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15. Using evidence from qualitative research to develop WHO guidelines

15.1 Introduction

Clinical, health system and public health guidelines are increasingly required to be based on the best available evidence. However, there is growing recognition that guideline questions sometimes fail to reflect the priorities of key stakeholders and that issues related to the acceptability and feasibility of interventions are not always addressed through a systematic review of the best available evidence when making recommendations, and when adapting recommendations for local use.

Qualitative research explores how people perceive and experience the world around them. Qualitative researchers typically rely on interviews, documents or observation to explore people's perceptions and experiences in connection with their health and with the use of health-care services. They then explore the data by means of qualitative analysis methods and present their findings narratively rather than through numbers.

Using qualitative research to inform guideline development has become easier in recent years as systematic reviews of qualitative studies, sometimes called qualitative evidence syntheses, have become more common and the methods involved in performing these reviews are now well developed *(1,2,3)*. It is therefore relevant to consider how WHO can incorporate evidence from qualitative research into guideline development and implementation, to complement evidence on the effectiveness and harms of interventions and on resource use.

Evidence from qualitative research can be used to assess: (i) the extent to which the potential benefits or harms of an intervention are important to people (the relative importance of the outcomes); (ii) the extent to which certain interventions are more or less acceptable to different stakeholders (patients, care givers, health-care providers, etc.); (iii) the extent to which different interventions are more or less feasible to implement in different settings, based on people's practical or day-to-day experiences with health-care services; and (iv) the potential consequences of different interventions on equity across populations. This chapter describes why and when evidence from qualitative research should be used in developing guidelines at WHO and briefly outlines the methods involved.

Chapter 10 of the *WHO Handbook for guideline development (2nd Edition) (4)* states that '…values and preferences pertain to the relative importance people assign to the outcomes associated with the intervention or exposure; they have nothing to do with what people think about the intervention itself'. We now regard this approach as too narrow as values may also be important when assessing the acceptability of an intervention and its consequences on equity. This chapter therefore describes the use of qualitative evidence for understanding people's values regarding outcomes (i.e. the extent to which the potential benefits or harms of an intervention are important to people) as well as for understanding the acceptability and feasibility of an intervention and its effects on equity.

15.2 When should evidence from qualitative research be used in developing a guideline?

15.2.1 When defining the scope of a guideline

Evidence from qualitative research can be used to help establish the scope of a guideline and to ensure that all topics that are relevant to its stakeholders and overarching goal are considered (see examples in Box 1).

Box 1. Hypothetical examples of the use of qualitative research to define the scope of a guideline

Example 1.1. For a guideline on intrapartum care in low- and middle-income countries, the guideline development group initially focused on clinical interventions for improving maternal and neonatal health, such as the use of vacuum extraction and caesarean section. However, an assessment of the qualitative evidence revealed that women often fail to seek intrapartum care because of lack of knowledge, lack of transport, or bad experiences with health-care facilities in the past. After considering these issues, the guideline development group expanded the scope of the guideline to include interventions for improving women's access to and use of health-care facilities.

Example 1.2. For a clinical guideline on interventions for specific types of lung cancer, the guideline development group initially focused on allopathic interventions. An assessment of the qualitative evidence revealed widespread interest in alternative medicine among people suffering from these cancers. The group therefore expanded the scope of the guideline to address questions about alternative treatments.

Evidence from qualitative research can also help to shape and clarify a guideline's key questions by informing the populations, interventions, comparators and outcomes that each key question should focus on. For example, people differ in their views on the comparisons that would be most useful to them in making health-related decisions (see examples in Box 2). Although the individuals involved in developing a guideline are generally familiar with its topic, their knowledge may be based on experiences in specific geographic or clinical settings or with particular population groups. By allowing a holistic approach to a research question, qualitative research can offer broader insights into the range of individuals, besides its sufferers, who experience the effects of an illness and into ways to define and deliver an intervention or intervention package.

Box 2. Hypothetical examples of the use of qualitative research to clarify the key questions addressed by a guideline

Example 2.1. For a guideline on dementia care, the guideline development group initially focused on interventions directed at people with dementia. However, qualitative research highlighted that dementia also affects the family members and carers of dementia sufferers in important ways. Accordingly, the group decided to expand the population of interest to include these groups.

Example 2.2. For a guideline on encouraging people to exercise by walking to work, the guideline development group initially decided to use 'no intervention' as the comparator. However, qualitative research showed that many people are interested in exercising at work. Thus, the group changed the comparator from 'no intervention' to interventions encouraging people to exercise at work.

