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Running head: PREGNANCY AND CHILDBIRTH IN THE GAMBIA

**WOMEN'S EXPERIENCES OF PREGNANCY, CHILDBIRTH AND THE
POSTNATAL PERIOD IN THE GAMBIA: A QUALITATIVE STUDY**

Citation

Sawyer, A., Ayers, S., Smith, H., Sidibeh, L., Nyan, O., & Dale, J. (2011). Women's experiences of pregnancy, childbirth, and the postnatal period in the Gambia: A qualitative study. *British Journal of Health Psychology*, 16(3), 528-541.

Abstract

Objective: In sub-Saharan African countries there are unique cultural factors and adverse physical conditions that contribute to women's experiences of pregnancy and birth. The objective of this study was to qualitatively explore women's experiences of pregnancy, childbirth, the postnatal period and maternal psychological distress in The Gambia. **Design and Methods:** Semi-structured interviews were carried out with 55 women who had given birth within the previous year. **Results:** Thematic analysis identified five themes: (1) childbirth as a rite of passage, (2) physical difficulties, (3) value of children in relation to others (4) children as a strain, and (5) going through it alone. The results suggest that having a child is a defining point in women's lives associated with happiness and delight. However, women also described situations which could lead to unhappiness and distress in the perinatal period. A child conceived out of wedlock or a baby girl can be sources of distress because of negative cultural perceptions. The strain of having a child, particularly the additional financial burden, and minimal support from men were also a concern for women. Finally, women recognised the danger associated with delivery and expressed recurrent worries of complications during childbirth which could result in the death of them or the baby. **Conclusions:** Further research is needed to identify women vulnerable to psychological distress so that health services and target interventions can be developed accordingly.

Pregnancy and the birth of a child are significant and challenging events in a woman's life, associated with considerable physical and psychological change. In developing countries the focus has understandably been on women's physical health and there has been comparatively little research exploring women's experiences of pregnancy and childbirth (Rodrigues, Patel, Jaswal, & de Souza, 2003). Qualitative studies in this area are invaluable as they allow an exploration of women's attitudes, perceptions, and emotions during pregnancy and childbirth in the context of women's lived experiences. For example in developing countries there are often unique cultural factors and adverse physical conditions that contribute to women's experiences.

In many low income countries pregnancy and childbirth are associated with a substantial risk to the life of the mother and child. The highest maternal mortality rates are found in sub-Saharan Africa where in some countries there is an estimated one in 16 lifetime risk of dying during pregnancy and childbirth (World Health Organization [WHO], 2004). It is also estimated that between 3% and 9% of pregnant women in West Africa experience severe maternal morbidity in pregnancy and labour, such as haemorrhage, obstructed labour, hypertensive disorders and sepsis (Pruhal, Bouvier, de Bernis, & Bréart 2000). Birth practices and traditions differ in developing countries from those observed in Western cultures. In some African regions many women do not use any health services during pregnancy; and there are high rates of deliveries at home and at mission houses, which are often overseen by traditional birth attendants (Adewuya, Fatoye, Ola, Ijaodola, & Ibiagami 2005).

There is substantial literature identifying the importance of children in sub-Saharan Africa for both men and women (Hollos & Larsen, 2008). The significance of having children is related to economic, cultural and spiritual factors (Inhorn & van Balen, 2002). For example, in a subsistence economy children are important in

providing a labour force and economic success has been shown to correlate with family size (Fortes, 1978). Childbearing also plays a central role in a woman's transition to adulthood, self-respect and honour (Donkor & Sandall, 2007; Fortes, 1978).

Recent evidence suggests that women in developing countries can experience mental health problems during the pre- and postnatal period (Oates et al., 2004). A review found that African women experience depression during pregnancy and after birth at a similar rate to that reported in developed countries (Sawyer, Ayers, & Smith, 2010). Most research which has investigated maternal mental health in sub-Saharan Africa has utilised "Western" quantitative measures, specifically questionnaires or diagnostic clinical interviews, which are based on the ICD-10 (WHO, 1992) or the DSM-IV (American Psychiatric Association, 1994). Although designed to reflect the presentation of mental health disorders cross-culturally they may be biased towards descriptions of psychiatric disorders in European and North American settings (Halbreich et al., 2007). Questionnaires or diagnostic interviews based on these criteria may be insensitive to symptoms of psychological distress reported in non-Western cultures (Halbreich & Karkun, 2006). For example in some sub-Saharan African cultures somatic symptoms may be manifestations of depression, which would not be picked up by commonly used measures of maternal mental health (Tomlinson, Swartz, Kruger, & Gureje, 2007). Qualitative research is therefore valuable in exploring women's mental health in developing countries as it avoids pre-conceived ideas of mental health.

