mexican women having received care in the United States: “Here there is so much paperwork”; “I put the papers in the box, and they lost them”; and “something’s wrong with the papers”; “One barrier to prenatal care in this study was the lack of understanding of the legal, political, and bureaucratic processes to access the health care system.”[^38] |
| Limited privacy | "As for that place (reception area), everybody is sitting there and looking at each other. You cannot talk about all your concerns. The kind of sickness that brought you there, you cannot say it before other people. [...] You feel that they are listening."[^40] |
| Limited choice of care settings | Pregnant women expressed that “they had too many different providers, resulting in the providers not knowing them personally,” so they have to “tell their story” with every health care provider."[^34] <br> Pregnant women in rural regions expressed that they want to “have more mobile clinics.” For some pregnant woman, “The clinic is too far to walk, and they stay at home.”[^28] |

Abbreviation: HIV, human immunodeficiency virus.
experience of pregnant women in contexts of vulnerability

pregnancy, delivery, postpartum, parenthood, and breastfeeding. Yet, many women expressed that the information they received was insufficient, redundant, inconsistent, or unclear. With respect to support, women appreciated when nurses provided information or facilitated navigation through the healthcare system.

Accessibility, organization, and continuity of prenatal care

Accessibility to healthcare varied from one study to another as well as among women in the same studies. It included accessibility to nursing follow-up, an interpreter for women with a hearing impairment or a different mother tongue, and to early prenatal care. Some organizational factors such as long wait times, rigid schedules, legal and bureaucratic constraints, especially for immigrants, and limited privacy influenced women's experience negatively. Women also identified transportation constraints and limited choice of care settings. Having the same nurse or the same interpreter throughout the prenatal care helped improve continuity of services according to women and contributed to a positive experience (Table 2).

Fulfillment of women's needs and expectations guides their decision regarding prenatal care

Several factors influenced the needs and expectations of women at the beginning of their prenatal nursing care, previous experience being one of them. For example, when referring to the accessibility of healthcare, one woman said: "I expected to be seen sooner than that." The women's context of vulnerability such as living with a deaf condition or having a particular situation also influenced their needs and expectations. Fulfillment of their needs and expectations positively impacted their prenatal care experience. For example, a woman said she liked her prenatal care because the nurse "asks [her] how [she is] doing and if [she has] any questions, is there anything [she wants] to know." Another reported feeling less anxious after receiving the support she needed. In contrast, unfulfilled needs and expectations may generate negative feelings. For instance, a primiparous woman said, she "[...] was frustrated enough, [she] expected more [...]" information.

Women's decision regarding their prenatal care

In situations where women felt their needs and expectations not being met, they made one of 3 decisions. They may choose to continue the prenatal care, as illustrated by a woman living with chronic conditions who preferred not to express her worries, in order to continue prenatal group sessions. They may choose to find alternatives to prenatal care, such as requesting a different prenatal care nurse, changing clinics, or finding solutions to compensate for their unmet needs and expectations. Finally, some women may choose to cease their prenatal care. The reasons for a modification or a cessation of prenatal care highlighted in all articles were often related to the quality of the relationship with the nurse.

Thematic synthesis

Together, the themes and subthemes represent the prenatal care experience of women in contexts of vulnerability. All results are presented as a theoretical model in Figure 2.

Their experience is influenced by the quality of the relationship with nurses, consideration of their context and situation, accessibility, organization, and continuity of prenatal care. Women express needs or expectations through their prenatal care. The fulfillment, or not, of their needs and expectations influences their decision about further use of prenatal care. Some women experience disappointing prenatal care, so they find solutions to fulfill their needs and expectations. Others cease prenatal care and "[leave]
the system,” which compromised continuity of prenatal care. This quote summarizes the entire situation: “For two years I moved from place to place. If I trust you, I will stay with you.”32(p53)

Quality assessment and sensitivity analysis

The results of the quality assessment of each study are presented in Table 3. The SRQR criteria regarding research paradigm (n = 9), ways to enhance trustworthiness (n = 8), conflicts of interest (n = 11), and researcher characteristics (n = 8) were frequently missing in the included studies. In one study,37 several criteria were either insufficiently described or not described at all. This study brought only one theme (Table 4) to the synthesis. In contrast, studies assessed as high quality according to the SRQR32,33,38,40 identified 3 themes and 7 subthemes. All themes and subthemes were present in more than one study.