Evidence from qualitative research may also shed light on how different stakeholders and population groups value different outcomes, be they clinical (e.g. reduction in pain or improved quality of life) or non-clinical (e.g. resource use, hospital utilization and satisfaction with care). In other words, qualitative research can be used to assess the extent to which the potential benefits or harms of an intervention are important to people. For instance, a policy-maker may be primarily concerned about the cost of an intervention, whereas a patient is more likely to be interested in pain relief or the experience of care. Similarly, people of different ages often value the same health outcomes differently and patients may value outcomes differently from their healthcare providers.

15.2.2 When assessing the acceptability of interventions to key stakeholders

The acceptability of an intervention or option can be defined as the extent to which that intervention is considered to be reasonable among those receiving, delivering or affected by the intervention. An intervention or option being considered in a guideline may be more or less acceptable to different key stakeholders. This is because health service managers, health-care providers and health-care recipients view the same intervention or option from different perspectives, depending on their concerns and experiences, and they attach different values to its consequences. Data from qualitative research can provide valuable evidence on the acceptability of a given intervention or option, such as a specific treatment or a new technology or procedure, to health-care workers and patients (see example in Box 3). Qualitative research is well suited to providing this type of evidence because it explores people's views and experiences, the issues underlying them, and how these are shaped by contextual factors, such as where and how an intervention is delivered and by whom.

Box. 3. Example of the use of qualitative research to understand a given intervention's acceptability to various key stakeholders

In a recent WHO guideline on optimizing health worker roles to improve access to key maternal and neonatal health interventions, systematic reviews of qualitative studies provided data on the acceptability to stakeholders (including patients and health-care professionals) of lay (or community) health workers who provide continuous support during labour in the presence of a skilled birth attendant. The systematic reviews showed that mothers appreciated this support and that midwives found lay health workers helpful in reducing their workloads. Midwives also acknowledged lay health workers' skills in communicating with mothers, although some disliked the involvement of other providers in the emotional support of the mother during labour because they felt that it changed the relationship between mother and midwife by shifting it in a more medical direction. This sometimes led to "turf battles" between the midwives and the lay health workers *(5,6,7)*.

In developing a guideline, evidence from qualitative research on the acceptability of an intervention or option may need to be gathered for a variety of stakeholders, depending on the intervention or option. For instance, for a guideline question on a clinical intervention, the key stakeholders may be the recipients of care as well as health-care providers. For a guideline

question on a health system or public health intervention, the key stakeholders may include not only the recipients of care and health-care providers, but also health service managers and the wider public. The WHO guideline steering group will need to identify, together with the guideline development group, the key stakeholders for a particular guideline.

15.2.3 When assessing the feasibility of interventions or options

The feasibility of an intervention or option being considered in a guideline is the likelihood that it can be properly carried out or implemented in a given context. Feasibility is influenced by the nature of the intervention itself; the human and other material resources required to deliver it; the recipients of the intervention and other stakeholders; the characteristics of the health system; and social, political and other contextual factors *(8)*. Data from qualitative research can provide valuable evidence on the feasibility of implementing specific interventions or options. They can, for instance, reveal whether patients feel they can self-administer a treatment or whether health-care managers can implement a new funding strategy for a health service (see example in Box 4). Again, qualitative research is well suited to providing this type of evidence because the method makes it possible to explore the range of factors that determine whether or not an intervention or option can be successfully implemented and how these factors are shaped by context.

Box 4. Example of the use of qualitative research to determine the feasibility of implementing an intervention

The WHO guideline "Optimizing health worker roles to improve access to key maternal and newborn health interventions" considered whether midwives should perform vasectomy to improve access to this procedure. A systematic review of qualitative studies conducted during guideline development showed that ongoing support, training and supervision were often insufficient in midwife task shifting programmes and that referral systems were frequently weak *(7)*. Another systematic review of country case studies revealed that issues related to governance, financing and delivery, including problems with supervision and support, stood in the way of scaling up task shifting programmes *(9)*. These factors may undermine the feasibility of implementing this intervention within routine health services. The final guideline notes that training and regular supervision are needed for this type of task shifting, and that adequate referral to a higher level of care for further management may be necessary *(5)*.

