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DEPARTMENT OF PSYCHOLOGY

Title: Exploring the lived experiences of a sample of South African fathers who had a premature baby.

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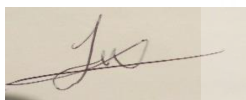
Signature:  **Student Number: 3334314**

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Abstract

Fatherhood and masculinity have been studied globally, and these constructs are used to make sense of a variety of realities of men. In South Africa, traditional constructions of fatherhood and masculinity persist. Given the unique history of men in South Africa, it allows researchers to investigate a plethora of phenomena relating to how men experience them, including fatherhood. Having a premature baby is fraught with medical and physical problems, which disrupts the fathers' transition to fatherhood. The experience of the transition to parenthood is exacerbated by the sudden premature birth of a child, which leaves fathers and mothers particularly vulnerable to intense emotional experiences. Much has been documented about fathers' subjective experiences of pregnancy, as well as fathers' experiences of having a premature infant. However, these studies were mostly conducted abroad. There seems to be a paucity of literature pertaining to South African fathers' experiences of having a premature baby. Therefore, the current study would contribute to the gap in the literature regarding fathers' subjective experiences of having a premature baby. This study focused on how a sample of ten South African men experienced having a premature baby using a descriptive phenomenological design to explore these lived experiences. The study adopted semi-structured interviews for participants to express their experiences more openly. The research took place online due to the current Covid-19 pandemic and used social media platforms (specifically Google Meet and WhatsApp). Ethics approval was obtained from the Biomedical Research Ethics Committee (BMREC- [Project registration: BM20/8/12]). Participants were requested to provide consent and were subsequently informed about their rights to participate pertaining to autonomy, confidentiality and anonymity. Results indicated that fathers experience immense stress and anxiety relating to having a premature baby. Experiences such as fear about the survival of their children, whether there would be deficiencies in their development, feeling helpless about not being able to do anything to ensure the wellbeing of their children and pressures to support are central to fathers' experiences of having a premature baby. Recommendations for future research centres on exploring fathers' access to support when faced with an experience of having a baby born earlier than expected. Fathers' perceptions regarding their experiences of having a premature baby relative to the public and private healthcare sector is also an area that requires more attention.

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Chapter 1: Introduction

Typically, the prospect of having a child is considered a joyous and revered experience that represents a significant life event in both parents' lives. This experience is characterised by feelings of excitement and a greater level of life satisfaction (Jackson & Andipatin, 2019; Rizzo, Schiffrin & Liss, 2013). Men and women undergo a significant identity change in the event of childbirth as each experiences a significant change in becoming a parent (Lindberg et al., 2008). Although this life-changing transition is characterised as a positive experience it is not without its challenges (Lindberg et al., 2008). These include, but are not limited to, stress, feelings of unworthiness, anxiety, and a decrease in wellbeing (Vanier, 2017). The experience of integrating a child is exacerbated when having to be responsible for a premature baby (Kowalenko et al., 2012). Preterm children generally face more medical and physical health issues often resulting in hospitalisation and sensitive care (Kowalenko et al., 2012; Hughes et al., 2012; Fletcher et al., 2011). This adds to the responsibility of caring for a newborn, as the unique challenges of being a father is aggravated during this period. The challenges mainly faced by fathers are feelings of uncertainty, stress, anxiety, helplessness and abandonment (Straus et al., 2019).

1.1 Defining fatherhood

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Traditionally, the prescriptive role of fatherhood has been perceived and described as the father being the protector and provider of the family, and the mother as nurturer and caregiver (Lindberg et al., 2008; Ratele, 2012). This ties into the traditional hegemonic roles prescribed to men and women from traditional societies (Mfecane, 2018; 2016), and could still be seen as significantly relevant in the way gender constructions of fatherhood and motherhood are viewed (Dayton et al., 2016). However, defining what a father is in contemporary society does not suffice in distinguishing what is meant by fatherhood. While the term father refers to a man assuming responsibility for a child, the term fatherhood is meant to denote a larger discourse attempting to flesh out the abstract intricacies of being a father (Bermin & Long, 2021; Ratele, 2012). Therefore, the term fatherhood is a hyperlink concept expanding the process of being a father contextually, what it means to be a father in certain parts of the world, and in different contexts. The term is also linked to the broad discourse of masculinity (Ratele, 2012).

There is a growing discourse (Lindberg et al., 2008; Amorim et al., 2017; Straus et al., 2019; Dayton et al., 2016; Enderstein & Boonzaier, 2015; La Rossa, 1997) suggesting that

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the seemingly traditional roles of fatherhood, in particular, are being eroded by different ways of thinking of paternity. More mothers are entering the workforce (Straus et al., 2019), and more fathers assimilate the identity of becoming involved/hands-on fathers (Smith et al., 2011). According to Ratele, (2012) an involved father is characterized as a man who does not merely fulfil the traditional role of the father as a provider and disciplinarian, but closely and intimately cares for the wellbeing and development of his child/ren. Therefore, fathers are not constricted in their roles as provider and protector, but also have a psychologically shared experience of caring (Enderstein & Boonzaier, 2015). This is evident in the growing incidents of fathers experiencing stress during pregnancy and childbirth (Straus et al., 2019). This could also signify the shift in the perception of fathers as a bifurcated associate during pregnancy (Amorim et al., 2017), to a more involved and vicarious bearer of a child (Campanati et al., 2018).

Considering that men are physically separated from the experience of pregnancy, it is implied that the experience of pregnancy itself has a limited effect, physically and psychologically on fathers (Bermin & Long, 2021; Amorim et al., 2017). This is closely interwoven with the social construction that fathers are “naturally” divorced from the physical experience of gestation (Amorim et al., 2017). This may augment the perception of fathers' lack of understanding of what it means to be physically pregnant. However, the psychological experience of fathers during pregnancy is an important factor to consider when thinking about fathers’ experiences during pregnancy (Dayton et al., 2016).

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There has also been a growing consideration of paternal mental health (as contrasted from maternal mental health) after a child is born (Fletcher et al., 2011; Baldwin & Bick 2017). Mental health for fathers is indispensable for child development (Kotelchuck & Lu, 2017), as the positive effects thereof is considered equally as important as, and for, maternal mental health (Fletcher et al., 2011; Kowalenko et al., 2012; Lindberg et al., 2008; Furaikh & Ganapathy, 2016). Despite the initial mother-infant relationship, studies have shown that infants could establish early attachments with others who are frequently close in proximity, in particular the child’s engagement with their father (Lindberg et al., 2008).

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1.2 Defining preterm baby

While most children are born healthy (Lindberg et al., 2008), children born prematurely are fraught with medical, behavioural and physical challenges (Kowalenko et al., 2012; Hughes et al., 2012; Fletcher et al., 2011). This exacerbates the already challenging experience of parents' adjustment to parenthood with the added anxiety and fear for their child's wellbeing (Kowalenko et al., 2012; Smith et al., 2011). A child born prematurely can be defined as extremely premature (less than 28 weeks), very premature (28 to 32 weeks), and moderate to late premature (32 to 37 weeks) (WHO, 2018). Children born prematurely are challenging in the sense that they require more medical attention due to the physical challenges inherent in being born prematurely (Amorim et al., 2017) which means that parents often have to provide extra finances as well as time spent in hospitals (Fletcher et al., 2011; Kowalenko et al., 2012; Lindberg et al., 2008). Given this, being born prematurely, as well as high-risk pregnancy in general, cannot be discussed without mentioning the kind of healthcare received. Premature infants are usually separated from their mother and father after birth, which disrupts the early bonding of parents to their newborn baby (Habib & Lancaster, 2010). The parents of preterm babies become psychologically disrupted in their transition into parenthood, and could also be seen as becoming parents prematurely (Smith et al., 2011; Lindberg et al., 2008; Andipatin, 2012). Hence, parents of preterm babies often face these challenges precipitously, without time to adequately prepare, whilst also navigating the added threats to their preterm child's survival.

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1.3 Problem statement

Researchers are starting to focus more on fathers' experiences of pregnancy (Lindberg et al., 2008; Fletcher et al., 2011; Kowalenko et al., 2012; Habib & Lancaster, 2010; Enderstein & Boonzaier, 2015). There is a plethora of literature on fathering and how the process of fathering affects the psychological wellbeing of children (for example see Fletcher et al., 2011; Baldwin & Dick 2017; Wong et al., 2016; Vanier, 2017; Amorim et al., 2017). However, in South Africa, there is a dearth of studies exploring the lived experiences of fathers having premature babies. As premature births are considered to be high-risk, which is an understudied field, there seems to be a paucity of literature on the lived experience of men having premature babies in South Africa (Enderstein & Boonzaier, 2015; Andipatin, 2012). Therefore, this study aimed at exploring fathers' lived experiences of having a premature

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baby is important as it addresses this gap and contributes to our understanding of fathers during this experience.

1.4 Rationale

As mentioned above, various studies have focused on parenting and how fathers are positioned during pregnancy. Much has been documented regarding the subjective experiences of mothers during this process (Hoffman et al., 2015; Spinelli et al., 2016; Vaerland et al., 2018; Mamun et al., 2006), with an increasing focus on fathers. Since there is a shift in the perception of the role fathers play during pregnancy (Lindberg et al., 2008; Vanier, 2017; Amorim et al., 2017), not much has been studied regarding the lived experiences of fathers having a premature baby in South Africa. The Sustainable Development Goals (Goal 3, target 3.4) for 2030 of the United Nations' report (2019) asserts that premature birth complications are an important public health issue. Mothers are mentioned concerning this public health problem as the bearers of children in the report. However, the plan only makes mention of mothers' experiences, despite the growing evidence that fathers are intricately involved during the pregnancy and birth process. As premature birth is considered high-risk which is an understudied field in South Africa, this study is significant as it investigates fathers' lived experiences with having a premature baby in South Africa. Therefore, this study will be contributing to the gap in the literature. Many of the existing studies focus on the subjective experience of pregnancy and even fathers' experiences of premature babies abroad (Straus et al., 2019; Dadkhatehrani et al., 2018; Pohlman, 2005). However, in South Africa, there seems to be a paucity of studies relating to the latter in context, which is different from where these studies were conducted.

1.5 Research question

What are the lived experiences of South African fathers who had a premature baby?

1.6 Aim

This study aimed to explore fathers' lived experiences of having a premature baby in South Africa.

1.7 Objectives

1. To explore the emotional experiences of a sample of South African fathers having a premature baby.

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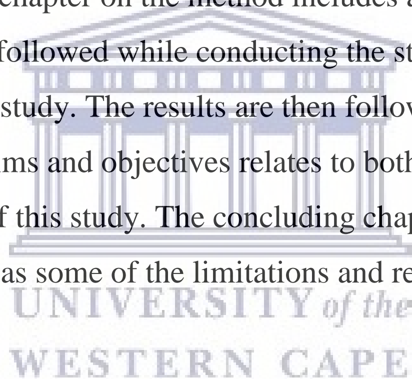
2. To explore the emotional experiences of a sample of South African fathers and their relationship with their premature child.
3. To explore the emotional experiences of South African fathers and their relationship with the mother during the high-risk pregnancy.

This section provides an overview and background of fatherhood and premature babies, as well as how this is located within the context of South Africa. This initial chapter also provides an overview of what this study aims to achieve, given the dearth of literature on fathers having a premature baby within the South African context.

What follows are chapters dedicated to provide a description of the literature, method, results, discussion and conclusion. In the chapter on the literature review, a detailed description of fatherhood and premature babies are provided. In addition, the various domains of literature related to fathers having a premature baby is discussed relative to issues within the South African context. The chapter on the method includes a detailed description of the steps and procedures that were followed while conducting the study. Following this is the description of the results of the study. The results are then followed by a detailed discussion of how the research question, aims and objectives relates to both the literature reviewed as well as the empirical findings of this study. The concluding chapter highlights the core essence of the findings, as well as some of the limitations and recommendations for future research.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Chapter 2: Literature review

2.1 Fatherhood and masculinity

A brief distinction between different terminologies must be clarified. The discourse on fatherhood and masculinities has expanded profoundly in the last two decades (Mfecane, 2016; Connell, 2005). The traditional role of the father has mutated and is no longer considered to denote the authoritarian provider and protector. With men no longer prescribing to traditional social and masculine constructions of being a father, new avenues have opened up for negotiating both masculinities and fatherhood (Gregory & Milner, 2011; Tucker & Govender, 2017). Therefore, a father is no longer defined as someone who fathered a child, but as someone who adopted the assumed role of taking responsibility for a child (Hobson, 2004; Fletcher et al., 2011; Lindberg et al., 2008; West et al., 2009). This means that fathers' involvement is not merely characterised as being the authoritarian and disciplinarian of the nuclear family, but rather as actively caring and being emotionally involved in raising children. Hence, this definition implies that modern constructions of being a father is no longer commensurate with the constricted traditional role of provider and protector.

The social construct of fatherhood and masculinity have been considered as inseparable, and cannot be made sense of without each other. Since fatherhood and masculinity are interwoven constructs, the discourse on masculinity is also changing concerning child development. Masculinity, in parallel to fatherhood, is closely linked by the perception of what a man should be like in society (Mfecane, 2016; Connell, 2005; October, 2019). The concept of hegemonic masculinity proposes that men should be financially stable to provide for women and children (Mfecane, 2016; Magodyo et al., 2017; Bermin & Long, 2021). However, modern conceptions of the construct denotes that fathers should not only to be considered as the authoritarian protector of the family but as a source of emotional support as well. This also informs how men's roles in society are changing from enacting traditional forms of masculinity to the adoption of alternative and caring masculinities (Tucker & Govender, 2017). Therefore, given the changing nature of these constructs it cannot be seen as static, but as ever-changing and fluid (Magodyo et al., 2017). These traditional forms of masculinity were challenged and renegotiated due to the oppressive nature it had on men themselves (Magodyo et al., 2017) and subsequently permutated the way in which men adopt some of their paternal roles. Fathers are increasingly considered as equals within the family

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structure because of the equal division of chores with women (Mercuri, 2018) and are more open to identifying as emotional caregivers to their children (West et al., 2012).