The Gambia is one of the poorest countries in the world and has very high levels of maternal and infant mortality (WHO, 2004), yet there is no previous qualitative research exploring Gambian women's experiences of pregnancy and

childbirth. Furthermore only one study has examined maternal mental health in The Gambia. This was part of an epidemiological study on general reproductive health which found approximately 6% of Gambian women were depressed during pregnancy and after childbirth (Coleman et al., 2006). Further research is needed to identify the causes of distress so that social and clinical interventions can be targeted accordingly. Therefore this study sought to address the gap in the literature by conducting in depth interviews with Gambian women to explore their experiences of pregnancy, childbirth, the postnatal period and maternal psychological distress.

METHOD

Setting

The Gambia is a small, low-income country in West Africa with a population of approximately 1.48 million. Access to healthcare facilities is good, with over 85% of the population living within 3km of a primary healthcare or outreach health post. More than 90% of pregnant women receive antenatal care and about 50% of women give birth in a health facility (Anya, Hydara, & Jaiteh, 2008; Cham, Sundby, & Vangen, 2005). Women were recruited from the area of Old Jeshwang, an urban village in the Municipality of Kanifing. Kanifing is a city in the Western Division in The Gambia and has a population of 322,735. The official language is English but indigenous languages such as Mandinka, Wolof, and Fula are widely spoken. Religions are Islam (90%), Christianity (9%) and indigenous beliefs such as animism (1%).

Participants

Participants were eligible to take part in the study if they had given birth within

the previous 12 months. Fifty five women were recruited from Old Jeshwang Health Centre or the local community. Women were approached at antenatal and postnatal clinics, which run at the health centre twice weekly. The researcher attended both days and all attending women were approached. The researchers worked closely with a community member and head of a local women's group who helped identify potential participants in the community. All women who were approached agreed to be interviewed. Twenty women were recruited from the clinic and 35 from the community. Demographic and obstetric characteristics are given in Table 1. Compared to the Gambian population there was a higher proportion of Mandinka women and a slightly lower proportion of Fula, Wolof, and Jola women. Women in polygamous marriages were also underrepresented (Gambia Bureau of Statistics, 2003). Data collection ended when no new information emerged from the interviews and data saturation had been achieved.

- insert table 1 about here –

Materials

An interview schedule was designed consisting of 12 open-ended questions exploring women's experiences of pregnancy, birth, the postnatal period and maternal psychological distress (see Appendix). Gambian advisors (health care workers, university academics, and students) were consulted to ensure appropriateness of questions. A questionnaire was also verbally administered to obtain socio-demographic, obstetric and pregnancy characteristics.

Procedure

Ethical approval was obtained from ethics committees at the University of Sussex and The Gambia Government/Medical Research Council Laboratories. Three trained multilingual female research assistants from the University of The Gambia accompanied the principal investigator. We introduced ourselves as student researchers who were interested in women's experiences of pregnancy, childbirth, and the postnatal period. Interviews took approximately 30 minutes and took place either in the participant's compound or in a room at the health clinic. Prior to the interview the study was explained to all women in a language they could understand, and they were assured that participation was voluntary. Participants were asked to sign the consent form to indicate their participation (or a thumbprint if the woman could not sign). Interviews were conducted in the participant's first language and recorded with a tape recorder. Interviews in English were transcribed directly. Interviews in Mandinka, Wolof, Fula and Jola were translated into English and transcribed. The Gambian research assistants translated the interviews which were then transcribed English by AS. Any ambiguities or interesting points that arose were discussed. All data collected in the study were stored anonymously with identifying details removed.

Analysis

Qualitative analysis of the transcripts was performed using inductive thematic analysis which is used to identify, describe and analyse themes and patterns within data. A systematic approach was taken (Braun and Clarke, 2006). First, transcripts were read and re-read to become familiarised with the data and initial codes of interest were generated. Second, initial codes were sorted into potential themes and relevant codes were collated under these themes. Third, themes were reviewed in relation to the generated codes and the entire data set. Finally, themes were named and defined.

The qualitative analysis software WinMax was used to organise codes and themes.

RESULTS

Thematic analysis of the interview transcripts yielded five themes: (1) childbirth as a rite of passage, (2) physical difficulties, (3) value of children in relation to others (4) children as a strain, and (5) going through it alone. These themes are described below and illustrated using quotes from participants.

Childbirth as a rite of passage

For women pregnancy and childbirth signified a change in status. The experience of childbirth represented a transition to adulthood where having a baby was seen as a normative part of development, which every woman must experience to show their womanhood. Along with this new found status of adulthood came an increased sense of responsibility, which was viewed positively by the women. Before becoming mothers women indicated that they had very little responsibility in their own lives.