15.2.4 When identifying the contextual factors to be considered in the course of implementing a guideline's recommendations

The recommendations in a WHO guideline are usually intended to be globally applicable. Nonetheless, decision makers at the national or sub-national level will need to adapt these recommendations to their specific contexts and health systems. The process of translating a recommendation into practice can be challenging and is often unsystematic *(10)*. Thus, a guideline should ideally indicate the specific factors that national or local decision-makers need to consider before implementing each recommendation. These may have to do with the health-care recipients, health-care providers, health-care managers, health-care delivery organizations or the general population of the target area, or with the wider health system. For example, a recommendation may call for specific health system requirements to be in place or for the involvement of particular stakeholders, such as carers or professional organizations.

Qualitative research can provide important information on implementation considerations, i.e. factors that may influence, or be important for, the implementation of an intervention or option in different settings (see example in Box 5). Where the WHO guideline steering group has already used evidence from qualitative research to assess the acceptability and feasibility of specific interventions, this evidence can also be used to formulate implementation considerations. This may involve the WHO guideline steering group taking the findings from systematic reviews of qualitative studies regarding the acceptability and feasibility of an intervention or option, considering the implications of these findings for implementation of the intervention or option, and then using this information to formulate implementation considerations.

15.2.5 When exploring the effects of different interventions on equity

All WHO guidelines need to consider equity issues *(4)*. Evidence from qualitative research may be helpful when exploring the potential effects of different interventions on equity across populations.

Qualitative research may be helpful in formulating the scope of a guideline and deciding on the interventions that are included as such research may indicate that particular socio-economic, ethnic or age groups, for instance, experience health-related interventions differently from others or have different views on the relative importance of various health out-

Box 5. Example of the use of qualitative research to identify implementation considerations for a guideline recommendation

In the WHO guideline on optimizing health worker roles to improve access to key maternal and newborn health interventions, systematic reviews of qualitative studies provided evidence on the acceptability and feasibility of the recommended interventions. The systematic review team also used this evidence to develop a list of the contextual factors to be considered when implementing each intervention. For instance, the guideline recommended that lay health workers promote specific health-related behaviours and the uptake of services in reproductive and sexual health, including maternal, HIV, family planning and neonatal care. However, it simultaneously called for attention to the following points *(5):*

- As for any other service, health promotion activities need to be perceived by both lay health workers and recipients of care as relevant and meaningful. Lay health workers may be more motivated if their tasks include curative tasks in addition to health promotion tasks. Promotional services should be designed in such a way that they are not perceived as offensive to recipients. Local beliefs and practical circumstances related to the health conditions in question should be addressed within the design of the programme.
- Lay health workers from the same community may be particularly acceptable to recipients of care. However, certain topics, including sexual and reproductive health, may be sensitive and confidentiality may therefore be a concern, particularly where providers are from the same local communities as recipients. Both the selection of lay health workers and their training need to take these issues into consideration.
- Responsibility for supervision needs to be clear and supervision needs to be regular and supportive.

comes. For example, interventions directed at women during pregnancy and childbirth may be inaccessible or perceived to be inappropriate by migrant women for financial, legal or social reasons, while other interventions may be seen as more suitable. This information can help to guide the key questions addressed by a guideline.

Qualitative research may also be helpful when recommendations are formulated as such research may reveal differences in the acceptability and feasibility of interventions across different populations. For example, older people may have more concerns about their ability to access health information that is delivered online, compared to younger people, and they may prefer other modes of delivery, such as one-to-one interactions with healthcare providers. Such differences in the acceptability of interventions might be an important consideration as the guideline development group formulates recommendations.

15.3 Methods for including evidence from qualitative research in WHO guidelines

The level of rigour that WHO guideline steering groups can choose to adopt when using evidence from qualitative research to inform the scope of a guideline varies. If no suitable systematic review of qualitative studies is available, the group may wish to prepare its own systematic review or to follow a less rigorous approach, such as identifying and assessing a few key relevant qualitative studies. However, when attempting to answer specific questions regarding an intervention's acceptability or feasibility, systematic review teams should retrieve, synthesize and assess the qualitative evidence with the same rigour that they would apply when examining intervention effectiveness or harms. Methods for conducting systematic reviews of qualitative data have developed rapidly over the last decade and are now well established *(1,2,3,11)*. The sections that follow explain the key steps involved in undertaking a systematic review of qualitative data.

15.3.1 Formulate the question

As with any systematic review, formulating the question is a critical part of the process. With the help of the guideline development group, the WHO guideline steering group should identify the acceptability and feasibility questions surrounding each guideline and use them to formulate a question or questions for the systematic review. Guidance on formulating such questions is available from several sources *(1,12,13)*.