2.2 Masculinity in South Africa

The concept of masculinity in South Africa can refer to how men should behave, but also takes on a unique stance relative to the history of the country. Hegemonic masculinity in the South African context was embedded in the racial context which characterised Apartheid, South Africa (Ratele, 2012; Mfecane, 2016). Historically, the minority of men were considered to embody the construct of hegemonic masculinity (Vincent, 2006; Walker, 2006). This entailed being the authoritarian and disciplinarian of the nuclear family, and being able to provide for families in close proximity (Mfecane, 2016). In contrast, the majority of men of colour in South Africa could not live up to this construction of masculinity as the socioeconomic and political climate of Apartheid was less accommodative and extremely oppressive. This often meant that men of colour were subject to vile treatment, often being emasculated and were forced to engage in migrant labour to support their families (Posel & Casale, 2006; Casale & Posel, 2006). In addition, men who were racially oppressed were also seen as less than, which was often verbalised as being “boys” (Dube, 2016; Morrell, 2002), Thus, the difference and affordability of enacting masculinity for men in the historical context was heavily divided along racial lines, and was imbued in the political context of the day, its impact is still seen in the ways in which men currently inhabit and construct their masculinity.

Currently under the post-apartheid democratic state, masculinity is seemingly taking a different form. The South African anthropological, sociological and psychological literature suggests that the construct of hegemonic masculinity is seen more as culturally informed (Mfecane, 2016; Ratele, 2016, 2012; Jackson & Andipatin, 2019), and not merely in the constricted way as mentioned above. Mfecane (2016) and Ratele et al. (2014) found that masculinity among isiXhosa, for example, are informed by traditional practices such as circumcision, the transition from being a boy to becoming a man (Jackson & Andipatin, 2019; Magodyo et al., 2017), and characterised by the enactment of certain behaviours that renders one to be a man. In an ethnographic study conducted among isiXhosa men, Mfecane (2016) found that practices such as alcohol consumption was central to being considered a man as part of these behaviours.

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However, certain tensions exist within cultural sensibilities of traditional masculinity which subsequently resulted in the emergence of alternative forms of being a man. Tucker and Govender (2016) found that different, alternative forms of masculinity among school children emerged under the oppressive condition of the traditional constructs of masculinity. These alternative forms of masculinity emerged in reaction to the harmful implications of enacting traditional forms of being a man (Tucker & Govender, 2016) such as the enactment of behaviours mentioned above. There is growing evidence that suggests that there is a disjuncture between what society deems to be manhood and men's own constructions of masculinity that contradict both their internal and individual experiences, resulting in the perception that this is harmful to both themselves and their close families (Tucker & Govender, 2016; Sheff, 2006). Many boys felt that they cannot live up to the construction of traditional masculinity, thus recreating and renegotiating their own masculinity in the face of more traditional forms. For example, the awareness of the harmful positions and beliefs of sex held in those enacting traditional forms of masculinity was concerning for many men and boys who often prioritised their health and wellbeing over exerting their dominant sexual prowess by exhibiting a sense of masculinity that is in direct contradiction of other traditional forms of masculinity (Sheff, 2006).

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However, it is interesting to note that men in groups often exert and reinforce patterns and characteristics of traditional forms of masculinity, despite the insistence of recreating alternative forms of being men in more recent studies. In a qualitative study focussing on male sexuality, Govender et al. (2019) found that boys in groups often endorse the justifications for standard forms of male sexuality, as an aspect of traditional masculinity, as a means to evaluate themselves and others. However, when interviewed alone, the endorsement and advocacy for more progressive forms of masculinity in the form of healthy relationships with women and their bodies prevail (Govender et al., 2019). This conflict characterises the struggle to clearly define men and boys relative to aspiring to more progressive and alternative forms of masculinities and having to retain their identity as men given the dominant traditional yardstick of what it means to be a man. This is due to the widely accepted perception and resilience of traditional masculinity being the dominant model of being a man in society, especially among other men.

Given the abovementioned literature on masculinity in South Africa, it is worth noting the oppressive stance of the construct of hegemonic masculinity on men. The traditional construction of masculinity proved resilient in a post-apartheid South Africa, which

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permeated every sphere of men's' lives. Thus, the oppressive nature of traditional forms of masculinity resulted in the emergence of alternative forms of masculinity, which speaks to men's awareness and resistance towards harmful ways of relating to manhood. However, the conflict of desiring more progressive masculinities and upholding the traditional stance of enacting masculinity is a conflict which many face, including fathers. Masculinity in South Africa is also closely interwoven with fatherhood in South Africa, which will be discussed next.

2.3 Fatherhood in South Africa

The constructs of fatherhood and masculinity have an impact on parenting globally. In South Africa, these constructions are not lost on men living in this country. However, what is unique about the history of fathering and masculinity in South Africa is the fact that Apartheid shaped and moulded the realities of many racially marginalised fathers (Mfecane, 2018; Ratele, 2012; 2017).

During Apartheid South Africa, the abovementioned constructions of masculinity and fatherhood prevailed. However, the conditions prescribed by the construction of hegemonic masculinity was explicitly divided along racially constructed lines. A small racial minority of South African males lived in a socio-political economy which was equally oppressive and closely interwoven with the aforementioned construction of hegemonic masculinity (Mfecane, 2018). Apartheid was designed to benefit a small racial minority and subjugated the racial majority. So-called whites[1] were considered to be more economically stable and were in a position to care for their families in close proximity, as opposed to the racial majority, who was deprived of the same privileges as many were deployed to do migrant labour, only seeing their families on an annual basis (Ratele, 2012; 2017; Mfecane, 2018). The juxtaposition of hegemonic masculinity and the lived experiences of black men under Apartheid was clear and emasculating, as they were derogatorily referred to as "boy"[2] (Morrell, 1998), and subsequently were not economically stable to provide for their families (Magodyo et al., 2017). Therefore, many fathers, previously considered the oppressed

[1] The racial terms "Black" and "White", were used and popularised by the Population Registration Act of 1950, but was repealed in 1991. However, the operational use of these terms for the purpose of this study is to demonstrate the historical significance of how it was, and still is, used to classify people into abstract categories on the basis of skin colour (Mosavel et al., 2011).

[2] The word "boy" in this context was used as an emasculating term to refer to all men of colour under Apartheid. This was often used to reinforce the idea that black men were not equal to white men under the political climate of Apartheid (Morrell, 1998)

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majority in South Africa, were not actively involved in the development of children which affected how children were raised (Madhavan et al., 2014).

As South Africa transitioned from an oppressive regime to a democratic state, many social and political changes transpired (Ratele, 2020, 2017; Mfecane, 2016). Part of these changes relates to how parenting is perceived, as many men are arguably not subjected to the vile treatment of the past. This allowed men to be involved as a present unit in the family (Madhavan et al., 2014). However, this does not mean that fathers are not absent in the lives of their children. Statistics regarding father absence in South Africa is contentious. On the one hand Statistics SA's General Household Survey (2017) indicates that 61.8% of children live without their fathers. However, what this statistic does not illustrate is whether fathers are involved in the lives of their children or not. On the other hand, the state of South Africa's fathers report (Van den Berg et al., 2018) indicates that 40% of fathers are absent in the lives of their children. Irrespective of what the statistics are, the crucial point is that the literature indicates that paternal involvement is positively correlated with healthy child development. (Madhavan et al., 2014; Edward et al., 2020; Lindberg et al., 2008). Some of the reasons for this is, but not limited to, the inability to find employment to support their families, drug and alcohol abuse, and gender-based violence (Mosavel et al., 2012). This is also related to the fact that despite the political change of power, many men often struggle to find employment and welfare to support their families.

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2.4 Defining premature baby

The Western Cape Government in South Africa, in alignment with the WHO, defines prematurity in infants as babies that are born less than 37 completed weeks of pregnancy (WCG, 2018; WHO, 2018). Prematurity is delineated into three subcategories: extremely preterm (<28weeks), preterm (28-32 weeks) and moderate to late preterm (32-37 weeks) (WHO, 2018). It is estimated that globally an approximate 15 million babies are born prematurely every year, with this number increasing exponentially in recent years with rates of between 5% to 18% of babies born prematurely (WHO, 2018). Of these 15 million preterm births, it is estimated that 1 million deaths occur as a result of being born prematurely, relative to other added causes (WHO, 2018). More surprisingly, according to the WHO (2018) three quarters of these deaths can be prevented with cost effective intervention, as well as adequate care. In addition to these, the differences in the survival rates of premature

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babies are exponentially higher in developed, high-income countries compared to low-income countries (WHO, 2018).

There are certain challenges that children face when being born prematurely. There are highly probable mortality and developmental risks inherent in being born prematurely (Davis & Burns, 2001), with developmental risks ranging from learning disabilities, lifetime physical disability, auditory and visual impairments (Singh et al., 2013; WHO, 2018). The use of the term “developmental risk” is only mentioned relative to its clinical meaning by the WHO. This term can be problematized as it could also mean a range of difficulties relative to certain consequences of being developmentally impaired such as being unable to hold a conversation, as well as not participating in developmentally appropriate tasks for a relative age (Singh et al., 2013). In this study, the focus remains on both the clinical and social consequences of being developmentally impaired due to being born prematurely. This broader meaning of the term captures the whole range of experiences due to being developmentally impaired without constricting it to its clinical use only.

According to the WHO (2018), prematurity is also the leading cause of death among children under the age of five years old. The burden of deaths among preterm babies are stark which indicates a difference in the risk of between being born prematurely and being born full term. This difference in premature mortality is also skewed relative to developing countries. For example, 90% of premature babies in developing countries die in the first few weeks compared to less than 10% in developed countries (WHO, 2018). This difference could be due to a range of systemic factors relative to developed and developing countries (Leibrandt et al., 2012), and the state of healthcare in those countries. Therefore, the probability of these implications for being born prematurely is higher than for children who are carried to term.

Given the difficulties that premature babies, it is noteworthy to mention the larger macro factors that affect the systems in which care is embedded such as health sectors. The implications regarding the aforementioned survival rates of premature babies can be inferred to larger economic and structural factors influencing the state of healthcare institutions in developed and developing countries as well (Lyon-Callo, 2008). It is likely that the stark differences in mortality is related to the healthcare received which is embedded within different systemic issues of different countries. This relates to how care is received and perceived under the different health sectors both globally and locally (Jabnoun & Chaker,

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2003). The stark differences in mortality rates of premature babies can be inferred from these differences in austerity in developing and developed countries. More specifically, how care in the different healthcare sectors of developed and developing countries are perceived by both patients and healthcare staff, which will be discussed further in the section below.

2.5 Private versus public healthcare sectors

Health sectors around the world reflects different quality of services for different classes of people (Dadkhatehrani et al., 2018; Coetzee et al., 2013). The difference in quality, which is a salient feature in the competitive nature of public and private hospitals, is perceived by a certain product received. However, in the healthcare sector the designation of quality cannot be defined in terms of the quality of receiving a product, but by the perceived quality of services received by healthcare staff (Jabnoun & Chaker, 2003). The literature on the quality of healthcare received by the public and private sectors all represent a marked difference.

The disjuncture between the public and private healthcare sectors around the world, although not applicable for certain countries, reflects a significant trend in difference relative to hospital experiences. Private hospitals are generally reported to provide better perceived quality services than public sectors (Jabnoun & Chaker, 2003; Irfan & Ijaz, 2011). For example, striving to discern the differences in the quality of healthcare between public and private hospitals, Jabnoun and Chaker (2003) found that private hospitals were perceived to offer greater quality of services defined by empathy, assurance, care and issues around general administration in the United Arab Emirates. Similar results were found by Irfan and Ijaz (2011), which showed that private hospitals generally fared better than public hospitals on these domains of quality healthcare in Pakistan.

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The healthcare system in South Africa is not homogenous and shows similar trends as the abovementioned studies. However, what differentiates South Africa among these countries are the many macro factors which influences the state of hospitals. These macro factors include class differences (Mayosi & Benetar, 2014), income inequality (Leibrandt et al., 2012), unemployment as well as a decrease in state expenditure on health and welfare (Lyon-Callo, 2008). These macro factors heavily influence the kind of healthcare that patients and health consumers receive, as well as the affordability to access adequate healthcare services. The heterogeneity in the healthcare sector is characterised by differences in

adequate healthcare received, level of engagement from healthcare staff as well as the kind of care received.

Private hospitals are commonly more expensive than public hospitals (Jabnoun & Chaker, 2003; Irfan & Ijaz, 2011). This skews many of the services offered in the private sector to only a particular class of people who are able to afford these services (Jabnoun & Chaker, 2003). Factors such as medical aid, health insurance and hospital plans are all benefits that many South Africans are not able to afford. Thus, given South Africa's status as one of the most unequal societies in the world (Phiri, 2014) with a Gini index co-efficient of 63.0 as indicated by the World Population Review (2021), as well as the lasting legacy of Apartheid, access to adequate healthcare based on the macro factors identified above is likely to exclude many of South Africans.

On the other end, the public sector, which offers healthcare to the general public (which comprises the majority of South Africans), is faced with a variety of problems. These problems relate to issues surrounding over crowdedness, unhygienic environments, heavy burden of diseases being treated and an increased ratio of patient to healthcare professionals (Coetzee et al., 2013). Coupled with these issues, decrease in state expenditure to facilitate the upkeep of public institutions is also a major contributing factor for the state of the public sector (Abramovitz & Zelnick, 2010). Additional macro factors such as inadequate management of healthcare institutions as well as poor working conditions for healthcare staff are all factors contributing to the care received from the general public (Abramovitz & Zelnick, 2010; Coetzee et al., 2013). A large South African study conducted by Coetzee et al. (2013) which surveyed 1187 nursing staff working in the healthcare sector across South African public hospitals found that nurses often reported dissatisfaction with their working conditions, with more than half intending to leave their hospitals. The dissatisfaction is likely to affect the kind of healthcare services received from patients, and is also likely to influence the care and support received by fathers having a premature baby. According to Dadkhatehrani et al. (2018), fathers' reports about the healthcare and support received in the public sector yielded negative responses such as disrespect from healthcare workers and long waiting hours. This all characterises the disjuncture between the public and private hospitals, as well as the difference in care received in these sectors.

The significant differences between the public and private healthcare sector is likely to influence the kind of care and support fathers receive while having a baby born earlier than

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expected. Dadkhatehrani et al. (2018) found that fathers generally reported having negative experiences with healthcare staff, ranging from negative attitudes, lack of information regarding the wellbeing of their partners and children as well as poor support from healthcare staff. These negative experiences can be traced to the larger macro issues influencing the state of healthcare in South Africa and beyond. These structural issues may also affect the survival of premature babies. According to the WHO (2018), adequate midwifery care could reduce the mortality rate of premature babies by 24%. This is significant as the arduous conditions reflected in the abovementioned literature may affect the quality of care received by premature babies and mothers, which could increase the already difficult experience of having a premature baby. Given this, it may also negatively affect fathers' experiences of having a premature baby in this way. However, there are not many studies addressing the question of how fathers specifically experience the healthcare system while having a premature baby.