“it’s [having a baby] normal to show your womanhood” (I20).

“ Actually it makes me really think seriously about life, I am more planning about what to do and what not to do because I know that my baby needs me very much, so I have really become more responsible because anything I do I have to think about my baby, financial plans in terms of future plans about family matters, about schooling you know...it’s really made me a more responsible person” (I38).

Coupled with this increased responsibility women recognised that they were less able to do daily activities like seeing friends and spending time with their husband and working. Nonetheless, this reduction in spare time was not viewed particularly negatively by women, as it is accepted when you have a child.

Physical difficulties

Physical difficulties associated with pregnancy and childbirth were a common complaint for women. Most women described the general toll that pregnancy and giving birth had on their health. Common ailments reported were sickness, stomach pain, loss of appetite, tiredness, and dizziness. However, these were considered as normal in pregnancy so were not a serious concern for most women.

“I feel bad because you know pregnant woman it’s not a well woman, you’re always sick” (I26).

Childbirth itself was physically strenuous for these women and was primarily characterised by severe pain. Women indicated that although the pain they experienced was terrible they tolerated it as part of the normal birthing process. Indeed, most women held expectations that childbirth would be very painful. For women who had already given birth this expectation was based on previous difficult childbirth experiences. For first time mothers the expectation of pain was based on stories that other women and elders had told. Women discussed practices they had been advised to follow to help reduce pain during labour. For example there is a belief that women should remain physically active throughout their pregnancy to maintain

strength for when they give birth. Women who were not active during their pregnancy said they were worried about giving birth because they did not follow this advice.

“It’s nice to have a baby but it’s very painful. Even if you have a knife and cut my hand I can bear this pain, but this pain, ow, it’s super. I don’t think there is any pain like giving birth” (I24).

“everyone when you are pregnant, especially when you are not working, everyone will tell you when you are deliver it’s going to pain. Because when you are pregnant you are supposed to work, so that your child will be active and you yourself will be active. But for me I did not do anything. So I was a little bit afraid. But anybody who see me sitting down they will just say when you deliver it’s going to be pain” (I19).

Women also recognised that there are serious threats to health and life during pregnancy and childbirth. Women voiced recurrent worries of complications during pregnancy or childbirth which could result in them or their baby dying. This is reflected in the overwhelming relief and happiness expressed by women after childbirth that they had delivered safely and their baby was healthy.

“When I delivered safely I felt happy that my baby was sound and healthy and there was no complications with me and the child as well” (I51)

“The first thing that comes to mind is that I thank God that I have delivered safely, and the baby and myself are alive and healthy. That is the most

important thing” (I37)

Losing a baby during pregnancy or birth was a cause of considerable distress and unhappiness for women. Women also reported feeling particularly anxious during their pregnancy because they were worried they would not have a normal delivery and would have to have an operation, which is associated with a heightened risk of complications. Women who had an operation during childbirth reported feeling scared that they might die, and being unable to care for their baby properly because of the long recovery time.

I was expecting to have a baby when everything was destroyed and this made me very depressed. Considering the fact that I was pregnant up to seven months and eventually lost it [the baby] was a great disappointment for me. It was caused by complicated malaria because it was my first pregnancy and I was late to go for my antenatal consultations and to be given drugs to help me”. (I39)

Women used their religious faith to help them cope with the worries they had about giving birth. There was a common belief that their fate was in God’s hands, and therefore they prayed to God to ensure a safe delivery.

“I think it is God who makes us suffer when we are pregnant and sometimes makes us happy. And this experience I went through I believe it is God who is saying I will suffer during pregnancy and childbirth, and I accept it in good faith” (I44)

Value of children in relation to others

The experience of pregnancy and having a child was strongly influenced by their value in relation to others. In The Gambia having children is one of the primary purposes of marriage and therefore many married women described feelings of delight when they found out they were pregnant. Some women also spoke of pregnancy guaranteeing security within their marriage. Not getting pregnant when married could lead to considerable distress for women. The woman often bears responsibility for not producing a child, and they may worry that the husband will either divorce them or take another wife if they do not get pregnant.

“so it [pregnancy] made me happy because by that time I am just married. I was praying to God before I get my pregnancy to keep me in husband” (I1)

Most pregnancies are expected to occur within marriage and having a baby out of wedlock is viewed as dishonourable. It was acknowledged that women who get pregnant under these circumstances may bring shame upon the family, and as a result may not be treated well or even be ostracised from the family. This was especially a concern when the baby’s father refused to acknowledge the pregnancy.