DISCUSSION

The quality of the nurse-woman relationship is an important focal point of the prenatal care experience. A positive experience of relationships reinforces the desire to continue follow-up, whereas a negative experience of the relationship appears to incite women to consult other resources.17,19 Another study42 found that nurses’ negative attitudes were an important cause of nonutilization of health care services.

The quality of the relationship with nurses and the consideration of their own context of vulnerability are key aspects of person-centered care. Person-centered nursing care,
Table 3. Quality Assessment of Included Studies Using the SRQR\textsuperscript{a}

| SRQR Items                           | Berry (1999)\textsuperscript{38} | Blackford (2000)\textsuperscript{29} | Burns (2019)\textsuperscript{39} | Cricco-Lizza (2006)\textsuperscript{35} | De Andrade Costa (2018)\textsuperscript{50} | Fernandes (2017)\textsuperscript{36} | Hubbard (2018)\textsuperscript{31} | Omar (1995)\textsuperscript{31} | Pretorius (2004)\textsuperscript{28} | Sanders (2008)\textsuperscript{32} | Scarle (2017)\textsuperscript{41} | Teixeira (2013)\textsuperscript{37} | Whitty-Rogers (2016)\textsuperscript{33} | Yakong (2010)\textsuperscript{40} |
|--------------------------------------|-----------------------------------|--------------------------------------|----------------------------------|------------------------------------------|---------------------------------------|----------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| 1. Title                             | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 2. Abstract                          | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 3. Problem formulation               | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 4. Purpose/research question         | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 5. Qualitative approach/             | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| research paradigm\textsuperscript{b} |                                   |                                      |                                  |                                           |                                        |                                   |                                 |                                 |                               |                                 |                                 |                                 |                                 |                                 |
| 6. Researcher characteristics       | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 7. Context\textsuperscript{b}        | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 8. Sampling strategy\textsuperscript{b}| X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 9. Ethical issues                    | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 10. Data collection methods\textsuperscript{b}| X                               | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 11. Data collection instruments      | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 12. Units of study                   | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 13. Data processing                  | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 14. Data analysis\textsuperscript{b} | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 15. Enhance trustworthiness\textsuperscript{b}| X                               | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 16. Synthesis and interpretation     | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 17. Links to empirical data          | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 18. Prior work/implications/         | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| transferability/contributions        |                                   |                                      |                                  |                                           |                                        |                                   |                                 |                                 |                               |                                 |                                 |                                 |                                 |                                 |
| 19. Limitations                      | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 20. Conflicts of interest            | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |
| 21. Funding                          | X                                 | X                                    | X                                | X                                        | X                                      | X                                | X                              | X                               | X                             | X                               | X                               | X                               | X                               | X                               |

Abbreviation: SRQR, Standards for Reporting Qualitative Research.
\textsuperscript{a}The letter “X” indicates presence of SRQR item. The blank space indicates that SRQR items are not present in the article.
\textsuperscript{b}Elements related to study rationale or justification of methodological decisions.
Table 4. Sensitivity Analysis

| Themes and Subthemes About Prenatal Primary Nursing Care Experiences of Pregnant Women in Contexts of Vulnerability | Berry (1999)²⁸ | Blackford (2000)²⁹ | Burns (2019)³⁹ | Cricco-Lizza (2006)³⁵ | De Andrade Costa (2018)³⁰ | De Fernandes (2017)³⁰ | Hubbard (2018)³¹ | Omar (1995)³¹ | Pretorius (2004)²⁸ | Sanders (2008)³² | Searle (2017)³³ | Teixeira (2013)³⁷ | Whitty-Rogers (2016)³³ | Yakong (2010)³⁰ |
|-------------------------------------------------|-----------------|------------------|-----------------|------------------------|------------------------|------------------------|----------------|----------------|----------------|----------------|----------------|----------------|------------------|----------------|
| Women’s experience is shaped by the prenatal care | X X X X | X X | X X X | X X | X X | X X | X X X | X X | X X | X X | X X | X X | X X | X X |
| Quality of the nurse-woman relationship | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Respectful humanistic care | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Consideration of the women’s contexts | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Physical/biological barriers | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Cultural and linguistic barriers | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Low income | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Low level of education/health literacy | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Weak social networks | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Sexual and gender orientation minority | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Quality of information and support | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Enough information | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Consistent, reliable information | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Redundant information | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Clear information | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |
| Nurses’ adequate support | X X X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X | X X |