However, it is worth noting the differences regarding the private and public health sectors in South Africa. The domain of literature on the state of healthcare in South Africa highlights the stark difference in both institutional support relative to healthcare staff in the public and private sector. Lyon-Callo (2008) noted that the public expenditure on healthcare systems influences the management of public institutions such as hospitals. Coetzee et al. (2013) found that healthcare staff's level of satisfaction with working in poor working conditions significantly impacted the negative attitudes portrayed by healthcare staff. Issues around over-crowdedness and the heavy burden of disease dealt with by healthcare staff in the public sector influenced the negative attitudes often exerted by healthcare staff. For fathers having a premature baby in the public sector, this could explain the low satisfaction fathers report with healthcare staff.

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2.6 Mother's subjective experience of pregnancy

Much has been documented about mothers' experience of pregnancy (Isaacs & Andipatin, 2020; Cupido, 2017; Lykke et al., 2010; Giallo et al., 2015; Scribano et al., 2013; Siegel & Brandon, 2014), as well as having a baby born earlier than expected (Lindberg & Orhling, 2008; Holditch-Davis et al., 2007; Lee, 2005; Veronez et al., 2017). The experience of becoming a mother for many are filled with excitement and joy, which marks the advent of a new journey. However, having a baby prematurely for mothers is extremely stressful, and is filled with adverse emotional experiences. Factors such as being unprepared to have the baby

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(Lindberg & Orhling, 2008) and not being ready to become a mother (Holditch-Davis et al., 2002) are some of the experiences faced by mothers having a baby born prematurely.

Holditch-Davis et al. (2002) and Cupido (2017) suggests that the experience of pregnancy and mothers having a baby born earlier than expected may have arduous effects on the identity and wellbeing of new mothers. Factors such as not being able to bond with the baby immediately after birth was reported to negatively affect mothers' psychological wellbeing (Holditch-Davis et al., 2002), which also interrupts mothers' transition in to motherhood. Early bonding for mothers is also crucial for future relationships with their children as these early experiences are key to having trusting and fulfilling relationships as an adult (Herbert & Kulkin, 2018; Medina et al., 2018). However, having a baby prematurely stifles such bonding and hinders mothers from connecting with their infants, as intensive neonatal care (often in the form of incubation) is required to care for the baby. Thus, feeling as if "something is missing" (Medina et al., 2018) in the mother-child relationship is a common psychological consequence for mothers having a baby born earlier than expected. This particular stream of literature contrasts the intervention strategies outlined by the WHO (2018), which suggests that mothers are often crucial in the survival of their babies. Interventions such as the 'kangaroo method' (WHO, 2018) requires mothers to frequently make skin to skin contact by laying the baby on the chest of the mother. Therefore, this intervention strategy suggests that early contact is crucial for the wellbeing of premature babies, which is different from what the above literature discusses. However, it is worth noting that different interventions may be needed depending on the category of prematurity, which also may or may not influence mothers' involvement in the survival of children.

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Mothers having a baby prematurely also need updated information regarding the wellbeing of their child (Lindberg & Orhling, 2008). Thus, neonatal nurses play an important role in supporting mothers with both information regarding the wellbeing of their child, as well as facilitating the possibility of getting closer to their children (Ayisibea & Kwakyewaa-Bosompem, 2020). In addition, Poh et al., (2014) also found that the essence of mothers' support comes from their partners, as well as the healthcare staff in hospitals. Fathers of premature babies, however, often provide mothers with care and support, which is crucial for the wellbeing of both mother and child (Poh et al., 2014). Therefore, it is important to further discuss the fathers' subjective experience of pregnancy to attain a holistic view of the kind of support offered by fathers.

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2.7 Fathers' subjective experiences of pregnancy

For many fathers, the subjective experience of pregnancy commences when the partner announces that she is pregnant (Wong et al., 2016). Vanier (2017) argues that the prenatal experiences of fathers are characterized by a psychological transition from being a partner to becoming a parent. This transition encompasses the surreal nature regarding the pregnancy which may be linked to the aforementioned perception, emotional preparation of the new role and anxiety regarding the expectations of the new role (Vanier, 2017; Wong et al., 2016; Makhanya, 2018; Johnsen et al., 2017).

One aspect of expectant fathers is the anxiety of becoming a father for the first time (Makhanya, 2018; Johnsen et al., 2017). This is characterised by a change in identity of being a man to becoming a father. This shift in identity evokes anxiety regarding constructions of what a father should be like, as well as being responsible for a child (Makhanya, 2018). Thus, in tandem with the surreal experience of becoming a father, witnessing the pregnancy triggers many anxieties relating to identity and becoming a father.

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Another theme stemming from fathers' experience of pregnancy is the perceived disequilibrium of the relationship they have with their partner (Wong et al., 2016; Su & Emory, 2016). Fathers often feel disconnected from their partners during pregnancy, as they do not experience the physical and emotional effects of being pregnant (Bermin & Long, 2021; Wong et al., 2016). Despite some of the notions that fathers vicariously experience certain symptoms of pregnancy, the disconnect between expectant mothers and fathers is significant. The theme in the literature domain on mothers and pregnancy suggests that bonding occurs when mothers feel gestational movement (Lindberg & Orhling, 2008). However, for fathers, this does not occur as they are seen as separate from the physical effects of pregnancy, and thus do not bond with the infant until much later. Therefore, the disequilibrium between mothers and fathers remains significant.

Biological differences in the experience of pregnancy alienates men from the physical experience of carrying a child, which could lead to fathers and mothers experiencing this process in different ways. According to Draper (2003), the disjointed experience of partners during pregnancy is associated with women fundamentally experiencing the process through

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natural bodily changes, and men through their perceptions of those experiences and the seemingly supportive role they should play. The differentiation of mothers' and fathers' experiences of pregnancy is characterised mainly by how the pregnancy is subjectively experienced. For both expectant parents, the transition occurs upon discovering that they are pregnant. Therefore, the experiences of men and women during pregnancy cannot be understood unilaterally.

2.8 Fathers' experiences of a premature baby

The experiences fathers have during pregnancy can also be inferred and understood when having a premature baby, as these entail much of the experiences mentioned above. However, what distinguishes having a premature baby from the experiences of pregnancy for fathers is the capricious advent, and relative emotional conflicts of having a baby born earlier than expected. Thus, having a premature baby can exacerbate the abovementioned experiences, and add to the extremely stressful experience of becoming a father earlier than expected (Dadkhatehrani et al., 2018).

Premature babies often include hospitalization, which causes enormous challenges that affect fathers' culmination of stress levels (Straus et al., 2019), which may not be managed well during these times. According to Pohlman (2005), fathers typically tend to ignore their needs during these times and may keep stress hidden. It is worth mentioning that the repression of emotional responses under the condition of having a premature baby may be a key feature tied to particular constructions of traditional hegemonic masculinity. As Mfecane (2016) points out, men's emotional expression has limited space under the construction of traditional masculinity. This means that fathers often have to repress their difficult emotions even when certain events and situations such as having a premature baby warrants the expression of them. Thus, as suggested by Edwards et al., (2020) fathers often have to remain strong by not expressing any negative feelings relative to having a baby prematurely, which is a hallmark of hegemonic masculinity. Therefore, traditional forms of masculinity in this context limits the emotional expression of men in this regard.

According to Dadkhatehrani et al. (2018), fathers experience various negative emotions such as feelings of abandonment, helplessness (which includes lack of finance, support and information), distrust in health care workers, and anxiety. The feeling of abandonment may stem from the setting of many hospitals, in which men are seen as not part of the process of caring for the child. Dadkhatehrani et al. (2018) and Edwards et al. (2020) postulates that

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fathers often report dissatisfaction with long waiting times, minimal information conveyed regarding the infant's progress, and disrespectful attitudes from professional healthcare workers. This may also relate to the abovementioned literature on the dissatisfaction levels of healthcare workers in the public sector, which affects the way staff care for patients and other health consumers. Fathers also experience anxiety and fear regarding the uncertainty of survival of the hospitalized infant and wellbeing of the mother (Dadkhatehrani et al., 2018; Vanier, 2017; Edwards et al., 2020). The experience of disconnection and abandonment from the event, with the added anxiety regarding the survival of the infant and extra financial responsibilities all characterize the stressful experience of fathers having a premature baby.

2.9 Legislative support and paternity leave

The literature on paternity leave is relevant, as fathers in Norway receive extended leave of approximately four weeks during the birth of their babies (Rege & Solli, 2010; Farre & Gonzalez, 2019). In South Africa, however, this is different as the legislation of paternity leave was recently extended to ten days of leave, from the previous three days (Karr, 2017). This could have significant implications for fathers having babies born earlier than expected. First, having a premature baby often requires extended hospitalisation periods for up to three months (Dadkhatehrani et al., 2018). The new legislation of ten days of paternity leave would suggest that fathers are not afforded to take adequate time off given the nature of having a premature baby. This means that a significant amount of time during the experience of having a premature baby, fathers will have to go to work, or receive unpaid leave.

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Secondly, the ten days of paternity leave afforded to fathers provides fathers who are having a premature baby with the difficult choice of when to take paternity leave, given the short duration thereof. Taking leave when the child is hospitalised to be supportive (Edwards et al., 2020) would mean that fathers have to return to work much earlier when babies are discharged. Upon discharge, fathers would also not be able to adequately bond with their babies given that paternity leave is either too short or already taken. These grave implications for fathers having a premature baby could have significant consequences given the literature (cited above) on the importance of paternal involvement during experiences such as having a baby born earlier than expected.

2.10 Mothers and fathers' experiences of having a premature baby

The above literature differentiates between both mothers and fathers' experience of having a premature baby. For mothers, the key stressor is experiencing distance during the

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incubation of their babies. This suggests an interruption in the necessary early bonding between mothers and their children. In contrast, fathers mainly experience stress related to external factors such as finance, lack of information and fear about the survival of their children. Mothers, on the one end, feel supported whenever they receive information regarding the wellbeing of their children, as well as receiving support from their partners in this regard. Juxtaposed with mothers' experience, fathers on the other end, report feeling dissatisfied with the lack of information, dismissive attitudes of healthcare staff and long waiting hours during the experience of having a baby prematurely. These differences are notable in the varied literature reviewed above.

The differences in experiences for mothers and fathers are exacerbated when considering these experiences on a broader level. The literature on patient and healthcare workers' experiences in the public and private sectors informs these discrepancies at a macro level. The discrepancy of the state of public and private hospitals could provide a logic for experiencing these events differently. Patients' reported dissatisfaction and perceived inadequate healthcare services and care in the public sector is consistent with the negative experiences fathers face during the experience of having a baby born earlier than expected. In addition, nurses working in the public sector also report dissatisfaction with working conditions, which affects their ability to care for patients and other healthcare consumers. What could also characterise and impact the discrepancy among public and private sectors is the dynamic between the patients and healthcare workers. Many nursing staff are overwhelmed, overworked and in often unsavoury conditions in the public sector which could affect their ability to attend to the needs of fathers having a premature baby (Pillay, 2009). This in turn could also compound the negative experiences of fathers mentioned above relative to healthcare institutions. However, what is missing from this domain of the literature is the discrepancy of fathers' experiences of having a premature baby in the public and private sector more specifically. This indicates that more research regarding this is needed.

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Chapter 3: Method

3.1 Research design

This study used a descriptive phenomenological research design which attempts to study phenomena or situations in the world as they are experienced by human beings in a given context (Hays & Wood, 2011). This Husserlian perspective, also known as transcendental phenomenology, concerns itself with pursuing different realities and not by establishing truth (Giorgi et al., 2017). It equips the researcher with methods to grasp and describe the subjective understandings of events as it appears in the consciousness of the participant (Giorgi et al., 2017). Experience manifests itself to consciousness as an appearance of an event that is sensorial (birth of a child, research setting, etc.) as well as through things that are not sensorial (ideas, identity, etc.) to the participant. The convergence of these manifestations is the make-up of the participant's unique experience, which will be described to the researcher through the understanding of the participant. Therefore, this study investigated the emotional experiences of a sample of fathers having a premature baby in South Africa using this design as a blueprint.

3.2 Research setting

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Given the current Covid-19 pandemic globally, this research study was conducted online using various social media platforms such as WhatsApp, Google Meet, and telephonically. These platforms enabled the researcher to collect data digitally under the current lockdown safety measures. This was an advantage as social media platforms consist of a proportionate number of potential participants which increased the probability of finding fathers who fit the criteria for the study. Also, conducting the study online was advantageous as it had no geographical constraints. Fathers from all provinces in South Africa were recruited and participated to obtain a richer and broader understanding of the experience of having a baby born earlier than expected.

3.3 Characteristics of the sample

The sample consisted of 10 South African fathers. Fathers were recruited from various parts of South Africa, with the majority living in the Western Cape (6); Gauteng (2); Mpumalanga (1); and the Eastern Cape (1). The mean age of fathers was 37.7, which ranges from 27 to 49. The majority of fathers identified as Coloured (5), which was followed by

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White (3), and Black (2). The majority of fathers preferred to do the interview in English, with only two participants preferring Afrikaans. All fathers reported living with their children. All children of the fathers were born relatively early, ranging from extremely preterm to moderately preterm (27-32 weeks). Fathers were also asked about their age, demographics and number of children they had prior to the interview, as part of the strategy to build rapport. This informed the researcher about the context in which fathers shared their experiences of having a baby born prematurely.

Table 1

Demographics of fathers

Participant (Pseudonyms)	Age	Race	Number of children	Province	Weeks of prematurity
Marco	28	Coloured	2	Western Cape	30weeks
Rudi	49	White	1	Gauteng	28 weeks
Hannes	40	White	2	Western Cape	32 weeks
Vuyo	42	African	1	Mpumalanga	30 weeks
Justin	40	Coloured	1	Eastern Cape	35 weeks
Riedewaan	27	Coloured	1	Western Cape	32 weeks
Ash	35	White	1	Western Cape	35weeks
Jeffery	42	Coloured	2	Western Cape	29 weeks
Thabo	45	African	2	Gauteng	30 weeks
Greg	29	Coloured	6	Western Cape	28 weeks

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3.4 Participants and sampling

The study used purposive sampling and snowball sampling techniques (Marshall, 1996). Purposive sampling was appropriate for this study as the research was directed at a particular sample, specifically fathers who have had a premature baby. This technique was useful as it enabled the researcher to access specific participants in an effort to answer the research questions. The snowballing technique was effective in recruiting sufficient participants. It was also an effective technique to use in the current context of the Covid-19 pandemic as the researcher was not be able to approach participants physically. Participants were also accessed on various social media platforms. The criteria for participating in this study was publicised and advertised on WhatsApp, Facebook, Twitter, Instagram and

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LinkedIn (see Appendix E) and fathers who reached out were subsequently screened for inclusion in the study. Majority of the sample came from Facebook (6) followed by WhatsApp (4).