15.3.2 Retrieve the evidence

Once the key questions have been formulated, the next step is to identify whether they have already been addressed by existing systematic reviews of qualitative studies. If a well-conducted and up-to-date systematic review cannot be identified, the WHO guideline steering group will need to consider conducting or commissioning a new review to address the guideline questions. As with other types of systematic reviews, a protocol will need to be written and a search strategy developed to identify and retrieve relevant evidence. The Cochrane Qualitative and Implementation Methods Group has published guidance on how and where to search for qualitative studies *(14)*.

15.3.3 Synthesize the evidence

A wide range of approaches to evidence synthesis is available for systematic reviews of qualitative studies. These reviews tend to take an iterative approach to the sampling, extraction and synthesis of qualitative data. To some extent, this differs from the more linear processes underlying systematic reviews of intervention effectiveness. The choice of synthesis method should be informed by *(15):*

- the nature or focus of the key question;
- the type of qualitative evidence identified – e.g. whether it is largely descriptive or whether a theoretical or conceptual framework has been used to organize and interpret the evidence;
- whether a theoretical framework or model for the issue or phenomenon to be explored by the systematic review already exists and can be used to guide the evidence synthesis or, if not, whether it needs to be developed as part of the analysis process; and
- the expertise of the systematic review team and the available resources.

Several texts provide guidance on the methods used to synthesize the evidence from qualitative research *(2,3,15)*.

15.3.4 Assess the level of confidence in the evidence

The CERQual Group (Confidence in the Evidence from Reviews of Qualitative research), which is a subgroup of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group, is currently developing an approach for assessing how confident we can be in the findings from systematic reviews of qualitative studies. This tool corresponds to the GRADE framework used by systematic review authors to inform guideline development groups as to how much confidence to have in the results reported in systematic reviews of studies on the effectiveness and harms of interventions *(4)*. The CERQual approach is still under development but is being piloted in several WHO guidelines *(5)*.

When using the CERQual approach, systematic review authors assess their level of confidence in each of the findings of a systematic review of qualitative studies and report this confidence as being high, moderate, low or very low. This is done through an assessment of each finding in terms of methodological limitations, relevance, coherence, and adequacy of the data *(16)*. This is comparable to the GRADE approach, which systematic review

authors use to assess the level of confidence in – or the certainty of – the estimates of effect for each critical and important outcome by evaluating risk of bias, directness, inconsistency, imprecision and publication bias. For qualitative studies, methodological limitations are assessed with a quality appraisal tool for qualitative studies, such as the Critical Appraisal Skills Programme (CASP) tool *(17)*.

A Summary of Qualitative Findings table can be used to summarize the key findings from a systematic review of qualitative studies and the level of confidence in the evidence supporting each finding, as assessed using the CERQual approach. This table should also explain how the CERQual assessment was conducted. Even in the absence of a CERQual assessment, a summary table of this kind should be developed because it greatly facilitates the use of qualitative review findings in developing guidelines. For illustrative purposes, Table 1 presents an excerpt from a table that summarizes the findings from a systematic review of qualitative studies on the facilitators and barriers to facility-based delivery in low- and middle-income countries.

Table 1. Example of a Summary of Qualitative Findings table

Review findings	Contributing studies	Confidence in the evidence	Explanation of the confidence in the evidence assessment
Refusal to provide pain relief Across multiple settings, women described health workers' refusal to provide pain relief or pain medication not being available for them during labor. Surgical procedures, such as episiotomy, were sometimes carried out without any pain relief. In lower-resource settings, this was often due to stock outs or lack of sufficient patient payment. In higher-resource settings, women reported that they were not offered pain relief or were denied pain relief when they requested it.	[13,21,58,68,75,77,80,81,90 ,92,93]	High	11 studies with minor to moderate methodological limitations. Thick data from 9 countries across multiple geographical regions and country income levels. High coherence.
Judgmental or accusatory comments Women reported feeling shamed by health workers who made inappropriate comments to them regarding their sexual activity. Insensitive comments may be experienced more frequently by adolescent or unmarried women, since many communities view pregnancy and childbirth as appropriate only in the context of marital relationships. Intentionally lewd comments humiliated the women while they were in an already vulnerable position during childbirth and in need of supportive care. As a result, women often felt that their health provider was disrespectful, uncaring, and rude.	[10,13,55,58,59,73,77,80,87,91]	Moderate	10 studies with minor to significant methodological limitations. Fairly thick data from 8 countries, predominantly low-income countries. High coherence.
Lack of privacy Women across many settings reported a general lack of privacy in the antenatal and labor wards and specifically during vaginal and abdominal exams. Women were exposed to other patients, their families, and health workers due to the lack of curtains to separate them from other patients, the lack of curtains on the outside windows, and doors that were left open. In low- and middle-income countries, the antenatal and labor/delivery wards were sometimes common or public areas, and women were sometimes forced to share beds with other parturient women who may be strangers. Women expressed their desire to be shielded from other patients, male visitors, and staff who were not attending them while they were in labor and particularly during physical exams. They felt that such exposure, particularly during this vulnerable time, was undignified, inhumane, and shameful.	[11,21,49,53,54,58,70,74,75, 84,95,96]	High	12 studies with minor to significant methodological limitations. Thick data from 11 countries across all geographical and income-level settings. High coherence.

