

ORIGINAL RESEARCH ARTICLE

Barriers to Antenatal Care in an Urban Community in the Gambia: An In-depth Qualitative Interview Study

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Abstract

This qualitative study investigated the barriers to obtaining access to antenatal care in a small, urban government-supported health centre in the Gambia. It thus addresses an important issue related to maternal health and the prevention of maternal deaths. In-depth interviews were conducted with 25 pregnant women, 13 healthcare workers and 9 male partners. Three areas were identified for study: recognition and acknowledgment of pregnancy, recognition of the need for care and practical barriers to attendance. Intentional concealment of early pregnancy was common to avoid adverse social consequences or for fear that malign interventions would cause a miscarriage. In the absence of symptoms many women considered it unnecessary to attend the antenatal clinic until well into the second trimester. Practical barriers to attendance included conflicting domestic demands and the attitude of some healthcare workers. Access to antenatal care in the Gambia throughout pregnancy should be considered in a stepwise fashion and barriers to care were identified at each stage. Interviews with male partners and health workers highlighted their key role. (*Afr J Reprod Health* 2017; 21[3]:62-69).

Keywords: Access, antenatal care, health services, qualitative, Gambia, Africa

Résumé

Cette étude qualitative a étudié les obstacles à l'accès aux soins prénatals dans un petit centre de santé soutenu par le gouvernement urbain en Gambie. Il aborde ainsi une question importante liée à la santé maternelle et à la prévention des décès maternels. Des entretiens approfondis ont été réalisés avec 25 femmes enceintes, 13 agents de santé et 9 partenaires masculins. Trois domaines ont été identifiés pour l'étude: l'identification et la reconnaissance de la grossesse, la reconnaissance du besoin de soins et des obstacles pratiques à la fréquentation. La dissimulation intentionnelle de la grossesse précoce était fréquente pour éviter les conséquences sociales négatives ou pour craindre que des interventions malignes ne causent une fausse couche. En l'absence de symptômes, de nombreuses femmes ont jugé inutile de fréquenter la clinique prénatale jusqu'à bien au deuxième trimestre. Les obstacles pratiques à la participation comprenaient des demandes intérieures contradictoires et l'attitude de certains agents de santé. L'accès aux soins prénatals en Gambie tout au long de la grossesse doit être pris en compte par étapes et les barrières aux soins ont été identifiées à chaque étape. Les entretiens avec des partenaires masculins et des agents de santé ont souligné leur rôle clé. (*Afr J Reprod Health* 2017; 21[3]:62-69).

Mots-clés: Accès, soins prénatals, services de santé, qualitative, Gambie, Afrique

Introduction

Maternal deaths and adverse birth outcomes remain a major cause of morbidity and mortality across sub-Saharan Africa (SSA). In the Gambia, West Africa, the maternal mortality rate is estimated to be 360 deaths per 100,000 pregnancies^{1,2}. Antenatal care is key to ensuring women receive appropriate treatment and counselling during pregnancy, and significant benefits are likely to occur from

interventions for malaria, anaemia and HIV^{2, 3}. Nonetheless, fewer than 30% of women in Africa attend an antenatal clinic during their first trimester and many have no contact throughout pregnancy, typically presenting only in the event of an acute crisis^{2,4}.

Pregnancy in sub-Saharan Africa is recognized to be a time of great vulnerability, with women reporting feelings of insecurity and fear of dying⁵. Socioeconomic and cultural reasons have

been advanced to explain variation in antenatal attendance. Previous research from a rural area of the Gambia has reported that the preference of women was for concealment for as long as possible, the reasons given being concern about gossip, adverse social consequences and fear of malign intervention⁶.

Throughout sub-Saharan Africa, in addition to social taboos, there is evidence that women are unsure of the purpose behind antenatal care⁷, probably due to a belief that childbearing represents a normal 'bodily experience' rather than an illness⁸. Practical barriers to using antenatal care include remoteness from treatment facilities and costs⁹⁻¹¹, a belief that attendance is necessary to obtain a document that permits delivery within the hospital⁸, and the attitude of health professionals¹²⁻¹⁵.

The barriers to antenatal care remain unstudied in an urban context. Women in urban areas of the Gambia have good access to health facilities and hospitals where antenatal care is readily available. Some health information is provided via education programmes. The aim of the study was to explore the attitudes of pregnant women, their male partners and key informants towards antenatal services and to identify barriers associated with access.