As the research aimed to understand fathers' lived experiences of having a premature baby, the main inclusion criteria to participate in the study was South African fathers who had a premature baby. The classification of the babies born prematurely included all categories, from 27 weeks to 37 weeks (WHO, 2018). Furthermore, fathers had to be 18 years and above as this is the legal age for adults to provide consent, and participants needed to be able to speak English, Afrikaans or isiXhosa. Lastly, the inclusion of fathers who experienced this event 6 months, or more, after birth was important as potential participants need to make sense of their emotions to talk about them. This was also related to issues of memory, and participants having time to process their emotions.

The number of participants sampled followed Creswell's (2007) guide to selecting an adequate number of participants in a phenomenological design. For this study, initially 8-14 participants were aimed to be recruited, as prescribed for a phenomenological study (Creswell, 2007; Creswell, 1998; Morse, 1994). Qualitative analyses generally require small sample sizes, but enough to obtain an adequate amount of data to reach saturation, address the research question, and to generate enough depth to describe the phenomenon in question (Creswell, 2007). Therefore, for this study, saturation was reached by the 6th participant as no new data emerged from the interview process. Four more participants were recruited from other provinces such as Gauteng, Mpumalanga and East London, to confirm whether no new information would emerge from the interviews of fathers from other provinces.

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3.5 Procedure

Upon receiving ethics clearance (please see Appendix D [Project registration: BM20/8/12]), the researcher proceeded with data collection. Due to the Covid-19 lockdown regulations in effect, the research had to be conducted online using various social media platforms. Therefore, an advertisement was posted on Facebook, LinkedIn, Twitter, WhatsApp and Instagram to recruit potential participants. The advertisements were also posted on various groups on social media related to fatherhood and premature babies. Three recruitment advertisements were posted in English, isiXhosa and Afrikaans.

Upon posting the advertisement, data collection proceeded slowly. However, Facebook rapidly provided the researcher the opportunity to recruit fathers at a faster pace. A

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page on Facebook called “I’m staying”, which is a proudly South African page supported the recruitment phase by acknowledging the month of November 2020 as world premature baby month. Posting the advertisement on this page provided the researcher with 70% of the sample of fathers. The majority of participants who made contact were the mothers of babies born prematurely, but indicated that the fathers would participate. The other 30% came from initial word-of-mouth and recommendations from these interviews.

Fathers were initially screened for inclusion in the study upon making contact. This was done through instant messaging on WhatsApp and Facebook, and telephonically. Before every interview, fathers were contacted and informed of their rights during the participation of the study, and were initially requested to sign a consent form (Appendix C) detailing their willingness to be recorded. Fathers who were interviewed all signed the consent forms digitally. The interviews were conducted in a quiet space for fathers’ convenience to express their experiences of having a premature baby freely. The time of the interviews also coincided with fathers’ time of privacy in their homes. Interviews usually took place within the first 24-hours of initial contact, and the average time of the interviews were 30-45 minutes.

Once initial contact was made, the researcher engaged in building rapport with the participants by asking ice-breaker questions, and ensuring that the fathers were comfortable to do the interview at their own preferred time. The information sheet (Appendix B) was provided either through email or via WhatsApp instant messaging. In the event where fathers did not understand something provided in the information sheet, contact was made immediately and explained to the participant.

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3.6 Data collection

Data collection involved online semi-structured interviews on WhatsApp, Google Meets, and telephonically, where participants needed to answer the predetermined but open-ended questions set by the researcher (see Interview Schedule Appendix A). The choice of which platform to use was at the convenience of the participant. Participants in the study were offered compensation in the form of data to connect for the interviews. However, all participants declined. Semi-structured interviews were very useful when conducting this qualitative study as it enabled the researcher to gain in-depth knowledge from the perspective of the interviewees (Shenton, 2004). Semi-structured questions were particularly useful to

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probe as it allowed the researcher to penetrate deeper in to the understandings of particular experiences.

The interview schedule was constructed in alignment with the aims, objectives and the relevant literature to enhance the trustworthiness of the study. Responses to these questions was recorded, with additional shorthand notes that were made during the interviews. The questions were also piloted with one participant in a Google Meets interview prior to the actual interview process to assess the relevance of the questions pertaining to the aims and objectives of the study, and to eliminate questions that were repetitive. The feedback from this interview yielded several questions as being repetitive, which led to the elimination of some questions (see Appendix A for interview questions). Certain questions also allowed for the opportunity to probe more, which afforded a more in-depth discussion around fathers' lived experiences of having a premature baby. Participants were also provided with electronic information sheets (Appendix B) detailing the nature, purpose, expectations and rights of the participants in the study. A consent form (Appendix C) was also issued where participants either signed electronically by themselves or with the help of the researcher.

3.7 Data analysis

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Data analysis took the form of a descriptive phenomenological analysis of responses from participants. This type of qualitative analysis was ideal for meaning making of events on a conscious level (Giorgi et al., 2017). By using this Husserlian perspective of inquiry it enabled the researcher to accurately describe the lived experiences as understood by the participant in a structured way. The interviews were transcribed verbatim by the researcher in collaboration with the data field notes. After rereading the transcripts and listening to the audiotapes the researcher got a basic sense of the data. Meaningful units were delineated by grouping similar words and phrases together and to establish links and commonalities between what participants were communicating. The core essence of these linked categories characterised the main experiences of fathers having a premature baby. Participants' expressions were then intuited and reduced into psychologically meaningful categories to develop superordinate themes. This was done through the researcher differentiating, transforming and describing the essence of the psychological experiences of fathers based on the commonalities found in the data. This three-step process was done to significantly condense the participants' responses without having to eliminate, distort or misrepresent the

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essence of their experiences (Giorgi et al., 2017). Based on the reduction of the data to meaningful units through the descriptive process, the emotional/psychological structure of the experience was uncovered, without having to interpret and analyse the essence of having a baby born prematurely.

3.8 Trustworthiness

Shenton (2004) defines trustworthiness as the degree to which the researcher persuades their audience to consider any investigation as worthwhile. It is important to consider the trustworthiness of a study as it assesses the truth-value of findings by the use of various strategies (Shenton, 2004). These strategies are *credibility*, *transferability*, *confirmability* and *dependability*. To ensure the *credibility* of the findings, participants' responses were reflected back to them to ensure that what they said were accurately recorded and understood. This often happened during the interview process, and was checked against the interview notes after the interviews were conducted. Detailed descriptions regarding the research setting, process and participants, as well as conducting semi-structured interviews were used to ensure the *transferability* of the findings, and to provide a vivid account of what transpired. To minimise the imposition of the researcher's own preconceived notions on the study topic, bracketing the beliefs and ideas of the researcher by fully describing his/her own experience with the phenomenon was an integral part of the process to ensure *confirmability* and reflexivity. This entailed journaling the emotional and cognitive experiences of the researcher immediately before, and after transcribing the interviews. This process assisted with recognising and differentiating whether the experiences were those of the researcher or the fathers as they appeared in the interviews. This also informed the broader research design. Triangulation was used where the supervisors examined the research process and subsequent interpretations to ensure credibility. A clear research path was kept to ensure the *dependability* of the study.

3.9 Reflexivity

As a young person of colour, who subjectively experienced his partner having a high-risk pregnancy, I needed to remain aware of my own thoughts, experiences and perceptions as both a man and father in the South African context. Reflexivity, as described by Palaganas et al. (2017) involves the examination of the researcher's background, interest and perspectives as an overarching influence on and in relation to the research. Due to the inherent subjective nature of qualitative research the perpetual awareness, assessment and reassessment of the

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researcher's own experience with pregnancy was bracketed and set aside in the research process to establish transparency. A reflective journal was kept prior to and during the data collection and data analysis process to write down any thoughts, emotions and perceptions. Although very difficult, this was an integral facet of being reflexive during the research process. Being a young male and father brought up ambivalent emotional responses in myself and in relation to the participants who were mostly twice my senior. For myself, I felt the inherent anxieties and fears of having a baby, as this is a fragile and powerful process of bringing life in to the world. Coexisting feelings of comfort and gratitude that my children are safe and healthy were coupled with the anxieties felt when in conversation with the fathers. The conflicting feeling of being young relative to older participants, and identifying with many of the experiences (anxieties and fears mentioned above) as a father were responses I had to be aware of in order to caution against biasing the results, as well as probing certain answers by asking unconscious leading questions that triggered these emotional responses in myself. Thus, after every interview, these experiences were jotted down in to a reflective journal. This also aided in dealing with these responses in subsequent interviews. For this reason, the researcher's reflexivity was a constant feature.

3.10 Ethics

Ethics approval was sought from the Biomedical Research Ethics Committee (BMREC). An advertisement was posted on social media platforms such as WhatsApp, Facebook, Instagram, Twitter and LinkedIn. Once approval was obtained, participants who met the inclusion criteria were contacted to determine whether they would be willing to take part in the study. Upon agreement, participants were provided with an electronic information sheet and a consent form to sign electronically in their preferred language. Electronic signatures were requested from participants prior to the interview. The information sheet and consent form was translated from English to Afrikaans and isiXhosa. Pseudonyms was used to ensure confidentiality and anonymity. Participants were also made aware of their rights to voluntary participation and their right to withdraw from the study without consequence. The data obtained was stored on a computer in password protected files to which only the researcher has access to. Signed consent was sought from participants to audio-record the interviews. Lastly, participants were provided with details for counselling referral services such as the South African Depression and Anxiety Group (SADAG), Lifeline and the Counselling Hub. None of the fathers reported whether they would use the support provided from these services. A short debriefing session after the interviews was held to check in with

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participants. Most fathers reported that talking about their negative experiences were a positive sign of processing and integrating the experience of having a baby born earlier than expected. Some even suggested that they felt happy about sharing their experiences to conscientise people around the emotional rollercoaster of having a baby born prematurely.

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Chapter 4: Results/Findings

4.1 Themes

The themes found in the descriptions provided by the fathers in this study points to the overall experience of having a baby born prematurely. The core essence of the experiences around having a premature baby is described by fathers as a deep ambivalent sense of fear with regards to losing their child, as well as having to deal with the anxiety and sadness of possibly having a developmentally impaired child due to being born prematurely. All fathers reported the fear of losing their child due to being born earlier than expected. However, all fathers mentioned that their children are healthy and alive with no developmental or health-related risks. Coupled with this deep and conflicting possibility of losing a child, as well as possibly having a child with developmental and health-related risks, fathers also described the arduous experiences of having to deal with disproportionate medical costs, providing support to the mother and baby as well as navigating difficult experiences related to healthcare institutions. This experience proved tremendously difficult for fathers who often described their experience as 'the most difficult emotional experience ever'. However, despite the arduous experience of having a premature baby, fathers stressed the importance of supporting both mother and child during this uncertain period.

The themes emerging from the data points towards a general sense of (1) the experience of having a premature baby (2) the relationship with the baby during the crisis of having a premature baby, and (3) the relationship with the mother during the high-risk pregnancy and having a baby born prematurely. Given this general sense, capturing the common description provided by fathers resulted in eight themes emerging from the data that highlights the essence of the experiences of having a premature baby.

Of these eight themes, one emerged as a general theme with two subsequent subthemes. The general theme which emerged from the data is "*Fear about survival and wellbeing of the baby*" which has its two subthemes namely *"Fear of their child's survival"* and "*possible developmental deficits and financial strain*". The remaining themes are "*Instinct to support*", *"Barriers to support and addressing fathers' needs", "Taking a backseat*", "*Impact on the mother*", and "*Closer to mom through communication*".

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4.1.1 Fear about survival and wellbeing of the baby

The first general theme relating to the experience of fathers having a premature baby was concerned with a deep and ambivalent sense of uncertainty relative to the survival and wellbeing of the baby. More specifically the fear about losing their child, as well as the possible developmental deficiencies resulting from being born prematurely exacerbated fathers' fears. Fathers often expressed feeling as if there was a dark cloud hanging over them which often made them feel particularly stressed about the mortality of their babies given how early they were born, as well as the size of the baby.

> *"…Yoh it was hard hey. That's all I can say, it was hard. But I tried every day to give her support when she was in hospital. She was in hospital for 2 months, 2 and a half months. And then the child was not picking up weight. Her development was very slow. It was very stressful. And it was hard to see her at the time I was going there…" [Thabo]*

> *"…Well, the main issue for me was that my baby was a 2.5 baby. And that the mother had to keep the baby on her at all times. In her… and put blankets and whatever to keep her warm cause the premature babies that are kangaroo babies need to be always kept warm because they are not fully developed. They are not fully 9 months in the womb like they are supposed to be. So yes that is one of the aspects… they are fragile man. They can get a virus quick. Quicker than our kids that are 9 months..." [Marco]*

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The core consequences of this stressful and uncertain experience were also sensibly visible to fathers themselves, their friends and family as characterized by losing weight and lack of sleep, which related to having a premature baby. For most fathers, the advent of this experience was precipitated by seeing babies physically underdeveloped after birth and seeing children suffer in hospital under life support (by seeing children on medical machines which assisted in keeping them alive). At the same time, gnawing feelings of anxiety and fear around normal development also contributed to these as conflicting negative thoughts infiltrated and triggered their concerns of whether their children would live abled lives. This deep concern for their children to live 'normal' lives often had presumptive cognitive consequences for fathers as characterized by the perception that their children will not fit in socially, and will require special attention. These experiences are expressed in the extract below:

> *(Afrikaans) "…Grootse kommer. Sal hy n normale lewe lewe. Sal hy n normale lewe lewe soos enige ander kind daar buite…" [Justin]*

> *[English] "…Biggest worry, will he live a normal life. Will he live a normal life like any other child out there…" [Justin]*

The above extract highlights some of the concerns around having to care for a baby that is born prematurely. *Marco* mentions that babies born prematurely often need more attention given their prematurity, and without this they could die. This speaks to efforts aimed at keeping premature babies alive and well. The end of the extract depicts the fragility of having a baby that is premature, and is magnified by the comment that premature babies are underdeveloped and prone to sickness. The fragility of possibly being developmentally impaired or having health related risks is also evidenced in the concern for how their babies may or may not suffer as a consequence of being born prematurely, as described by *Justin*.