Review findings	Contributing studies	Confidence in the evidence	Explanation of the confidence in the evidence assessment
Denial or lack of birth companions Women desired the supportive attention and presence of a birth companion, who may be a family member, husband, or a friend. However, women across the world were often prohibited from having a companion of their choice during delivery. Although not always clearly explained to clients, it was often official hospital policy to ban birth companions, as they were deemed unnecessary by the administration. The lack of companionship left women feeling disempowered, frightened, and alone during childbirth as they yearned for the comfort provided by familiar faces.	[6,9,21,48–50,54,66,72, 75,78,90]	Moderate	12 studies with minor to significant methodological limitations. Fairly thick data from 9 countries across many regions, but predominantly middle-income settings. High coherence.
Detainment in facilities Some women reported that a new mother or baby may be detained in a health facility, unable to leave until they pay the hospital bills.	[73,90]	Low	2 studies with moderate methodological limitations. Fairly thin data from 2 countries (Benin and Sierra Leone). Extent of coherence unclear due to limited data, but findings were similar across the studies.

Reproduced from (*18*).

15.4 Using a structured framework to integrate evidence from qualitative research and other sources to inform the development of recommendations

Once the findings from qualitative research on the acceptability and feasibility of an intervention have been reviewed and summarized, the next step is to present this evidence alongside evidence on the intervention's benefits and harms, resource implications and implications for equity and human rights. Chapter 10 of the *WHO handbook for guideline development (4)* suggests using for this purpose decision tables in which the WHO guideline steering group lays out what is known about each factor (benefits and harms, acceptability, feasibility, etc.). Decision tables can then be used to record the guideline development group's judgments about each factor and how they contributed to the development of the recommendation. The example in Box 6 illustrates how evidence from qualitative research informed one specific WHO recommendation. Table 2, taken from the same guideline, shows how this qualitative evidence was presented to the guideline development group as part of a decision table.

When populating decision tables, WHO guideline steering groups will find that the Summary of Qualitative Findings tables are good sources of information as these provide short summaries of each finding as well as an assessment of our confidence in these findings.

Box 6. Example of the use of a structured framework to integrate evidence from qualitative studies and other types of evidence during the guideline development process

In the WHO guideline on optimizing health worker roles to improve access to key maternal and newborn health interventions *(5)*, the guideline development group used the DECIDE (Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence) framework *(19)* to present different types of evidence to the guideline development group. The systematic review teams prepared:

- systematic reviews of randomized controlled trials to provide information on the effectiveness and harms of each intervention examined by the guideline; and
- systematic reviews of qualitative studies to provide information regarding the acceptability and feasibility of these interventions.

One of the interventions covered by the guideline was the use of midwives to perform tubal ligation (i.e. surgical sterilization) on women who had just given birth. The effectiveness data showed a similar rate of complications for doctors and midwives, although the certainty of this evidence was graded as low. The qualitative syntheses also suggested that being "upskilled" was motivating for midwives and linked to higher status, promotion and job satisfaction (evidence of moderate confidence). On the other hand, some were unwilling to take on tasks beyond obstetric care because they did not view these as part of their role and were afraid these tasks would increase their workload (evidence of moderate confidence). The review also identified the potential for "turf battles" between doctors and midwives over their respective clinical roles (evidence of moderate confidence) *(6,7)*.