“When I was pregnant I was unhappy because you know I don’t get married when I am pregnant. Even your parents will not be happy with you. Because it is a mistake, that is the problem”. (I14)

“You know sometimes these man can impregnate you and they will refuse the

pregnancy and abandon you. You know all those things can bring depression. You think too much, you know. All those things are problems. And at the end of the day you will not be that much comfortable with yourself” (I6)

The sex of the baby also had significant implications for the way women were treated by their husband and his family. More value is often placed on the birth of a boy in comparison to a girl. Women recognised that men preferred to have a boy, and women who gave birth to a boy were treated better by the husband and in-laws. Desire for the birth of a boy was particularly strong for women if they had previously only given birth to girls.

““Positive change.....all I know was after childbirth I was taken care of. My husband was also happy because he was pleased to have a baby boy, and you know, that was something that was very important, and the in-laws was switching from howling and yelling at me all the time, you know because of the preference for boy child. They now accept me in their family very well. So I think that’s a great positive change that we have”. (I36)

Children as a strain

When pregnancy was planned and women were able to provide for their child, having a baby was assumed to bring happiness and joy. However, it was also recognised among women that pregnancy can sometimes be unwanted because of difficulties associated with raising a child, particularly if a woman already has too many children or if the mother is young. Having a child placed a strain on finances and for women who already had a lot of children the addition of another child was

viewed as a burden. Additionally, women who had children when they were young worried that they were not financially ready to support a child.

“This is why there are certain things it is very tough, it could have negative impact on your family because you cannot provide everything for them, but you have to, because there are certain things that you cannot say no, like education. Because if you want to take them to, if you want them to have a quality education you have to pay out money. See, those are certain things too that can have a negative thing too. You have to buy food too. You see? You know what I am saying?” (I25)

Women who got pregnant when they were still at school spoke of having to stop their education, which resulted in regret and unhappiness. Being pregnant and having a child also put strain on the marital relationship, which was exacerbated when the relationship was in difficulty. A negative marital relationship was identified by the women as reasons why a woman may be unhappy to have a child.

“During this pregnancy I was sad almost throughout it because it was an unplanned one as I was going to school and never wanted pregnancy to interrupt my education. I was angry about it and could not abort it because the baby also has a right to live but it was painful to bear” (I34)

“if you want it and you have husband, you want to be pregnant, then you don’t have to be unhappy you should be happy. If you don’t have husband, if you are raped or you have problem with your husband you will be unhappy because

you will not be wanting your baby, it will be bringing you bad memories”

(I19)

We are on our own

In The Gambia pregnancy and childbirth are viewed primarily as women’s domains and men have limited involvement. This cultural attitude was reflected in most of the women describing that they were on their own during these times and received little assistance. Women strongly believed that having a child is a joint issue and husbands must share the responsibility with their wives.

“It’s [pregnancy] a joint issue, it’s a joint issue, so they have to participate also, but they don’t do. They don’t so much care about it” (I10)

Some women did speak of having supportive husbands, which helped them through their pregnancy and made their experience easier. Both emotional support such as being kind and loving, and practical support such as providing food were viewed as important by women. Lack of support and care from the husband were identified by many as reasons why women feel distressed and unhappy during the perinatal period.

“Men should be very much involved in this, because the distress that you have. If you have your husband by your side and your husband is encouraging you, bringing you food and giving you psychological support it will help you a lot. Like for instance, my husband normally, he will bring things, a lot of things for me to eat, saying this is good for your child. Always asking, even if I am

stressed. If he sees me, and I am not that much happy, he will come by my side and ask me whether something is wrong with me. So he is very supportive during my pregnancy". (I37)

"when I had my baby my husband was not around and I did not have that much family around me, this was my first baby so it was very difficult when I had the baby, most of the time I was alone at home taking care of the baby and taking care of the household chores so I was so tired and I became depressed and some nights I would cry" (I38)

Traditionally men do not attend births in The Gambia; however these women wished this attitude would change so that men could be present to offer support and encouragement. Many women felt if men were present with them during childbirth the relationship between husband and wife would be improved. Some women spoke of the hope that if men witnessed the pain that they went through when giving birth men would be more patient in the future and be less likely to beat them. Women also thought that men may have more respect for the women if they have witnessed the difficulty and pain that women experienced in order to have a child.

"When your wife is giving birth you be there, you see how painful. Because one day.....Maybe you like punish her, OK, you will think the day she was giving birth she was very tired and it was so painful, so you might think of that side and then you might leave her for the punishment you are about to do."
(I24)

DISCUSSION

The aim of this study was to explore women's experiences of pregnancy, childbirth and the postnatal period in The Gambia. This study draws attention to the range of physical and emotional experiences associated with pregnancy and childbirth in Gambian women. Rather than reiterate these results this discussion will focus on interesting points in relation to (1) the significance of children for Gambian women (2) the experiences of psychological distress (3) the involvement of men during childbirth, and (4) the ubiquity of pain in childbirth.