The deep fear regarding the survival of the children is more clearly expressed by the next subthemes. These themes provide more detail regarding the fear of losing a child, and whether the child will live and experience 'normal' psychological and physical developmental trajectories.

4.1.1.1 Fear of their child's survival.

One aspect of the deep and ambivalent experiences of having a premature baby involves the survival of their children and relates to fathers fearing for the lives of their babies. Fathers often described trembling anxieties about whether their children will live or die in hospital due to being born prematurely. The conflicting thoughts of having a child and not having a child occupied the minds of fathers incessantly, which evoked intense anxieties around this uncertainty. The hope of their babies surviving was accompanied by a harsh and possible reality of gloom and death, which characterized the emotional landscape fathers had to navigate.

[Afrikaans] "…Soos ek se, ek was ma bang hy verloor sy lewe. Ek meen mens wil mos nou nie die kind verloor nie. So ek dink die meeste stress was om hom te kry dat hy lewe..."

[English] "…Like I said, I was scared he loses his life. I mean a person does not want to lose a child. So I think the most stress was to get him to live…" [Hannes]

"…I think my biggest concern was if she was going to be alive, because she was in a medically induced coma…" [Riedewaan]

"…Yoh biggest worry… I wanted her to live. But the biggest worry was the "…" because the drip and everything, shaving the head, the drip on the forehead; it was difficult to find a vain so they put it in the head. Actually it was very painful on my daughter…" [Vuyo]

Constant negative thoughts and emotions about their children's survival was mostly mentioned as many fathers feared the possibility of losing their children. This often entailed not having the strength to live with the loss of a child, and not wanting any more children in the event of death. This was often compounded by previous experiences of death in the

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family that some fathers had to deal with, as mentioned below by *Greg*. This is evident as the majority of fathers expressed unbearable uncertainty regarding what to expect during this time. This is expressed in the extracts below:

> *(Afrikaans) "…Vir my het dit gevoel, om eerlik te wees, vir my het dit gevoel, as ek die kind verloor sal ek nie meer kinders maak daarna nie. Dai was my feeling. Ek sal nie weer kinders maak na daardie laaitie nie. As ek hom moet verloor het, sale k nooit weer kinders wou he nie. Dit was te veel man, dit was te veel vir my. Nie weer nie…"*
>
> ***Interviewer:*** *Dit klink baie baie stresvol.*
>
> ***(Facing down)*** *"…Nai te veel dinge man, because why jy sien, my ma en my pa het een dag gegaan toe ek nog n laaitie was. Nee ek sal nie weer deur dit wil gegaan het nie. Sal nie weer wil kinders gehad het nie…."*
>
> *[English] "…For me it felt, to be honest, for me it felt, if I lost this child I would not have had another child. That was my feeling. I won't have more children after that child. If I would have lost him, I would not have had any more children. It was too much man. It was too much for me.*
>
> ***Interviewer:*** *That sounds very very stressful.*
>
> ***(Facing down)*** *"…Nah too many things man, because why you see, my mom and dad went when I was a child. No I would not have wanted to go through that again. Would not have wanted more children…"[Greg]*
>
> *"…If you hear about how some of the prematures don't survive and everything, you kind of like doubt… it's not a nice thing…" [Vuyo]*
>
> *[Afrikaans] Die feit dat jy nie weet of hy of sy dit miskien gaan maak nie. Daar is so baie wat kan verkeerd gaan met vroegebore babas [Justin].*
>
> *[English] The fact that you don't know whether he is going to make it. There is so much that can go wrong with premature babies [Justin]*

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Stress and anxiety regarding the anticipation of their children's survival was often accompanied by their perceived inability to make the situation better. Feelings of helplessness and powerless pervaded fathers' experiences of having a premature baby, as they felt as if there is nothing they can do. Not being able to do anything during this event also made fathers feel worthlessness as this defined their fatherly duty to protect their children, which was reported among most fathers.

> *"…Uhm, actually helplessness was the main one. It's really not being able to do much about it. …" [Ash]*
>
> *"…Yeah and as a dad your job is to protect the children. The first thing that came to mind was "what could I have done". For me that was the most stressful part. So I just felt helpless man, there wasn't really much I could do, and that stressed me out…" [Riedewaan]*

Not being able to help exacerbated the experience of having a premature baby as many fathers deeply felt their lack of assistance and their inability to prevent this experience from happening, and their limited influence on making the situation more bearable. Not being able to help seemed to conflictual to the integral aspect of fathers protecting their children

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from the suffering of being born prematurely, and not being able to do anything about it. This is expressed in the below extract:

> *"…Yeah and as a dad your job is to protect the children. The first thing that came to mind was "what could I have done". For me that was the most stressful part. So I just felt helpless man, there wasn't really much I could do, and that stressed me out. Like I said, that feeling of helplessness, not being able to do anything about it. Not able to make it better for them, not being able to fix it. That was very stressful…" [Ash]*

The above section describes the stressful aspects of having a baby born prematurely. Fathers felt that vacillating between having a baby and not having a baby was a deeply ambivalent and conflicting experience, which left fathers uncertain regarding what to expect from the situation. However, the above experience only depicted one aspect of the major experience. This was characterised by the possibility of losing their children due to prematurity as well as becoming a father if their child survived. The other side of the experience involved concerns around the difficulties the child and parents would face due to being born prematurely. Concerns about the life that the child would live when surviving the premature birth is another aspect felt by fathers. This is discussed in the below sections.

4.1.1.2 Developmental deficits and financial strain

The feelings of fear, anxiety and powerlessness were often exacerbated by additional concerns such as the developmental wellbeing of their children. The conflicting feelings of whether their children were going to survive as they suffered quite early, as well as the fear of living a 'normal' life if the child survived was an emotional experience that was reported by all fathers. The possibility of their children having to suffer through developmental deficits and health-related risks, which could be either physically, psychologically or socially, was emotionally taxing for fathers. Fathers did not directly confront specific developmental and health related risks, but expressed their concerns about the social consequences of possibly living with these risks. This is expressed in the extracts below:

> *[Afrikaans] "…En ook die feit van as hulle miskien groot word. Hoe sal hulle miskien lei. Jy weet, daar word baie kinders geboelie by die skool. So dit was ook een va onse vrees gewees. Gaan hy miskien kort is? En hoe gaan hy wees as hy miskien groot is in die society…" [Justin]*

> *[English] "…And also the fact of when they grow up, how they will suffer. You know, there are many children that are bullied at school. So this was also one of my fears. Is he maybe going to be short? And how is he going to be when he maybe grow in the society..." [Justin]*

> *"…The main stress? Yah just probably that she would be under developed in some kind of way. Maybe it be mentally or physically. So that was my main concern…" [Ash]*

> *"…that was a little bit stressful for me because I was thinking about possible long term effects, you know, effects on the brain and so forth. So that time it was just the potential long term effects that it*

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could possibly have on my baby. I was also trying to prepare myself mentally for that if that was going to be the outcome…" [Riedewaan]

The emotional spaces of fear about survival and being developmentally impaired was accompanied by immediate external pressures as well, which was felt as an engulfing omnipresence of financial responsibility during an already difficult time. The capricious event of having a baby prematurely left fathers unprepared to deal with the financial strain of medical costs, especially given the lengthy period of intensive care in hospitals.

[Afrikaans] "…Dan skop die ander finansiele kant ook in. En dit is nou weer 'n ander stress. So dit is maar die feit dat hy moet hy moet lewe en die finansies was die groot ding gewees want ek dink sy storie het n totaal van oor die drie miljoen rand beloop…" [Hannes]

[English] "…And then the other financial side also kicks in. And that is now another stress. So it's just the fact that he must live and the finances that was the big thing because I think his story was a total of over three million rand…" [Hannes]

Reported medical bills were disproportionate, which further evoked an overwhelming sense of anxiety in fathers which added to their feelings of helplessness and powerlessness. The anxiety of paying the medical bills to ensure the wellbeing of their children stayed with fathers throughout this experience, especially because they described themselves as the providers of their families. This is captured in the statement below regarding the disproportionate cost of healthcare for their children:

*"…So with regards to that, it was the medical factors, the financial stressors, I mean one day we asked for the bill for the day, and they gave us a stack of papers that size [**gesturing with hands**], and halfway through we just gave up because its… I think I stopped at R40000 for the day. The number is just so big to think, and she was just in hospital for 3 months. So yah, that takes over everything. I think when you the provider, the financial burden is huge…" [Jeffrey]*

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The above highlights the intense experience of having a baby born earlier than expected. The deep sense of ambivalence regarding having a child and not having a child coexists with the possibility of having a living child who will possibly be developmentally impaired. In addition to the internal emotional tug of war, the added financial strain evoked intense helplessness in fathers who regard themselves as the providers of their families, which added to the already stressful experience of having a premature baby. However, despite the stressful experiences described by fathers, all fathers extensively mentioned their supportive role in the experience.

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4.1.2 Instinct to support

The abovementioned experiences of fathers having a premature baby speaks to both internal and external pressures. This is characterized by fathers grappling with their internal emotional and cognitive experiences about having a baby born prematurely, and having to deal with the external financial burden and pressure of being the provider of the family. These pressures often resulted in fathers feeling overwhelmed by their sense of responsibility. This pattern of dealing with internal and external factors was also observed when fathers described their role during this arduous experience of having a premature baby. Upon asking how they felt about what was expected from them, the majority of the fathers contested the idea of placing an external expectation on them, and adamantly reframed their role as more instinctive and internally motivated.

> *"...I don't know if I have any thoughts or feelings about what was expected from me because I feel like what was instinctively there was to be there for my child and my partner...*" *[Riedewaan]*

Resistance towards framing their role as an external demand was directly in conflict with fathers' 'natural' felt sense to support. Perceiving their role during this experience as being informed by external social commands was not accepted, and was reframed as having an internal source characterized by caring and genuine felt concern regarding being there for, and caring and supporting their children and families. This is actively asserted by *Riedewaan*, *Rudy* and *Ash*:

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> *"...Yah I did feel... Yoh, what was expected of me was just to be there as often as I could, or just help in any way I could. That was what was expected of me. So yah, I knew, it's just that kind of instinct that kicks in when you do that. So yah, that's kind of how I dealt with that..." [Rudy]*

> *"...I think instinctively I knew how I needed to act, if I can put it that way..." [Ash]*

Given the perceived instinct, support was often conceived and described as being strong and resisting the possibility of giving in to their emotional experiences, and not being seen as weak. Interestingly, fathers felt that being strong in the form of setting aside the abovementioned emotions and not expressing or communicating any feelings to their partners was key to being strong for their families.

> *"...Honestly then it was a bit difficult to communicate because I wanted to be strong. I thought that if I was to show my emotions then I'm weak or I feel like this is getting to me then she wouldn't be strong the way she's supposed to be, because I didn't want her to know. I just thought, let me just hide this for her own sake. It was kind of like killing me, but then I saw she's getting stronger..." [Vuyo]*

The arduous impression of communicating any difficult feelings about the experience was perceived to be detrimental to the emotional wellbeing of mothers and children. Therefore, staying strong for the family often entailed not processing their own felt

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experiences and 'doing what needs to be done' by not revealing any distress as a man that is related to this experience. This is explained in the below extracts:

> *[Afrikaans] "…Om sterk te wees vir haar, om daar te wees vir haar. Al was ek n bietjie bang gewees. Ek meen 'n man wys nooit sy goed (emotions) nie want jy moet altyd daar wees vir jou vrou. Want die vrou het meer stress en whatever ookal. Maar die man gaan ook soms deur dit maar hy wys dit nooit nie…" [Justin]*

> *[English] "…To be strong for her, to be there for her. Despite me being a little scared. I mean, a man never shows his stuff [emotions]because you always have to be there for your wife. Because the wife has more stress and whatever. But the man also goes through this, but he never shows it…" [Justin]*

> *"...I had to be strong. Not just for me but for her as well. because she feeds off the energy that she gets like if we… if I am in a bad state and I am gonna be sad she's gonna feel it because she is my child. She can sense when you in a bad state or when you happy. Whatever mood you in, they can sense it quick cause they feed from us as parents..." [Marco]*

Fathers also expressed that their greatest responsibility was towards the mother. Supporting the mother in this instance was perceived as a way to increase the wellbeing of the child, as the mother is described as being directly in sync with the baby. Therefore, fathers felt a significant obligation towards the wellbeing of their partners as a way to ensure the wellbeing of both mother and child. This is expressed in the extracts below:

> *"...As a man, to be honest with you, your biggest job is to support the wife, or the mother of the child, I'll be honest with you. That's actually your biggest priority because, for instance, Brent [pseudo name] was being breastfed. So if I stress the wife out, whatever came from me and there was no support, it would hamper her. That hampering would hamper the child, and so on. For me, it was just to be there, kind of, you know talk to him and things. But honestly, as a male, yoh, your greatest responsibility is to the mother because the mother is the one that is actually more connected to the child than I would be connected to the child, you see…" [Rudy]*

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Despite the experience of having a premature baby was an emotional rollercoaster characterized by the experiences above. The majority of fathers in the sample described that they were able to support their partners by staying strong by forgoing and concealing their own emotional distress. Fathers were able to make sense of their experience through the prism of staying strong for their partners and subsequently for the wellbeing of the baby. Upon further exploration of how they made sense of their role relative to the situation, fathers described drawing strength from their faith as well as receiving varied experiences from healthcare system

4.1.3 Barriers to support and addressing fathers' need

Upon exploring how fathers made sense of their experiences, the majority of fathers reported drawing strength from their faith, as well as their experience in the healthcare sector. Fathers' belief that the 'mercy of God' encouraged them to have a greater appreciation of their children and families, which was one of the major ways of making sense and assisted

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with processing these experience as a supporting and coping mechanism. As participant *Hannes* and *Thabo* asserted:

> *[Afrikaans] "…Wel ons het net naby aan god gebly ek meen dit is maar die belangrikste gewees.* En ek dink dit het ons as familie net sterker gemaak. *En nader aan God gebring want ek meen ons was baie in gebed ook in dai tyd. Dis die genade van die here dat hy dit gemaak het…" [Hannes]*

> *[English] "…Well we just stayed close to God, I mean it was just the important thing. And I think it just made our family stronger. And brought us closer to God because I mean we were in prayer a lot at that time. It is through the mercy of God that he made it…" [Hannes]*

> *"…Of this experience, it was more of me saying, maybe God is trying to show us that we should appreciate life more as it is. That we should definitely, because half the time men don't really appreciate what they have, especially when it comes to kids. Because when you have kids… kids are born but then the fathers are never really there to support to the women who gave birth to those kids. But then I told myself, you know what, I am going to try to be the best Dad that I can and that I will be there from day one until I can…" [Thabo]*

For many fathers, healthcare staff also relieved some of the heavy emotional strain through their reassurance and expertise. The healthcare staff were instrumental for containing some of the difficult experiences mentioned above, which also made some fathers feel less stressed. The certainty and perceived experience displayed by medical staff eased some of the anxiety among fathers. This is explained below:

> *"…Yah, I kind of had faith and trusted the system and the people that were kind of dealing with the issue…" [Ash]*

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It is worth mentioning that not all fathers felt this way. A faction in the sample (4) felt that the healthcare system did not support their needs. For some fathers, there were constant barriers to support their families, specifically pertaining to healthcare staff, hospital rules and regulations. These regulations made fathers feel excluded, especially given the perceived widespread crisis fathers are aware of relative to not being present in their children's lives. Disheartened fathers desperately explained that fathers should also be privy to the information regarding their children in hospital, and should not encounter any inhibitions and barriers to information and access to their children.