Methods

This qualitative study was conducted in a small urban government-supported health centre in the Gambia, a few miles from the capital Banjul. The health centre opened for 24 hour care in 2009 and now has approximately 600 women a year using the antenatal services. Less than one third of women attending the antenatal clinic (ANC) present during the first trimester, with the majority presenting much later in their pregnancy.

Study design and sampling technique

In-depth interviews relating to current and previous pregnancies were conducted using a semi-structured topic guide with 25 pregnant women (W), 9 male partners (M) and 13 key informants and healthcare workers (KI) (8 male, 5 female). The study was conducted in 2013 with further interviews carried out in 2016.

Pilot interviews with the interpreter were undertaken to ensure that questions were culturally appropriate, and open so that participants could report issues not anticipated by the researchers. For pregnant women (and, if willing, her male partner) a maximum diversity population was sought to include women with a range of demographic characteristics such as early and late antenatal attendance, age, parity and ethnic background. The women were nearly all married, with just four women single or with a partner but unmarried. The majority of the marriages were monogamous, and all but five of the women had some level of education. Exclusion criteria were temporary residency, age under sixteen, multiple pregnancy or serious complications.

The key informants were chosen carefully to represent a wide diversity of health care workers, and included a Marabout (traditional healer). All participants received information sheets and were invited to ask questions before giving written consent. Recruitment ended when theoretical saturation was achieved and no new ideas or explanations were elicited from additional interviews.

Data collection

Interview length ranged from 45-60 minutes. Interviews were conducted in a private room at the health centre or in participants' homes or place of work. Interviews were undertaken in English (SS and HS for female participants and KR and HS for male partners and health care workers) and translated when necessary into local languages (Mandinka, Wolof or Fula) by a field support worker. All interviews were audio-recorded and manually transcribed immediately, clarifying any indiscernible portions with the original interpreter. Following each interview a reflective log was compiled to note emergent themes for exploration with future participants.

Data analysis

Interviews were examined using Applied Thematic Analysis¹⁶. Through this iterative process, emergent themes were identified and documented using Word software. Overarching themes were then placed into

the appropriate stage of the pathway to accessing healthcare.

Results

Three areas were considered for in-depth study: Recognition and acknowledgment of pregnancy, recognition of need for care during pregnancy and practical barriers to attendance.

Recognition and acknowledgment of pregnancy

Signs and symptoms of pregnancy were widely known and most, although not all, women considered a missed menstrual period to be confirmation of pregnancy. Women frequently reported that they disclosed their pregnancy to their husband first and then to female relatives. This appeared to be more complex within polygamous families where relationships between wives could be particularly close.

“I get experience from the first one (pregnancy) and when this time I don’t see my period of one month only, I wait for the second one, still I don’t see my period. I asked my husband then, I am pregnant, I’m going to go and join (the antenatal clinic)” (W3)

Male partners also recognised that missing a menstrual period was a sign of pregnancy, and for some male partners, it was an event that apparently warranted attending the health centre to confirm pregnancy:

“She told me that she missed her period. Then I said then we should go to the hospital where you can have some pregnancy test.” (M5)

Despite women usually being aware of their pregnancy, their willingness to disclose their pregnancy was contingent on many socio-cultural factors, and concealment of pregnancy was common and intentional. There were two main reasons for this: shame of social consequences or fear of evil spirits. Concealment was stated to be common among very young or unmarried women due to shame. This taboo was a major influence on ANC attendance. Indeed, all participants mentioned this

as one reason women attend late or not at all. The Gambia is a predominately Muslim country and extra-marital relationships and pregnancies were cited as impermissible under Muslim law. What is more, they were considered to be hugely disrespectful to one’s own family.

“So maybe that’s the reason they hide it [single parent pregnancy]. Because of their parents and they are not married. You know it’s not something legal here in Gambia” (W11)

This shame was not limited to women. One male partner described children born from extra-marital relationships being excluded from society and even abandoned by their families. Pejorative terms were also used to label such children: for instance, as *“idiots” (M4)* and *“illegitimate child” (M4)*.