Significance of children

Consistent with past research (Geller, 2004), most women identified pregnancy and the birth of a child as positive experiences, associated with happiness and delight. Anthropological research suggests that having a child in sub-Saharan Africa might be especially positive for women for the following reasons. Firstly, social security reasons as children are seen as necessary for the families' survival; secondly, social power reasons where the children are seen as a valuable power resource; thirdly, social perpetuity reasons where children continue the family heritage (Inhorn & van Balen, 2002). Consistent with these findings past research in The Gambia has shown that a childless marriage is a threat to marital stability (Sundby, 1997). This concern was reflected in the current study by women's positive responses to pregnancy because of the security it provided them within their marriage. Motherhood is also a defining factor in a woman's self-respect, in her understanding of what it means to be a woman, and in her treatment by others in the community (Dyer, Abrahams, Hoffaman & Spuy, 2002; Hollos & Larsen, 2008). This is

consistent with women's responses in the present study where childbirth represented a transition to adulthood.

Experiences of psychological distress

Although pregnancy and the birth of their baby was a time of happiness and excitement for most women in this study, many women reported feeling unhappy and distressed during the perinatal period. This is consistent with quantitative research conducted in sub-Saharan Africa which suggests the pre-and postnatal periods can be a time of considerable stress for women (Sawyer, Ayers, & Smith, 2010). These findings are important because research has shown that maternal psychological distress can have adverse consequences for the mother's health, the early mother-infant relationship and the child's health and development (Adewuya, Ola, Aloba, Mapayi, & Okeniyi, 2008; Halbreich & Karkun, 2006; Stewart, et al., 2008).

Women's experiences were closely related to the circumstances surrounding the pregnancy and childbirth. In particular to how the pregnancy and baby was viewed by others such as the husband and family. In The Gambia a woman who becomes pregnant without a husband might be viewed as promiscuous and single parenting is seen as socially unacceptable. Therefore the stigma associated with being single may contribute to worse mental health (Adewuya et al., 2007). Moreover, in Gambian culture it is a thing of pride for the woman to have a man own up to being responsible for the pregnancy. Therefore if the father does not accept the child he may display ambivalent behaviour towards the child and mother, which may be a source of distress (Owoeye, Aina, & Morakinyo, 2006). Moreover, the economic burden of being a single parent is likely to be a considerable worry as the women will not have the financial support from the father of the child and because the child is born out of

wedlock they risk being ostracised by their family. Few studies have investigated rejected paternity as a risk factor for maternal psychological distress in Africa? and therefore future research should take this into consideration.

Women identified a preference for a male child in Gambian society, and this was acknowledged as particularly important for the husband. There is a deep-rooted cultural preference for a male child in sub-Saharan Africa as males continue the family lineage in patriarchal societies and are expected to look after their parents while female children are expected to marry and move to their husband's compound. Women are often blamed for the sex of the child, and not giving birth to a boy could lead to marital disharmony or the husband marrying another wife (Adewuya et al, 2005). Giving birth to a girl has been identified as a potential risk factor for postnatal distress in other African countries (Adewuya et al, 2005; Hanlon, Whitley, Wondimagegn, Alem, & Prince, 2009). Our results indicate there might be a relationship between maternal distress and sex of the child in Gambian women, and this relationship should be explored further.

It was acknowledged that a child may not be wanted despite occurring within marriage, particularly if the woman is young, already has too many children, or is having marital problems. Although most studies (in samples 18 years or over) have found that age is not related to maternal mental health, risk of depression is higher in teenage mothers (Robertson, Grace, Wallington, & Stewart, 2004). Being young and the demands of being a new mother are likely to be associated with significant stress especially if the woman is not financially prepared to have a child (Nakku, Nakasi, & Mirembe, 2006). The financial strain of having a child when a woman already has too many children was a source of distress in these Gambian women, and this finding has also been replicated in a recent study of antenatal distress in Ethiopian women

(Hanlon, Whitley, Wondimagegn, Alem & Prince, in press). Other studies in developing countries have also reported that poverty is associated with postnatal depression (Patel, Rodrigues, & DeSouza, 2002).

Marital conflict has been consistently associated as risk factor of postnatal depression in sub-Saharan African countries (Sawyer, Ayers, & Smith, 2010). Having a child within a difficult marriage could make the situation worse, leading to distress and unhappiness for the women (Hanlon et al., in press). Lack of support from the husband was also commonly identified by women as reasons for distress during the perinatal period. The important role of social support in maternal mental health has already been demonstrated in Europe, North America and other sub-Saharan African countries (Adewuya et al., 2007; Beck, 2001).