> *"…What I did have a lot of issues with was, in terms of institutions – they tend to, there's all this conversation around fathers being active in their children's lives and that being an active father in children's lives, and then institutions they tend to have this bias where everything that has to do with the child is the mother's prerogative. I feel like institutions tend to disregard the father in those situations. And I feel like that's a little discouraging man, because you try to be the father that…like even leading up to the actual, you know before birth when we went to the ICU, they would make me wait outside, like I'm the child's father and they make me wait outside when the mother goes to check up and stuff. It is very discouraging and I think I had a lot of thoughts about it – institutions give a lot of discouragement and bias towards fathers in terms of that. Even in the hospitals, every time nurses and doctors speak about my daughter's situation or give us an update or whatever, they tend to like, they will approach me and then they would ask where is the mother. I'm like you can tell me, I'm the father there's nothing wrong with that. And like they would insist on where's the mommy. And I'm like*

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this is my child, you don't have to wait for the mother, her father is here, you can tell me now. Why must you wait for the mother, you know what I'm saying? So there was a lot of that and it was an issue for me. I still, even today I still "…" cool with the other children and so forth, institutions they, they tend to disregard the father man. I feel like it's very discouraging for a father who want to be part of their daughter's life, and then institutionally you get discredited and disregarded of the discussion around your child and what is happening around your child…" [Riedewan]

Other regulations such as the Covid-19 lockdown regulations[3] placed further strain on the psychological wellbeing of some of the fathers going through this experience. Not having access to hospitals during the Covid-19 pandemic left fathers feeling pushed away even further, as some of them were not even able to know the gender of their child, or whether the child survived the experience or not. The abovementioned ambivalent feeling of losing a child due to being born prematurely, not knowing whether their children will be developmentally impaired was aggravated by having this experience from a distance. One father claimed that he was not allowed at the hospital due to the lockdown regulations imposed for Covid-19:

"…It was a bad experience as well due to this whole Covid pandemic. I couldn't get even when the child was born. I didn't even know what time the child came, and I didn't even know what gender the child was. So I tried to call the hospital as many times as I could, but they didn't pick up their phones. But when I got through to them they didn't want to tell me what gender the child was, cause they said because it's over the phone and any random person can phone the hospital and say he is the father of the child. So I had to wait a couple of days before I could find out the gender, or what gender the child is. And I didn't even have a photo of my child cause the mother didn't have a phone. So I didn't even know how the child look. The only time I saw the child was when the child was discharged from the hospital, and that was a week after she gave birth. So that was my traumatic experience of my second birth…" [Marco]

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Despite the need to support their families to ensure the wellbeing of their children, fathers often felt as if they were not being supported. Incessant feelings of loneliness and fatigue due to work was a constant feat for all fathers as they had to sustain their jobs, provide financially to other children and be present for the mother and baby in hospital.

"…But I also think being a male, like we perceive males, you feel very alone because everybody is focused on the baby and the mother, and you have no support. So I think that was, people would speak to you, but I would basically just be numb most of the time. I needed to be this pillar and you couldn't sort of have emotions. So even attaching yourself to the child at the time, for me I couldn't..." [Jeffrey]

Oscillating between different places such as hospitals, workplaces and home for at least three months placed heavy strain on the physical and emotional wellbeing of fathers. This was essentially expressed as running on fumes, as adequate sleep and self-care eluded many of fathers' experience. This is expressed below:

[3] The Covid-19 Lockdown regulations in South Africa was a legislative intervention to reduce the rapid spread of the Corona virus. These regulations subjected South Africans to confine themselves in their homes, and restricting access and movement into many organizations (including hospitals).

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[Afrikaans]"…Jy moet gaan werk, en jy moet maar oor jou moegheid gekom het. En jy is die anker in die familie. So jy het maar alles bymekaar gehou en vir almal maar prober deur dra. Ek was bekommered en jy is moeg want jy werk elke dag. En as jy in die aand by die huis kom, en die oudste seuntjie was maar drie. So al lewe wat hy geken het in dais sewe maande was hy kom van sy dagmoeder af en hy klim in die kar dan gaan ons hospital toe. Hy het daar toe sy huiswerk gesit en doen en ons het elke aand deur gery. Ons was daar gewees van ses uur tot 11uur saam. So, jys moeg, jys uitgepit, jy weet nie meer watte kan toe nie..." [Hannes]

[English]"You have to go work and you have to get over your tiredness. And you are the anchor in the family. So you have to keep everything together and try to bring everyone through. I was worried and you are tired because you work every day. And if you get home at night, the eldest son was three, so all he knew was he came from the nanny and he gets in the car, and then we go to the hospital. He did his homework there and we drove there every night. We were there from six until eleven pm. So you are tired, depleted, you do not know which way to go." [Hannes]

"…Physically I was drained. I was tired really, and that was Friday travel for 4 or 5 hours to Bloem and 4-5 hours back. And mentally, physically that stress it gets to you. And there's nothing specific that would concern you…" [Rudy]

As seen above, the experience of having a baby born prematurely does not only involve the ambivalent sense of losing a child, or having to navigate the possibility of their children leading 'normal lives'. This experience is also compounded by different forms of support (receiving institutional support and providing support) during this difficult time. However, despite the challenges faced by fathers, majority of the fathers knew that their need for establishing a relationship with their children had recede in to the background relative to ensuring the wellbeing of the child and mother. This will be explained in the next theme.

4.1.4 Taking a backseat

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Upon asking about the relationship fathers had with their children, two pervasive responses came from the sample. Fathers acknowledged that initially, the children needed their mother more than their fathers. This admission of taking a backseat during the initial part of the experience was reported amongst all fathers. Therefore, fathers often reported stepping back to afford the mother time with the child.

"…I was very… I had to take a back seat, because obviously they want the mother to be around quite a bit, and during those time they were very strict, they restricted the visiting times…" [Ash]

Coupled with this, fathers also felt a sense of fear of hurting the child while exploring touch. Fathers described not wanting to exacerbate the condition of the baby by exploring touch and holding their children as the need for them to recover was a much larger goal. This was common across the sample and is explained in the below statement:

"…I don't know, initially, I felt like initially I was a little bit afraid to like hold her and stuff because I just had this feeling, you know this very fragile view of her… like I said I was very paranoid because in the beginning I was even afraid to pick her up and hold her and stuff. So afraid that something would happen and stuff, you know what I mean?…" [Riedewan]

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The distance that fathers kept with their children was short-lived. As the child grew, fathers felt like they were becoming more involved through the experience of touching the child, changing nappies and feeding the child. For some, this felt like the beginning of their relationship with their child. Relationships were also characterised as starting off with immense fear, paranoia and possessiveness, which sparked quick reactions. However, witnessing their premature children grow and catching up to other children made fathers become gradually relaxed and less protective.

The experience of having a premature baby undergirded many of the relationships that fathers had with their children. Fathers reported that their current relationship and interaction with their children was not informed by the experience of having a baby born earlier than expected. Others felt that this was the case, and that this experience shaped their relationship with their children. However, only first-time fathers and fathers who were actively trying to have a baby with their partners but were struggling to conceive reported their relationship being shaped by the experience of having a premature baby.

4.1.5 Impact on the mother

Upon exploring their relationship to the mother, and how the mother experienced the high-risk pregnancy, all fathers in the sample reported that they thought the experience was difficult for the mother. Having a sense that the child would possibly not make it was not exclusive to fathers, but was also a difficult emotional experience for mothers.

> *"…That time she was stressing a lot. But then, after some time… she had doubts about if the child would make it. It was part of her stressing, but I tried to help her keep safe. Ja, but it was hard on her. I tried my best to support her…" [Vuyo]*

Fathers assert that mothers were negatively affected by the high-risk pregnancy by frequent doctor's appointments as well as general anxiety around the pregnancy. This was also characterised by seeing them struggle with physical and emotional pain. This further led fathers to support mothers, which is intricately linked to the perceived role fathers had mentioned above. This is seen in the below extracts:

> *[Afrikaans] "…Baie. In die sin van, haar liggaam was te swak om die babatjie te dra. So obviously een of ander vlies was verdin gewees …"*

> *[English] "…A lot… in the sense of, her body was too weak to carry the baby. So obviously some membrane was thinned…" [Hannes]*

> *"…According to me, I feel like the pregnancy was too hard on her. She tried it alone, but luckily for her she did not have to be alone. I was always there. I told her that I'm always available for her. And I would always call her when I'm not there…" [Thabo]*

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This experience, according to some however, was not as hard on some of the mothers, especially those who had been through high-risk pregnancies, and experienced premature births before. Fathers felt that because their partners went through the experience before, that this prepared them psychologically for the challenges and difficulties experienced:

> *"…Uhm, not as much as I thought it would, because as I said she's been through this before. Uhm, but she was aware of the dangers involved. And I think she was very focussed on the little one, where I took a back seat…" [Ash]*

> *"…For us it only benefitted us, the whole experience with Luca (**pseudo name**). And like I said maybe prepared us to better deal with Clark (**pseudo name**). Made things easier. So ja I think we benefitted out of it, and I think a lot of people aren't that fortunate…" [Greg].*

4.1.6 Feeling closer to partners

For all the fathers in the sample, the experience of having a premature baby brought them closer to their partners in various ways and for various reasons. They felt that this challenging time made them share a common experience relating to their child, and made them value their partners more. Having a common goal and obligation towards their children's lives was something that facilitated the strength of their relationship. This is seen in the statement below:

> *[Afrikaans]"…Dit het ons meer sterker gemaak, nader aan mekaar. Uhm om deur so iets te gaan bring altyd iemand nader aan mekaar. Ons verstaan mekaar nou bietjie beter. Uhm ja ons is lief vir mekaar, so ja…"[Justin]*

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> *[English]"…It made us stronger, closer together. Uhm to go through something like this always brings someone closer to one another. We understand each other a bit better. Uhm, yes we love each other..." [Justin]*

> *"…Uhm, in a way in the sense that we haven't given each other that much attention because the focus was on the baby, it still brought us closer together. Just because it was one, I didn't felt its "…" that we were favouring towards making things better, you know. So we had one common goal. It kind of brought us closer together, yah...." [Ash]*

Becoming closer and strengthening their relationship was often expressed and characterised by having a sense of communication regarding the wellbeing of their child. This was key to sustain their bonds as parents and partners. However, limits to communication in the form of expressing difficult feelings to partners were a common feat. Upon asking whether it was difficult to communicate any difficult feelings regarding their experience, fathers reflexively thought about how the communication of their feelings would affect the mother of their babies. Fathers felt if they expressed the difficult feelings mentioned above, it would spill over on to the already difficult emotional experience of the mother, and hamper the wellbeing of their children. Therefore, talking about difficult emotions with friends and

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other family members were much easier. Not to their partners. This is seen in the below extract:

> *"...I think it was easier talking to friends actually about it, and not too much… I didn't wanna get too much uh emotional about it talking about it with her. So uh, yah, it was probably easier talking to friends about it, because they weren't connected…"*
>
> ***Interviewer:*** *Can you tell me a little bit about why that was the case?*
>
> *"…uh, just because I didn't want to make my partner more aware about the situation. She was quite emotional at that time, and for me I didn't think it would help talking too much about it. It was easier to just focus on the positives; you know what I mean. So when she started eating, and we praised her like "yay well done", I wasn't focused on any negatives. So yah. So you trying to keep her emotional side positive at that time. Uh, and I think it helped because if you get a mother that's very negative, the baby also feels that..." [Ash]*

The core essence of having a premature baby proved to be stressful with physical and psychological consequences for all the fathers in this sample. The ambivalent sense of possibly losing their children because of being born prematurely, and having to contemplate the possible developmental difficulties were the core of fathers' lived experiences of having a baby born prematurely. The overwhelming flood of internal (the turbulent emotional spaces mentioned) and external pressures such as financial responsibility as well as operating in various spaces such as work and home added to the challenges and difficulties of having a baby born prematurely for fathers. Experiences such as fear about the survival and the developmental trajectory of their children, remaining strong by not expressing difficult feelings with their partners and feelings of helplessness all contributed to the difficult and often unbearable crux of having a baby born earlier than expected.

However, despite these challenging feelings, fathers felt a strong sense of obligation and responsibility towards supporting their children and partners, which was perceived as instinctive and gave purpose to this experience. Initial relationships with their children was felt by a sense of fear of hurting the child and seeing their children as fragile, which often contributed to the core experience. However, this was short-lived as fathers quickly adapted to caring for their children through touch, holding and feeding their children, which also marked the beginning of their relationships with their children. This was experienced as gradually developing an emotional attachment with their children. Fathers also reported their partners being negatively affected by the high-risk pregnancy, and the premature birth. Remaining a strong supporter to facilitate the wellbeing of the mother, and subsequently the baby was perceived to aid with making the experience better for the mother. This experience brought fathers closer to their partners. Being closer often entailed better communication,

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which was also seen as a barrier as it was easier to communicate any difficult feelings to friends and family, rather than their partners.