As a result of these taboos, it was stated that some women resort to termination of their pregnancy or choose to disengage completely from antenatal services. Another vulnerable group of women who also concealed their pregnancy for fear of the social consequences, identified by many key informant interviews, were older pregnant women with married daughters, who were ashamed of attending the clinic for fear of meeting pregnant women who were their daughter’s peers.

“Maybe the daughter is grown up and the daughter is also married, having kids. They will say that the daughter is having kids; still the mother is having kids. That one also will make the mother to feel shy” (K13)

A second reason cited for concealment was the perception that miscarriage could be the result of malignant intervention. Disclosure of pregnancy during the first trimester was reported to be *“dangerous”* by many women due to the risk of harm from what were called *“bad people”* *“witches”* and *“enemies”*. Such spiritual manipulation was said to cause the pregnancy to *“drop down”*, meaning miscarry.

“Yes, you can hide yourself, to maybe to protect yourself until maybe you’re three to four months. But if you are one month, you try to show out

yourself, you can get punishment from bad people.”
(W10)

This deep superstitious belief was reported to hold a big influence over the lives of many women and their partners. On numerous occasions the male partners explained how women would “hide” or “tie” their pregnancies throughout the first trimester in order to avoid disclosing it to the wider community. This was to protect themselves from ‘evil people’ who were believed to possess the power to adversely affect a pregnancy and its outcomes. This would lead to women staying at home for the first three months of pregnancy, hence delaying ANC attendance.

“You can do black power to destroy the pregnancy. I never see it but I heard from people so that’s why me I don’t inform anybody about my wife’s pregnancy”
(M2)

Not one of the women volunteered that miscarriage could be a natural or inevitable outcome in pregnancy.

Recognition of need for care during pregnancy

Although educational levels varied greatly amongst the women interviewed, all understood that antenatal services were important to ensure a healthy pregnancy.

“We are blind people. We don’t know anything about pregnancy and we don’t know anything about clinic. But ...what I know is, if I am sick, or if I am pregnant, I report myself and they (midwives) check me, they advise me and they give me medicines”
(W3)

However, the identification and, importantly, the acknowledgement of pregnancy was not necessarily an indication for early attendance at the antenatal clinic. Attendance during early stages of pregnancy was frequently associated with experiencing symptoms that were unfamiliar or particularly severe, for example, excessive vomiting, severe abdominal pain or symptoms attributed to concurrent malaria infection.

Many participants reported that women without severe symptoms would wait before attending antenatal care, and when they did present it was with the general complaint “*I am sick*” suggesting that they felt a need to present with abnormal symptoms before approaching the health service in order to receive care. This contrasted with the notion that all women should attend for antenatal care early, even with asymptomatic pregnancies. Central to this appeared to be a need to be as certain as possible that she was indeed pregnant:

“She want to see those symptoms that she experienced at pregnancy, she wanted to be sure herself before she come to the clinic. If not she will come after she have seen those symptoms yes she’s pregnant, she will come for confirmation” (M7)

Pregnant women also described turning to a range of services during pregnancy, of which formal antenatal care was only occasionally their first choice. These included traditional healers, typically in the form of Marabouts who could be approached for “juju” or spiritual protection. This was manifest in the form of talismans worn by women to protect their pregnancy against witchcraft. Also used were herbal medicines that were preferred for their improved taste and cultural value, having been used by participants’ “forefathers”. These appeared to be taken as primary prevention, for example certain herbal medicines were reported to promote physical health in pregnancy:

“It’s like potato leaf, but they are different. You take it and you dry it, you wash it, you boil it, you drink... it helps your blood, increase your blood
(W13)”

In this urban context, traditional African beliefs frequently existed side-by-side with biomedical approaches to treatment and many women described using traditional treatments alongside biomedicine with no sense of inconsistency or conflict. This blending of traditional and biomedical was also apparent within the services accessed, for example certain Marabouts were reported to actively encourage pregnant women to access formal antenatal services. One key informant described a

constant struggle to try and convince people to use modern medicine over traditional forms:

“So I think they may have the awareness but we are competing with these people, you know they go to the radio and advertise so they think they are authentic. So they just take us as an alternative option. So we are competing with them, but sometimes they are ahead of us.” (K14)

Pharmacies were accessed when medication was not available at the antenatal clinic or when symptoms were not considered severe enough to attend clinic. However, it was recognized that the antenatal clinic enabled women to benefit from a full consultation and not just the prescribing of medication:

“I think the hospital is best because they check you before giving you medicine” (W13)
“If the hospital clinic doesn’t have it (medicines), you can go and buy it from the pharmacy. But the pharmacy, those people they just sell” (W14)

The responses from the healthcare workers were different. Healthcare workers reported that women did not attend for antenatal care because of “carelessness” (K17) and “negligence” (K13). When probed, this appeared to be a somewhat judgmental view of less educated women who did not attend appointments due to their lack of knowledge of pregnancy and the value of antenatal care. These assumptions appeared to reflect healthcare workers’ attitudes towards low socio-economic status and lack of education that were conflated into accounting for poor antenatal attendance through “ignorance”.

A solution to tackle this ignorance advocated by KIs was “sensitization”. Sensitization was mentioned extensively to describe health education programmes on television, radio and within health centres to increase awareness of pregnancy and the need for antenatal care amongst men and women. Many women were familiar with the health promotion messages delivered through the media and community sensitization programmes. However, on further enquiry it was found that they considered community-based discussions to be more effective as some women were not able to access the

necessary technology in order to receive the health promotion messages.

“If you are in a community and you come to join this sensitization, or the workshop, you know if any information you got there you can share with your relatives or family” (W15)

Practical barriers to attendance

Practical barriers to attendance included obtaining the permission of the husband or the head of the household, domestic difficulties, the correct documentation and the attitude of the health workers.

Confirmation of pregnancy and requirement of antenatal care were often ascertained independently by the women, and their determination to seek antenatal services was usually considered to override the practical barriers. None the less, most confirmed that they would not attend without their husband’s permission. Within polygamous households, decision-making was again deferred to the husband. However, the relationship between the wives and its implications on antenatal access was variable. One woman reported having a very close relationship with her husband’s second wife, whilst others reported that wives hardly interacted.

“Sometimes two of them make some arrangement without the husband. Whatever they decide, even the husband says no, two of them will be in one part, the husband has to do it” (W3)

One factor commonly considered to delay attendance was the inconvenience of attending multiple antenatal appointments. Some women found it difficult to prioritise antenatal care and consciously sought to delay attendance to prevent having to “come up and down”. Multiple journeys were reported to be strenuous and to inconvenience other essential activities, such as selling products to make money and undertaking household chores.

“Some of them, first in the morning, they take their things to go and sell in the village. After selling before twelve, whatever they get they will come and cook for the family. To stop that is a big problem to them” (W8)

The lack of appropriate documentation was another reason given. Every woman is given a Maternal Record Card at the first visit and having “no papers” was reported to be a reason why access could be delayed. Reasons for incorrect documentation were not elicited, other than a case where it was being held by the husband.

“if you don’t get any clinic card, you feel you don’t [want to] go to the health centre. Because if you go there, they will help you, but they ... might blame you” (W10)

Although some women considered transport as an impediment to accessing antenatal services, many women who were interviewed lived within walking distance of the health centre and did not feel it related to them. Associated costs of transport for those living further away were occasionally considered a limiting factor.

Once a woman had arrived at the clinic, access was reported to be relatively straightforward, although the attitudes of staff members were considered pivotal at this point. Bearing in mind that many of the key informants considered the women to be “ignorant” it is not surprising that the attitudes of staff members, once the woman was at the clinic, could influence the likelihood that she would attend for future appointments.

Overall, positive interactions with the health centre staff were reported to make the women more likely to return to the ANC not only in the present pregnancy but also in a future one.

Discussion

This qualitative study considered access to antenatal care in a stepwise fashion, enabling the identification of barriers at different stages. Previous reports from throughout sub-Saharan Africa have recognized some of these barriers, but a number of these studies have been quantitative surveys. It is interesting to note that when a structured questionnaire^{4,11,12,14,15} is used there is more emphasis on the practical barriers to attendance whereas the more open-ended, less-constrained approach with a qualitative study^{5,6-8,10} enables the identification of additional and more complex barriers.

During the first three months the barriers are almost

entirely identified by qualitative studies. In the Gambia the fear that malevolent people will activate evil spirits in order to cause abortion prevents acknowledgement of early pregnancies. Intentional concealment is also common in adolescent girls in order to avoid adverse social consequences^{6,7}. In this study it has been shown that older women, too, were sometimes ashamed of their pregnancies, especially those with married daughters who themselves might be pregnant.