Women's concerns about the fear and danger associated with pregnancy and childbirth is similar to findings reported in comparable studies in Ethiopia (Hanlon et al., 2009; Hanlon et al., in press). Women were especially worried during their pregnancy about having an operation to help them deliver and women who had a caesarean section reported feeling very scared and distressed. Studies conducted in other sub-Saharan Africa countries have identified caesarean sections as a risk factor for postnatal depression and one study in Nigeria found that undergoing an unplanned caesarean section was related to posttraumatic stress disorder (Adewuya, Ologun, & Ibigbami, 2005). The women in this study also spoke about their personal distress and distress of others when their baby had died. Studies conducted in Nigeria have also identified pregnancy loss and stillbirth as risk factors for pre- and postnatal depression (Adewuya et al., 2007; Obi, Onah, Okafor, 2009). Perinatal loss is associated with sadness, guilt, somatic symptoms, depression and anxiety (Badenhorst & Hughes, 2007). Studies have shown that women are scared to get pregnant again in case of a

repeat occurrence and this was observed in one woman in the current study (Adewuya et al., 2007). In most sub-Saharan African settings perinatal loss and subsequent emotional distress are rarely talked about because of cultural beliefs (Obi et al., 2009). Therefore considering the high levels of maternal morbidity and perinatal deaths in The Gambia health care services need to be developed to address these women's needs. Future studies should also explore the effect of cultural beliefs on the grief process and the long term reaction to perinatal loss in these women, especially during the next pregnancy.

Involvement of men during childbirth

In Gambian society pregnancy and childbirth are generally regarded entirely as a woman's domain. It is unlawful to allow a male (with the exception of medical staff) to be present during childbirth. Moreover, the open plan of the labour suites in The Gambia is a barrier to any male involvement. This contrasts with current western practice where men typically accompany their partner in childbirth. Most of the women in this study thought having their husband more involved during pregnancy and childbirth would be beneficial. Research from several countries suggests that father's support during childbirth improves delivery outcomes such as significant reductions in length of labour, the amount of pain medication needed, and the need for emergency care for the baby (Pestvenidze & Bohrer, 2007). Considering these benefits it seems that men's involvement in childbirth should be promoted in The Gambia. However, more qualitative research is needed with Gambian men to explore their views on the roles of male partners in childbirth.

Ubiquity of pain

Finally pain during childbirth was a predominant experience for women in this study. Labour pain is one of the foremost similarities of women's childbirth experiences irrespective of socio-cultural background (Oladokun et al., 2009). In The Gambia pain relief given during labour is minimal and this may partly explain why the majority of women included in this study were willing to tolerate pain, believing it to be inevitable. There is little information on women's views about the use of pain relief during labour in sub-Saharan Africa but research conducted in Nigeria suggests that although women's knowledge was limited, they were positive about its use (Oladokun et al., 2009). Future research in The Gambia should explore women's knowledge and views of receiving pain relief during labour. Considering the ubiquity of pain reported by women in this study healthcare services should consider introducing the option of pain relief during labour.

Limitations

Caution should be taken when generalising these results to all Gambian women. The study took place in an urban district of The Gambia, and may not be representative of the general population. Many of the women were recruited from health centres and more women also gave birth at a health service than is typical in The Gambia. Women who do not have access to health facilities or who have home births are likely to give very different accounts of pregnancy and childbirth. For example in rural Gambia the risk of complications and dying during childbirth is higher than in urban areas.

Conclusion

In conclusion this study indicates that although motherhood is a defining point

in many Gambian women's lives the circumstances surrounding pregnancy and childbirth have the potential to promote unhappiness and distress in women. This finding challenges the widely held belief that maternal distress is a Western phenomenon. It is essential that future studies continue to identify women vulnerable to psychological distress so that adequate health services and target interventions can be developed accordingly.