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Chapter 5: Discussion

5.1 Objective 1: The emotional experiences of fathers who had a premature baby

5.1.1 Fathers' challenges of having a preterm baby

The experience of having a premature baby is filled with difficult feelings ranging from fear, helplessness and worthlessness relative to the possible death and the developmental wellbeing of the child, as well as stress related to financial wellbeing of one's family and the added medical costs of hospitalisation. The fear around death is particularly stressful for fathers, as the prospect and preparation of being a father is threatened by losing a child due to being born prematurely. The birth of premature babies for fathers disrupts the transition of being a partner to becoming a father, as depicted by Vanier (2017) and Wong et al. (2016). Being born prematurely also involves the risk of having developmental difficulties, which was also significant for fathers. The anxiety regarding their children's developmental difficulties confirms the WHO's (2018) assertion that developmental difficulties among babies born prematurely are more prevalent than being born to full term. However, concerns for possibly having a developmentally impaired child is only partially confirmed as fathers did not report any developmental issues as a consequence of being born prematurely. In addition, it is worth noting that fathers were more concerned with the social impact of being developmentally impaired, and not with the array of possible clinical implications of being born prematurely. Nonetheless, the findings above suggest that possible developmental deficits are valid concerns for fathers having a premature baby.

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Fathers often felt ambivalent as the constant worrying that their children would not make it is a major finding. Information received about the survival rate and the physical characteristics of children born prematurely all triggered immense anxiety around the survival of the child. The WHO reports that 15 million premature births are recorded annually with approximately 1 million of those births resulting in death (WHO, 2018). This relates to and corroborates the literature speaking on fathers' experiences of anxiety around the fear of whether the child will survive because of hospitalization, fear for the wellbeing of the infant and mother (Dadkhatehrani et al., 2018; Vanier, 2017; Edwards et al., 2020). Therefore, this attests to the reality that constant fear and anxiety about the survival of the child is a major factor of having a baby born earlier than expected among men.

Coupled with anxiety about the survival of the child, incessant thoughts and worry about developmental deficits permeates the experience of many fathers. Considering whether

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children will develop adequately contributed to the anxieties and fear experienced by fathers. This was also accompanied by possible social complications that children may endure as a result of being developmentally impaired in some way as a consequence of being born prematurely. This finding confirms the WHO's (2018) assertion that there is a high probability for being developmentally impaired when being born prematurely, ranging from learning disabilities, lifetime physical disability, auditory and visual impairments. The possible social consequences of being developmentally impaired due to being born prematurely is not specifically addressed by the WHO (2018), and only speaks towards the possibility of being developmentally impaired. Therefore, linking social challenges caused by being developmentally impaired to being born prematurely is a new finding in this study.

The abovementioned findings of the study also speak to the survival of premature infants and not actually losing a child, as specifically outlined by both the WHO (2018) and the WCG (2018) in developing countries. However, much of the experiences reported in this study deviates from the literature as all fathers' children survived the turmoil of being born prematurely. Thus, this finding only corroborates the anxiety felt about possibly losing a child due to being born prematurely, and not to the lived reality of actually losing a child due to being born prematurely as explicitly mentioned in this domain of the literature. As the loss of a child is a real possibility, the anxiety of possibly losing a child is only partially corroborated in this sense and not the actual feeling of losing a child due to being born prematurely. This can also be inferred from the anxiety of possibly having a child being developmentally impaired to actually having a child being developmentally impaired.

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5.1.2 Financial difficulties

The added financial strain placed on fathers during this time is also varied. This ranges from taking care of disproportionate medical bills relative to their level of economic affordability, being the only source of income for that period and having to take care of the family. Disproportionate medical bills were some of the main stressors reported, which corroborates the findings related to financial stressors during the experience of having a baby born prematurely (Dadkhatehrani et al., 2018; Vanier, 2017; Amorim et al., 2017; Fletcher et al., 2011; Kowalenko et al., 2012; Lindberg et al., 2008). The prolonged stay in intensive care dramatically increases the medical bills which is often exorbitant. This means that fathers do not only have to bear the emotional challenges of having a baby born earlier than expected, but have to straddle much of the financial burden during the time of having a premature baby.

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Therefore, the responsibility of having to be the provider of the family, as depicted by Mfecane (2016), places an even more strain on the emotional wellbeing of fathers while having a premature baby (Mfecane, 2016; Magodyo et al., 2017; Connell, 2005; October, 2019; Dadkhatehrani et al., 2018). In addition, having to keep working and being present at the hospital to support the mother during this time results in fathers becoming extremely fatigued, which impacts on fathers wellbeing.

It is worth noting that given the influx of women entering the workforce and becoming an equal provider within the family space (Straus et al., 2019), it is likely that men do not have to bear the financial burden on their own. Thus, given the source of the financial burden placed on fathers having a premature baby, it does not necessarily translate to fathers having to be the sole bearers of this burden. Therefore, sampling fathers' financial experience of having a premature baby may skew the veracity of how this burden may affect the family as a unit to reducing it to how it affects the father alone. Therefore, despite fathers reporting this experience across this sample, as well as in the literature, this finding should be interpreted with caution to not exclusively placing this stress on fathers alone, but should be considered within the framework of the wider family, including mothers as working citizens.

5.1.3 Institutional support

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Given the significant stress endured, fathers mainly reported feeling helpless and powerless. These feelings came from not having the capacity to improve the experience for the mother and child's suffering through the difficult time. According to Dadkhatehrani et al. (2018), fathers experience various negative emotions such as feelings of abandonment, and helplessness, which characterises their lack of assistance during this arduous experience. This is indicative of two key characteristic implications of having a premature baby. The first suggests that fathers do not have enough support from healthcare staff during the emotional difficulties of having a baby born prematurely, as reported by fathers within the study. The second suggests that despite these negative experiences, fathers persevere to provide added support to the mother and child, in the face of not being supported by healthcare staff as a means to care for the wellbeing of their partners and children.

Despite feeling helpless, powerless and stressed, many fathers made sense of these feeling by staying closer to God. Staying closer to God as a spiritual coping mechanism is a key finding relating to men's experience of having a premature baby. This means that fathers rely on their faith as a way to deal with the difficult emotional experiences of having a premature

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baby, as well as to sustain the hope that their child will survive (which relates to the core experiences among fathers in this study). In addition, this mechanism of sense making was also closely tied to the meaning of how fathers should appreciate their role as a parent and what that means for children in the context of South Africa. This could indicate efforts to remedy what has been observed by the state of South Africa's fathers report (Van den Berg et al., 2018), suggesting that a significant proportion of fathers are not involved in the lives of their children. However, the impact of this finding as a coping mechanism and a way of meaning-making was not explored in its totality which calls for further research in this domain. This finding, however, appears to be an uncommon finding within this area and therefore represents a significant finding within this study.

In addition, fathers reported both positive and negative experiences impacting on their trust in the medical staff. This finding is consistent in other studies both globally (Jabnoun & Chaker, 2003; Irfan & Ijaz, 2011), and nationally (Mayosi & Benetar, 2014; Leibrandt et al., 2012). This contradiction in experience relative to healthcare providers and institutions could be mainly informed by the relative distinction of private and public hospitals. Fathers who had access to private hospitals had better experiences than those who used public hospitals. Fathers who accessed private hospitals, experienced constant reassurance from healthcare providers, which often entailed checking to see how they are doing and giving enough information regarding the mother and baby which aided in relieving some of the stress experienced by having a baby born earlier than expected. Fathers felt that despite being relatively distanced from the process, they still had access to seeing the mother and child during visiting hours. This corroborates what Irfan and Ijaz (2011) found relative to the adequate support provided from private healthcare institutions. This point asserts that receiving adequate support from healthcare providers in private hospitals informs the reassurance fathers receive when having a premature baby.

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Contrasting this finding is the experience of some fathers feeling totally isolated from the possibility of being involved during this process. The negative experiences with public hospitals were characterised by impolite hospital staff, and a disregard for providing enough information regarding the mother and baby which rendered fathers discouraged. This is confirmed by Dadkhatehrani et al. (2018) and Edwards et al. (2020) who postulates that fathers often reported dissatisfaction with long waiting times, minimal information conveyed regarding the infant's progress, and disrespectful attitudes from professional healthcare workers. Exacerbating this sense of isolation are the effects of the Covid-19 pandemic which

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discouraged fathers tremendously, as they were denied access and information regarding the health status of their children; even the gender of their children in some cases. Various outcries for fathers to become involved for the wellbeing of the mother and child, as reported by Kotelchuck and Lu, (2017) is contrasted by healthcare professionals' approach to commit to involving fathers during this process as seen by Dadkhatehrani et al. (2018) and Edwards et al. (2020). This contradiction is made visible by the privileges afforded by private hospitals compared to public hospitals, and by the exacerbating effects of the Covid-19 pandemic.

The abovementioned experience also relates to the importance of paternal involvement during the experience of having a baby born earlier than expected. Edwards et al. (2020) postulates fathers' involvement as being instrumental during the birth process which suggests that fathers should be involved during the process of having a baby born prematurely. This directly contrasts the findings above, suggesting that fathers feel excluded from the birth process, which speaks to a desperate need to challenge the discourse surrounding fatherhood and its traditional masculine role in society. This contradiction has two grave implications for the wellbeing of mothers and children during the birth process.

Firstly, fathers' discouragement, helplessness and level of satisfaction could reinforce the feeling of being lonely and excluded during the birth process. This is intensified by institutional barriers experienced in the public sector (Mayosi & Benetar, 2014; Leibrandt et al., 2012), which contributes to stifling fathers' involvement during the birth process. For example, as *Riedewaan* indicated that he was excluded from the birth process and information received by healthcare staff which discouraged him tremendously, which also occurred before the Covid-19 lockdown regulations. The evidence of paternal involvement, as asserted by Edwards et al. (2020), therefore, is not adequately taken into consideration during the experience of having a baby born prematurely. Therefore, this could negatively impact the wellbeing of mothers and children in hospital, as indicated by (Kotelchuck & Lu, 2017). As such, this means that this experience of fathers having a premature baby does not help fathers to become involved at a time they desperately need to.

Secondly, the broader public institutional barriers are informed by larger macro factors, as asserted by Coetzee et al., (2013). These barriers to effective support for health consumers are reinforced by being over-burdened with diseases, unsatisfactory working conditions and over-crowdedness. Given that the public sector is responsible for providing healthcare to the majority of the general population, and the extent of the general population not being able to

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afford adequate healthcare, it is unsurprising that fathers using the public health sector report dissatisfaction relative to public healthcare providers, as indicated previously by *Riedewaan*. However, more research is needed regarding the link between the level of dissatisfaction with the public health sector and of fathers having a premature baby.

5.1.4 Supporting mother and child

Upon investigating fathers' relationships with their children, fathers felt they had to be strong for their families. Being strong was characterised by setting aside their lived emotional experiences to appear present for the mother and child. Fathers felt as though should they express any negative experiences, it would place the wellbeing of the mother and child at risk. Therefore, not expressing emotions as a supportive strategy was key for fathers having a premature baby. This speaks to the hegemonic tendency identified in the literature, where men do not engage in processing their feelings, which characterised the need to provide emotional support given to their children and partners. This also speaks to Pohlman's (2005) and Dadkhatehrani et al. (2018) findings that fathers typically tend to ignore their needs during these times and may keep stress hidden. Therefore, this could be seen as a typical experience of having a baby that is born earlier than expected.

It is worth noting that the tendency to dissociate from internal experiences is informed by the larger social construct of what it means to be a man. The finding that men, specifically fathers, do not show their emotions during emotionally charged situations (such as having a baby born earlier than expected) is not new and manifests in this study as well. Interestingly the repression of negative emotions may be a key feature tied to particular constructions of traditional hegemonic masculinity. As Mfecane (2016) points out, men's emotional expression has limited space under the construction of traditional masculinity and is unlikely to seek out support structures for this. The tendency to repress any emotional challenges may indicate the influence and resilience of certain factors of traditional hegemonic masculinity in the wake of alternative, progressive and fluid masculinities (Tucker & Govender, 2016), but also speaks to the lack of help-seeking behaviour during times of emotional distress.

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As mentioned above, fathers often had to dissociate from their internal experiences to support their partners and children, often characterised by "staying strong". It is interesting to note that fathers did not view their supportive role as something that is expected, but as instinctive and internally motivated which is not different to what mothers sometimes feel when raising their children. Reframing their role not as an external prescriptive role imposed

on them, but as having an internal motivating source is a significant finding. What is missing from this finding is the source of the internal motivation, and why men feel that the expectation of support should not be considered as an external pressure. The counterintuitive nature of this finding suggests that more research on this need to be conducted.

The juxtaposition of traditional hegemonic masculinity in the form of dissociating from feelings (Connell, 2005; Ratele, 2017, 2012; Mfecane, 2016), coupled with the instinct to support their families by not showing emotion is both a confluence and disjuncture. The confluence is characterised by not showing or sharing any emotion (as dictated by traditional social constructs and forms of masculinity), and using this as a vantage point for supporting their partners and children, both represents a marriage between both traditional and alternative forms of masculinity. Having to disregard or minimise emotions to express care and support are hallmarks of both traditional and alternative caring masculinities, which represents this marriage.

What characterises the disjuncture is the widely accepted notion of traditional masculinity and fatherhood as social constructs that are imposed on men (Mfecane, 2016; Connell, 2005; Gregory & Milner, 2011), and the expression and enactment of paternal support as an instinct motivated by an internal sense of obligation towards the mother and child. Traditional notions of what a father and man should be, divorces from the reported internal motivations of fathers, not enacting but being and living their masculinity and fatherhood by instinctively supporting their families. These ambivalent findings are not viewed as separate however, it serves the characterisation of fatherhood and masculinity as intricately interwoven (Connell, 2005; Mfecane, 2016; Ratele, 2012).

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The abovementioned support also informs the desired outcomes for mothers and children. Fathers felt that they needed to stay strong and support their partners, as this would directly affect the wellbeing of their child. Not expressing emotional experiences to mothers is perceived as a protective factor against disrupting the mother-child bond, which would further increase the wellbeing of the child. This finding is related to the literature on paternal mental health and child outcomes (Fletcher et al., 2011; Kowalenko et al, 2012; Lindberg et al., 2008; Furaikh & Ganapathy, 2016) which states that paternal mental health increases healthy child development and outcomes. However, remaining strong often entails repressing any felt emotions in order to protect the wellbeing of the mother and the child. This finding leans more towards sacrificing certain strategies such as expressing emotional experiences of

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fathers for the wellbeing of the mother and child, and not as an indication of paternal mental health which is related to positive child outcomes. Therefore, this distinction is important to consider when analysing the experiences of fathers having a premature baby.