Recognition of the need for care during pregnancy was identified by both the surveys and qualitative studies. The primary motivation for attending the ANC was the appearance of symptoms or events that were perceived as abnormal⁵. In addition the qualitative study reported here revealed more complex approaches to antenatal care. The conflict between religion and superstition was frequently mentioned and a transition from reliance on traditional healers towards western medicine was evident. Traditional African beliefs now exist side-by-side with biomedical approaches to treatment in the context of rapid urbanization. There appears to be no sense of inconsistency.

Most practical barriers to attendance were identified by both types of study. Although government supported health centres in the Gambia do not charge, the costs of care in other countries was regularly cited as a difficulty^{7,10,11,14}. Also cited were conflicting domestic demands, journey time and distance to the HC^{10,4,12}. In addition the qualitative studies reported many more instances of poor relationships with the health staff, shame or humiliation if the documentation was not in place⁷, and an overriding suspicion that they were perceived as poor and uneducated⁵. Positive interactions with the health centre staff were reported in the present study to make the women more likely to return to the ANC not only in the current pregnancy but also in a future one.

A previous study of barriers to early antenatal attendance, conducted in 2007 in a rural area of the Gambia allowed a comparison between urban and rural settings⁶. The groups interviewed were very different: most of the women in the rural study were in a polygamous marriage and poorly educated whereas the men interviewed were men of status. In this urban study most of the women were in a monogamous marriage and had some education.

The men interviewed were their husbands or partners.

Despite these differences, and despite the proximity of health centres and hospitals in the urban setting, many of the taboos and cultural constraints associated with concealment of an early pregnancy were the same in both communities. Fear of witchcraft and beliefs in supernatural forces were widespread in both the rural and the urban women and many wore talismans to prevent a miscarriage.

Pregnancy in both the rural and the urban communities was considered to be a normal condition and in both communities, women frequently presented early for care only if they had symptoms which were unfamiliar or severe. This urban study also revealed more complex approaches to antenatal care. In the urban setting most women were familiar with health education and health initiatives ('sensitization') and understood that antenatal services were important. However, this understanding did not necessarily translate into early attendance.

A qualitative study is ideal for a study such as this. It allows exploration of complex and personal themes beyond the constraints of a quantitative study. The women and their partners were usually interviewed in their own homes and there was no sense of rush, each interview lasting for between 45 minutes and an hour, whereas in the antenatal clinic women generally spend very little time with the midwife¹⁷. Interviews continued until there was a merging of consistent themes and no new themes were uncovered. The additional interviews conducted more recently confirmed all that had been reported before. There were different perspectives from each group interviewed.

There are also drawbacks to studies of this type. One limitation was that the data was only collected through interviews. In addition to improving the internal validity of the study design, using other methods such as focus groups or observation of the clinic workplace might have provided further information. Furthermore, the interviews were conducted by people who would be perceived to be part of the health centre staff and therefore not completely impartial. However, the emergence of the same themes suggests that it is unlikely that some of the interviewees were trying to say what was expected of them.

Conclusion

It is useful to consider antenatal care access in the Gambia in a stepwise fashion, recognising different barriers to care at different stages. It is only after a woman has recognised that she is pregnant, admitted it to others and recognised the need for antenatal care that she is ready to contemplate attending the antenatal services. The inclusion of interviews with male partners and health workers has highlighted the key role that others play in this process.

In this urban setting there appears to be little conflict between traditional and western medicine and the two co-exist without any sense of inconsistency. This study indicates that pregnant women in urban areas consider carefully their use of available health care and are well-informed about their options during pregnancy.

These findings have implications for antenatal care policy in the Gambia, and the need for further development of outreach programmes to engage pregnant women who are asymptomatic or belong to vulnerable demographic groups.

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Contribution to Authorship

SL, MC and HS conceptualised and planned the study. SS, KR, HS and SL conducted all field research; SS, KR and MC conducted data analysis; SL drafted the manuscript and MC, HS, SS and KR revised it. All authors read and approved the final manuscript.

Details of Ethics Approval

Ethical approval was received in the Gambia from the combined Ethics Committee of the Medical Research Council and the Gambian Government, and in the UK from Brighton and Sussex Medical School.

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