REFERENCES

- Adewuya, A. O., Fatoye, F. O., Ola, B. A., Ijaodola, O. R., & Ibiagami, S. M. (2005). Sociodemographic and obstetric risk factors for postpartum depressive symptoms in Nigerian women. *Journal of Psychiatric Practice*, 11, 353-358.
- Adewuya, A., Ola, B., Aloba, O., Dada, A., & Fasoto, O. (2007). Prevalence and correlates of depression in late pregnancy among Nigerian women. *Depression and Anxiety*, 24, 15-21.
- Adewuya, A., Ola, B., Aloba, O., Mapayi, B., & Okeniyi, J. (2008). Impact of postnatal depression on infants' growth in Nigeria. *Journal of Affective Disorders*, 108, 191–193.
- Adewuya, A., Ologun, Y., Ibigbami, O., 2005. Post-traumatic stress disorder after childbirth in Nigerian women: prevalence and risk factors. *British Journal of Obstetrics and Gynaecology*, 113, 284-288.
- American Psychiatric Association (1994). *Diagnostic and Statistic Manual of Mental Disorders*. 4th ed. Washington, D.C.: American Psychiatric Association.
- Anya, S. E., Hydera, A., & Jaiteh, L. (2008). Antenatal care in The Gambia: Missed opportunity for information, education and communication. *Pregnancy and Childbirth*, 8, 9.
- Badenhorst, W. & Hughes, P. (2007). Psychological Aspects of perinatal loss. *Best Practice and Research: Clinical Obstetrics and Gynaecology*, 21, 249-259.
- Beck, C. T. (2001). Predictors of postpartum depression: an update. *Nursing Research*, 50, 275-285.
- Berle, J. O., Aarre, T. F., Mykletun, A., Dahl, A. A., & Holsten, F. (2002). Screening for postnatal depression: Validation of the Norwegian version of the Edinburgh Postnatal Depression Scale, and the assessment of risk factors for

- postnatal depression. *Journal of Affective Disorders*, 76, 151-156.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Cham, M., Sundby, J., & Vangen, S. (2005). Maternal mortality in rural Gambia, a qualitative study on access to emergency obstetric care. *Reproductive Health*, 2, 3.
- Coleman, R., Morison, L., Paine, Powell, R. A., & Walraven, G. (2006). Women's reproductive health and depression: A Community Survey in the Gambia, West Africa. *Social Psychiatry and Psychiatric Epidemiology*, 41, 720-727.
- Dyer, S. J., Abrahams, N. A., Hoffaman, M. & Spuy, Z. M. (2002). 'Men leave me as I cannot have children': women's experiences with involuntary childlessness. *Human Reproduction*, 17, 1663-1668.
- Fortes, M. (1978). Parenthood, marriage, and fertility in West Africa. *Journal of Development Studies*, 14, 121-149.
- Gambia Bureau of Statistics (2003). *The Gambia Population & Housing Census – 2003: Spatial Distribution of the population and socio-cultural characteristics*.
- Geller, P. (2004). Pregnancy as a stressful life event. *CNS Spectrums*, 9, 188-197.
- Gureje, O., Lasebikan, V., Ephraim-Oluwanuga, O., Olley, B., & Kola, L. (2005). Community study of knowledge and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, 186, 436-441.
- Halbreich, U., Alarcon, R., Calil, H., Douki, S., Gaszner, P., Jadresic, E., et al. (2007). Culturally-sensitive complaints of depressions and anxieties in women. *Journal of Affective Disorders*, 102, 159-176.
- Halbreich, U. & Karkun, S. (2006). Cross-cultural and social diversity of prevalence

- of postpartum depression and depressive symptoms. *Journal of Affective Disorders*, 91, 97-111.
- Hanlon, C., Whitley, R., Wondimagegn, D., Alem, A., & Prince, M. (2009). Postnatal mental distress in relation to the sociocultural practices of childbirth: an exploratory qualitative study from Ethiopia. *Social Science and Medicine*, 69, 1211-1219.
- Hanlon, C., Whitley, R., Wondimagegn, D., Alem, A., & Prince, M. (in press). Between life and death: exploring the sociocultural context of antenatal mental distress in rural Ethiopia. *Archives of Women's Mental Health*.
- Harpham, T., Huttly, S., De Silva, M., & Abramsky, T. (2005). Maternal mental health and child nutritional status in four developing countries. *Journal of Epidemiology and Community Health*, 59, 1060-1064.
- Hollos, M., & Larsen, U. (2008). Motherhood in sub-Saharan Africa: The social consequences of infertility in an urban population in northern Tanzania. *Culture, Health & Sexuality*, 10, 159-173.
- Inhorn, M., & van Balen, F. (2002). *Infertility around the globe: New thinking on childlessness, gender and reproductive technologies*. Berkley, University of California Press.
- Nakku, J., Nakasi¹, G., & Mirembe, F. (2006). Postpartum major depression at six weeks in primary health care: prevalence and associated factors. *African Health Sciences*, 6, 207-214.
- Oates, M. R., Cox, J. J., Neema, S., Asten, P., & Glangeaud-Freudenthal, N., Figueiredo, B., et al. (2004). Postnatal depression across countries and cultures: a qualitative study. *British Journal of Psychiatry*, 184, 10-16.
- Obi, S., Onah, H., Okafor, I. (2009). Depression among Nigerian women following