The guideline development group decided to recommend the use of midwives to perform tubal ligation only in the context of rigorous research. It justified this decision by stating that the intervention may be effective and may reduce inequalities by extending care to underserved populations, but that some uncertainty surrounds its acceptability and feasibility. Hence, the group recommended additional research.

Table 2. Example of the use of evidence from systematic reviews of qualitative studies in a decision table used to assist a guideline group to formulate a recommendation

Evidence to decision framework – health systems recommendation

Should midwives perform tubal ligation (postpartum and interval)?

Problem: Poor access to contraception options ***Intervention:*** Midwives performing tubal ligation ***Comparison:*** Care delivered by other cadres or no care ***Main outcomes:*** Length of surgery; complications during surgery; postoperative morbidity ***Setting:*** Community primary health-care settings in low- and middle-income countries with poor access to health professionals ***Perspective:*** Health system	***Background:*** A more rational distribution of tasks and responsibilities among cadres of health workers is seen as a promising strategy for improving access within health systems. For example, access to care may be improved by training and enabling "mid-level'" health workers to perform specific interventions that might otherwise be provided only by cadres with longer (and sometimes more specialized) training. Such task shifting strategies might be particularly attractive to countries that lack the means to improve access to care, including contraceptive care, within short periods of time.

Subgroup considerations: none specified

	Criteria	Judgements	Research evidence	Additional considerations
ACCEPTABILITY	Is the option acceptable to key stakeholders?	Uncertain ☑ Varies ☐ No ☐ Probably no ☐ Probably yes ☐ Yes ☐ Detailed judgments	A systematic review of task shifting in midwifery programmes (7) did not identify any studies that evaluated the acceptability of tubal ligation when performed by midwives. We are therefore uncertain about the acceptability of this intervention to key stakeholders. Indirect evidence: For other interventions delivered by midwives, the same review suggests the following: • Midwives and their supervisors and trainers generally felt that midwives had no difficulty learning new medical information and practising new clinical procedures (moderate confidence). Midwives may also be motivated by being "upskilled" because this often brings improved status, opportunities for promotion and greater job satisfaction (moderate confidence). • Midwives may be unwilling to take on tasks beyond obstetric care, such as in family planning and sexual health, because they do not feel it is part of their role and they fear having an increased workload (moderate confidence). • Some doctors are skeptical about extending the role of midwives in obstetric care, although those who worked closely with midwives tended to have more positive attitudes towards them (low confidence). Lack of clarity in the roles and responsibilities of midwives and other health worker cadres, as well as differences in status and power, may also lead to poor working relationships and "turf battles" (moderate confidence). A review of country case studies on task shifting for family planning (5), which primarily included lay health worker programmes, suggests that women appreciate having female health workers deliver their contraceptives. However, the review also suggests that some health workers apply their own criteria, often based on a woman's age and marital status, to determine who should receive contraceptives. Other factors that may affect the uptake of the intervention have to do mainly with the contraceptives themselves rather than the types of health workers involved. Some examples are a lack of familiarity with the different methods of contraception, religious beliefs and other cultural notions surrounding family planning, a fear of side effects; service fees, and a lack of support from husbands. Source: (5,7)	

	Criteria	Judgements	Research evidence	Additional considerations
FEASIBILITY	Is the option feasible to implement?	Uncertain ☑ Varies ☐ No ☐ Probably no ☐ Probably yes ☐ Yes ☐ Detailed judgments	The interventions require relatively well-equipped facilities, including access to surgical instruments, an operating room and resuscitation equipment. In addition, changes to norms or regulations may be needed to allow midwives to perform tubal ligation. Training and regular supervision are also needed, and adequate referral to a higher level of care for further management may be necessary. However, a systematic review (*7*) suggests that ongoing support, training and supervision were often insufficient in midwife task shifting programmes (moderate confidence). Source: (*7*).	

Adapted from (*5*), showing the acceptability and feasibility sections of the table only.

15.5 Conclusions

Evidence from qualitative research can contribute in a variety of ways to guideline development and implementation, and examples of this are increasingly frequent. For each and every guideline developed at WHO, the responsible technical officer and the guideline steering group need to consider how to use qualitative research to improve the quality and usability of guidelines and to take into account the needs of all stakeholders. The same principles for the identification, assessment and synthesis of quantitative evidence apply to qualitative data, and an explicit and transparent framework for translating evidence into recommendations is always required. However, the use of qualitative evidence calls for specific and unique methods and WHO staff need to ensure that the relevant expertise is commissioned in order to ensure a high-quality guideline.

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