(continues)
Table 4. Sensitivity Analysisa (Continued)

| First Author (Publication Year) | Berry (1999) | Blackford (2000) | Burns (2019) | Cricco-Lizza (2006) | De Andrade Costa (2018) | Fernandes Demarchi (2017) | Hubbard (2018) | Omar (1995) | Pretorius (2004) | Sanders (2008) | Searle (2017) | Teixeira (2013) | Whitty-Rogers (2016) | Yakong (2010) |
|-------------------------------|--------------|-----------------|-------------|--------------------|-----------------------|-------------------------|----------------|-------------|----------------|----------------|-------------|----------------|----------------------|---------------|
| Accessibility, organization, and continuity of prenatal care | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Organizational factor | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Transportation constraints | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Fulfillment of the women’s needs and expectations guides their decision regarding prenatal care | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Women’s decision regarding their prenatal care | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Continuing as is | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Finding solutions | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Ceasing | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |

aThe letter "X" indicates that themes and subthemes are present in the article. The blank space indicates that they are not present.
in opposition to task-oriented care, encourages interactions and helps develop trust. In addition, person-centered care focuses on needs and expectations. As women’s needs and expectations evolve over time, they have to be reassessed regularly. The studies included in this review reported mainly negative experiences. Another systematic review specific to Muslim women highlighted similar results regarding women having experienced poor maternity care during the prenatal to postnatal periods. Indeed, it can be more challenging for nurses to provide care to women in some contexts of vulnerability.

Clinical implications

It is essential that nurses take a woman’s context into account when providing prenatal care. As documented by our work and by Briscoe et al, nurses make an important contribution to a positive experience. Providing woman-centered prenatal care based on her contexts of vulnerability is a way to ensure equity and social justice, which are foundations of nursing practice.

Prenatal nursing care also needs to be based on women’s needs and expectations. To this end, nurses should give women the opportunity to express their concerns, needs, and expectations and to pose questions. With regard to the quality of nurse-woman relationships, nurses should provide person-centered care with respect and without judgment. In addition, nurses could offer support by accompanying women or by integrating family members in their prenatal care.

Research implications

Future studies should investigate how nurses operationalize their role to promote positive prenatal care experiences for women in contexts of vulnerability. One strategy could be to better understand the nurse-woman relationship and its influence on the utilization of prenatal care. The gender of the nurse was scarcely explored in included articles. It would be interesting to look at its influence on the relationship. It would also be valuable to investigate specific contexts of vulnerability, including pregnant women with chronic conditions or pregnant women of lesbian, gay, bisexual, queer, pansexual, and two Spirit (LGBQP2S) community.

Limitations

Other health care providers contribute to prenatal care. This study focused on nursing care, but studies could include other professionals, such as physicians, midwives, and gynecologists. The low number of articles included and the limited diversity of vulnerability contexts found in these articles support the need to validate the generated theoretical model through subsequent research. Other contexts (ie, cognitive or psychological) and situations (ie, domestic violence, victims of sexual assault, or legal problems) may deserve further attention, and some settings, such as prenatal classes, have scarcely been addressed. We do not purport our results to be transferable to other contexts of care, such as hospital and postnatal care settings.

CONCLUSION

This article proposes a theoretical model to be used by nurses to describe the experience of pregnant women in contexts of vulnerability. To promote a positive experience of prenatal care, nurses should fulfill pregnant women’s needs and expectations and favor a quality relationship, accounting for their contexts when providing care, providing quality information and support, and ensuring the accessibility, organization, and continuity of prenatal care. In so doing, nurses can help ensure that women in contexts of vulnerability foster utilization of prenatal care and reap its benefits.
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