- pregnancy loss. *International Journal of Gynecology and Obstetrics*, 105, 60-62.
- Oladokun, A., Eyelade, O., Morhason-Bello, I., Fadare, O., Akinyemi, J., Adedokun, B. (2009). Awareness and desirability of labor epidural analgesia: a survey of Nigerian women. *International Journal of Obstetric Anaesthesia*, 18, 38-42.
- Owoeye, O. A., Aina, O. F., & Morakinyo, O. (2006). Risk factors of postpartum depression and EPDS scores in a group of Nigerian women. *Tropical Doctor*, 36, 100-103.
- Patel, V., Rodrigues, M., & DeSouza, N. (2002). Gender, poverty and postnatal depression: A study of mothers, Goa, India. *American Journal of Psychiatry*, 159, 43-47.
- Pestvenidze, E., & Bohrer, M. (2007). Finally, daddies in the delivery room: Parents' education in Georgia. *Global Public Health*, 2, 169-183.
- Pruel, A., Bouvier, M. H., de Bernis, L., & Bréart, G. (2000). Severe maternal morbidity from direct obstetric causes in West Africa: incidence and case fatality rates. *Bulletin of the World Health Organization*, 78, 593-602.
- Robertson, E., Grace, S., Wallington, T., & Stewart, D. (2004). Antenatal risks for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry*, 26, 289-295.
- Rodrigues, M., Patel, V., Jaswal, S., & de Souza, N. (2003). Listening to mothers : qualitative studies on motherhood and depression from Goa, India. *Social Science and Medicine*, 57, 1797-1806.
- Sawyer, A., Ayers, S., & Smith, H. (2010). Pre- and postnatal psychological wellbeing in Africa: A systematic review. *Journal of Affective Disorders*, 123, 17-29.

- Stewart, R. C; Umar, E., Kauye, F., Bunn, J., Vokhiwa, M., Fitzgerald, M., Tomenson, B., Rahman, A., & Creed, F. (2008). Maternal common mental disorder and infant growth – a cross-sectional study from Malawi. *Maternal and Child Nutrition*, 4, 209-219.
- Sundby, (1997). Infertility in The Gambia: traditional and modern health care. *Patient Education and Counseling*, 31, 29-37.
- Tomlinson, M., Swartz, L., Kruger, L-M., & Gureje, O. (2007). Manifestations of affective disturbance in sub-Saharan Africa: Key themes. *Journal of Affective Disorders*, 102, 191-198.
- UNESCO. (2006). *Education For All Monitoring Report - Literacy for Life*. Paris.
- World Health Organization. (2004). *International Classification of Diseases, 10th revision*. World Health Organization, Geneva.
- World Health Organization. (2004). *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*. World Health Organization, Geneva.

Appendix – Interview Schedule

How did you feel about being pregnant?

How would you describe your emotions whilst you were pregnant?

Did pregnancy affect you in any other way? If so, how?

Think back to when your labour first started and talk me through what happened from there.

Was birth the way you expected?

How would you describe your emotions after your baby was born?

Can you tell me about any positive changes that you experienced after your baby was born?

Can you tell me about any negative changes that you experienced after your baby was born?

How did you feel about your baby?

What effect did the baby have on your life?

Have you experienced unhappiness during pregnancy or after childbirth?

What do you think caused it?

Table 1. Sample characteristics of main demographic and childbirth variables

		<i>N (%)</i>	
Ethnicity	Mandinka	30 (54.5)	
	Fula	4 (7.3)	
	Wolof	6 (10.9)	
	Jola	3 (5.5)	
	Other	12 (21.8)	
Marital status	Single	8 (14.8)	
	Married	31 (57.4)	
	Polygamous Marriage	14 (25.9)	
	Divorced/Separated	1 (1.9)	
Level of education	None	16 (29.1)	
	Basic	1 (1.8)	
	Secondary	21 (38.2)	
	Tertiary	14 (25.5)	
	Other	3 (5.5)	
Employed	Yes	18 (32.7)	
	No	37 (67.3)	
Number of children	One	21 (38.2)	
	Two	9 (16.4)	
	Three	9 (16.4)	
	More	16 (29.1)	
Miscarriage	Yes	12 (21.8)	
Abortion	Yes	8 (14.5)	
Stillbirth	Yes	6 (10.9)	
Pregnancy planned	Yes	33 (55.9)	
Sex preference	Boy	20 (36.4)	
	Girl	7 (12.7)	
	No preference	28 (50.9)	
Place of delivery	Hospital	30 (54.5)	
	Health Centre	21 (38.2)	
	Home	4 (7.3)	
Type of delivery	Unassisted	52 (94.5)	
	Caesarean	3 (5.5)	
Hours in labour (Mean (<i>SD</i>))	Range 1-168	17.6 (29.1)	
Months since birth (Mean (<i>SD</i>))	Range 1 day – 12 months	8.0 (3.6)	
Age (Mean (<i>SD</i>))	Range 18-46	27.7 (5.1)	30