Mental health for fathers is indispensable for child development as the positive effects thereof is considered equally as important as, and for, maternal mental health (Fletcher et al., 2011; Furaikh & Ganapathy, 2016). However, this finding also contradicts paternal mental health in a particular way, in that fathers maladaptively deal with their emotions, and can also be seen as sacrificing their own experience of processing emotions for the wellbeing of their partners and children. This was reported by all fathers having a baby born earlier than expected. Therefore, this finding supports the extant literature that mental health and support from fathers are indispensable for healthy child outcomes. However, the internal defence of dissociating from feelings is considered a maladaptive and unhealthy way of processing negative experiences which places a significant strain on father's mental health It is worth noting is that remaining strong in this context may or may not be indicative of fathers' ability to remain strong insofar as it is beneficial for the mother and child. This means that paternal mental health could include an intricate, yet delicate balancing act of forgoing emotional expression long enough to benefit the mother and child, which may or may not stretch fathers' ability to repress their felt experiences.

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The above experiences of fathers having a premature baby relates to objective one, which aimed to explore fathers' lived experience of having a premature baby. It also answers the research question posed by this study, in exploring the lived experiences of South African fathers who have had a premature baby. This highlights that the experience of having a premature baby is filled with anxiety, fear, as well as pressures from financial and health services generally, which exacerbates the already arduous experience of having a baby born earlier than expected.

5.2 Objective 2: Emotional experiences of fathers and their relationship with their premature child

5.2.1 Fathers' relationship with their preterm child

Relating to their babies, fathers often felt that they needed to take a backseat during this experience. This was often expressed with the concern of the mother needing to be more involved, and the father playing a more supportive role towards the mother. This finding is

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also supported by the literature suggesting that fathers acknowledge the salience of the mother-infant bond immediately after the birth process, and the importance thereof for the development of the infant (Lindberg & Orhling, 2008; Holditch-Davis et al., 2002). Furthermore, for premature babies, this finding is particularly important as mothers are often involved in facilitating the survival of their babies. For example, aspects such as the mother-infant bond and the kangaroo method are crucial to aid in the survival of the child. These aspects are largely enacted by mothers placing her at the centre of the foreground (WHO, 2018).

As time passed, fathers gradually became more involved with their children by feeding and changing diapers. The first contact with the child was also considered to be the beginning of the relationship, which was characterised by overprotectiveness and possessiveness. This is corroborated by Dadkhatehrani et al. (2018) and Edwards et al. (2020) who found that fathers were generally overprotective of their babies due to being born prematurely. This finding is also in confluence with some of the findings above. Upon exploring touch, fathers felt that they could not hold their children due to the possibility that they might hurt their children. However, as mentioned above, lockdown regulations, and the negative experiences in the public sector for some fathers only made these experiences possible after their child was discharged from hospital.

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Relative to the newly-found relationship of the father and the child, some fathers felt that their relationship to their child was shaped by the experience of having a premature baby, and others felt it did not. On the one hand, this relatedness emanated from the thoughts and emotions experienced from having a baby born earlier than expected. Fathers felt that they share a special bond with their children due to this experience. On the other hand, fathers felt that despite the negative experience of having a premature baby, they would still have the same relationship with their child. The sense that the negative experience somehow shaped their relationship with their child was not supported by many of the fathers. However, interestingly, fathers who were first-time parents at the time reported that this experience somehow shaped their relationship with their children. The emotional turbulence of having a premature baby, as well as becoming a parent for the first time made certain fathers perceive their bond to be greater with their premature baby. However, the difference in the characterisation of relationships between first time fathers and fathers who had children prior to having a premature baby was not explored in depth.

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The abovementioned findings relate to objective two, which aimed to explore the relationship with their new-born baby. Initial contact with children was postponed by knowing that the children need their mothers for survival. As time passed, fathers began their relationship with their children. However, this relates to the objective in two ways. Firstly, that fathers felt that the experience mentioned in objective one somehow shaped their relationship with their babies as they perceived their babies as fragile. This results in fathers becoming overprotective of their premature babies. Secondly, other fathers felt that they would have had the same relationship with their babies if they were not born prematurely.

5.3 Objective 3: Emotional experiences of fathers and their relationship with the mother during the high-risk pregnancy

5.3.1 Relationship with the mother during birth process

Upon exploring the relationship with the mother during the high-risk pregnancy and birth process, fathers reported the mother to experience the pregnancy as difficult and strenuous. Fathers also stated that their support was crucial to the mother during this time, as mentioned by *Hannes*. Supporting the mother during the event of having a premature baby was a major finding, which is also corroborated by Wong et al., (2016) and Makhanya (2018). This consistent experience of the difficulty of having a premature baby by mothers and fathers speaks to the domain of research related to fathers experiencing their partners' pregnancy as both difficult and strenuous, which was exacerbated by the babies' early arrival (Wong et al., 2016; Makhanya, 2018; Su & Emory, 2016). The experience also brought fathers closer to their partners, as the shared responsibility and goal to ensure the survival of their child cemented their relationship as parents, even in those who were not in a romantic relationship with their partners at the time. This is another uncommon finding, as not many studies speak about how the experience of having a premature baby affected the relationship of the parents in a positive way despite not having a romantic relationship.

Lastly, some fathers reported that it was not difficult to communicate any negative feelings regarding this experience to those other than their partners. This is characterised by the awareness of speaking about negative feelings as a means to alleviate any unprocessed feelings. However, what qualifies the expression of emotion in this context is that many fathers felt that speaking to people who were not connected to the event of having a premature baby was crucial, as their knowledge of it would not affect the wellbeing of the mother and child. This is connected to the idea of staying strong by setting aside negative

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emotions to ensure the wellbeing of their children, but attests to alternative ways of sharing difficult feelings with others who are disconnected to the experience. This is also an uncommon finding, as there are limited studies exploring how fathers communicate their negative feelings and with whom.

This section relates to objective three, in that it achieved the prospect of exploring the relationship of the father to the mother during this experience. It answers the question of what the relationship looks like among fathers and their partners while having a premature baby. This also relates to objective one, as the difficulties experienced of having a premature baby may affect the relationship fathers have with mothers by staying strong. However, the obligation and mutual goal towards the survival of the child does augment the connectedness between fathers and their partners, but is not characterised by revealing negative emotions related to the event.

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Chapter 6: Conclusion

6.1. Conclusion

This study aimed to explore the lived experiences of a sample of South African fathers who had a premature baby. This was achieved by using a descriptive phenomenological research design to provide a structural description of fathers' experience of having a baby born earlier than expected. The arduous experience of having a baby born earlier than expected proved difficult for fathers in different ways.

The experience of having a baby born prematurely is a challenging and difficult endeavour for fathers. The findings of this study indicate that fathers' core experiences were influenced by an array of factors, which includes the possibility of losing their babies, coupled with the possibilities of having a developmentally impaired child due to being born prematurely. This deep and ambivalent experience was the essence of fathers' experiences of having a baby born earlier than expected, which weighed heavily on all fathers. The experiences surrounding this core essence of having a premature baby relates to the financial responsibility of covering expensive medical bills, having to uphold employment expectations and ensuring the wellbeing of the mother and child. This proved exhausting for fathers, which also affected their mental health negatively. Despite feeling helpless and powerless during the experience of having a baby born earlier than expected, fathers highlight the salience of supporting their families during this time. Staying strong for their families was key to the wellbeing of their families, which often meant sacrificing their own mental wellbeing in the process.

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This study also corroborated many of the findings in the literature on fathers having a premature baby. However, new findings were also uncovered which speaks to the significance of this study. Owing to the Covid-19 pandemic, the South African lockdown regulations excluding fathers from the birth process, which exacerbated the arduous experience of having a baby born prematurely was one of the major findings of this study. Fathers' deep anxiety that their children may experience social challenges due to being born prematurely was also a significant finding, as the possibility of being developmentally impaired compounded fathers' emotional experiences during this event. Staying closer to God as both a coping mechanism and sense making strategy to remain in the lives of children was also an uncommon finding in this domain of research. In addition to these findings, fathers also reported that their role as a father is characterised by their "instinct" to support

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the mother and child was also a new finding. This is significant, especially against the backdrop of the profound and overwhelming understanding in the literature that fatherhood is a social construct. Lastly, the core experience of having a premature baby which was reported throughout this study also resulted in mothers and fathers becoming closer. This was characterised by having a common goal towards the survival of their children.

6.2. Limitations

The limitations are suggested on several levels of the study. One major shortcoming of this study was that it was conducted online using social media platforms such as WhatsApp and Google Meets. The volatile nature of poor internet connection often disrupted the interview process, which could have resulted in a disruption of the flow of the interviews. In addition, due to the online nature of the interviews, reflexivity was particularly difficult, as the dynamic of the interviewer and interviewee took place in a virtual fashion, which could have resulted in a loss of key non-verbal information. In addition, non-verbal cues were especially difficult to pick up on given the direct nature of the questions. The limitation of online communication in the form of interviews could not have allowed the design to capture most experiences given both the volatile nature of the internet, as well as issues around reflexivity mentioned above.

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6.3. Recommendations for future research

This research focused specifically on the lived experiences of fathers having a baby born prematurely. The focus of this study was therefore limited to fathers' experiences. More research regarding the difference in fathers' experience relative to the public and private healthcare sector needs to be considered, as this plays a significant part in how the experience is perceived and felt. In addition, it would be worth investigating what the relationships of fathers and their children look like on the backdrop of having a premature baby as a first child specifically. Focusing on all fathers' experience of having a premature baby limits the exploration of these dynamics. Forms of alternative masculinities is also a growing domain of research, which could help understand how fathers make sense of this experience. Therefore, considering the resilience of hegemonic masculinity's role in fathers having a premature baby is an important area that needs more research. Lastly, another recommendation may be to investigate the motivating source of support fathers feel when having a premature baby, as this consistently emerged during this study.

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Appendix A: Interview Schedule

Interview Procedure:

Time of interview: ______________________________

Date: ____

Place of interview: ______________________________

Researcher: ____________________________________

Interviewee: ____________________________________

Interview Questions:

1. What was your experience of having a premature baby?
2. What would you say are the main stressful aspects of having a premature infant?
3. How did you make sense of this experience?
4. How did this experience affect you as a man?
5. How was your relationship with the mother affected?
6. What did your newly-found relationship look like with your newborn baby?
7. What was some of the emotional factors at play with having a premature infant?
8. Did you find it easy to communicate any difficult feelings regarding this?
9. Is there anything else you would like to add?

   Is there anything you would like to ask me?

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Appendix B: Onderhouds procedure (Afrikaans)

Onderhoudsprosedure:

Tyd van onderhoud: ____

Datum: ____

Plek van onderhoud: ____

Navorser: ____

Onderhoud gevoer met: ___________________________________(Vir die navorser se eie gebruik)

Ice breaker questions:

- ***Naam, oudedom/geslag van baba?***
- ***Hoe gereeld sien vader vir baba? Woon vader met baba (en ma), of apart?***
- ***Overall ondervinding om n vader te wees (eerste-keer vader, of alreeds n vader?***
- ***Hoeveel ander kinders het vader, indien alreeds n vader?***
- ***Is jy gebore in Suid Afrika?***

Onderhoudsvrae:

Objective 1

To explore the emotional experiences of South African fathers having a premature baby.

1. Om n vroegebore baba te he moes baie stressvol gewees het, kan jy my vertel van jou ervaring?
2. Wat sal jy se is die mees stressvolle aspekte om n vroegebore baba te he?
    - Kan jy my vertel wat som van die gevoelens was waarmee jy gesukkel het?
3. Hoe het u sin gemaak uit hierdie ervaring?
    - Waaraan het jy gedink toe jou baba gebore word?
4. Wat was die emosies wat jy ondervind het gedurende daardie tyd?
    - Wat was jou grootste kommer?
    - Hoe het jy gevoel oor wat verwag was van jou?

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Objective 2

To explore the emotional experiences of South African fathers and their relationship with their premature child.

5. In terme van pa wees, hoe voel jy het hierdie ervaring jou geraak?
6. Hoe was jou verhouding met jou pasgebore baba?
    - Hoe lyk die verhouding met jou kind nou?
    - Om n minute te vat om terug te kyk, voel jy omdat jou kind vroegebore was dat hierdie ervaring jou verhouding met jou kind gevorm het?

Objective 3

To explore the emotional experiences of South African fathers and their relationship with the mother during the high-risk pregnancy.

7. Hoe het die hoe-risikoe swangerskap die moeder affekteur?
    - Kan jy my vertel hoe die ervaring jou verhouding met die moeder geaffekteur?
    - Affekteur hierdie ervaring nogsteeds jou verhouding nou?
8. Het jy dit maklik gevind om enige moeilike gevoelens, met betrekking tot hierdie, te kommunikeer?
9. Is daar enigiets anders wat jy wil byvoeg?

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Appendix C: Interview Guide (isiXhosa)

Inkqubo yoDliwanondlebe:

Ixesha lodliwanondlebe: ______________________________

Umhla: ______________________________

Indawo yodliwanondlebe: ______________________________

Umphandi: ______________________________

Udliwanondlebe: ______________________________(Le yereferensi yomphandi yeyakhe kwaye awuyi kufakwa kwiziphumo).

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Imibuzo eqhekeza umkhenkce:

- **Igama, isini / isini, ubudala bomntwana**
- **Ngaba utata umjonga kangaphi umntwana? Ngaba bahlala nomntwana (kunye nomama), okanye ngokwahlukileyo?**
- **Ngamava apheleleyo wokuba ngutata (utata wokuqala, okanye utata okhoyo?**
- **Bangaphi abanye abantwana abanabo utata, ukuba utata sele enaye?**
- **Ngaba wazalelwa eMzantsi Afrika**?
- **Imibuzo Yodliwano-ndlebe:**

Objective 1
To explore the emotional experiences of South African fathers having a premature baby.

1. Linjani amava akho okuba nomntwana wakho ngaphambili kunokuba bekulindelwe?
    - Wavakalelwa njani xa wawunomntwana wakho?
2. Ungathi zeziphi ezona zinto zixinzelelekileyo zokuba nomntwana kwangoko kunokuba bekulindelwe?

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- Ungandixelela ukuba zeziphi ezinye iimvakalelo owawukhe wahlangabezana nazo?

3. Ubuyenza njani le nto?
4. Ndixelele ngezinye zeengcinga owawunazo xa wawunomntwana wakho ngaphambili kunokuba bekulindelwe?

Objective 2
To explore the emotional experiences of South African fathers and their relationship with their premature child.

5. Kukuchaphazele njani oku ngamava njengendoda?
6. Uve njani ngokuzalwa komntwana wakho ngokweemvakalelo?
   - Yintoni eyona nto ikhathazayo?
   - Luchaphazele njani ulwalamano lwakho nomama?
- Yintoni eyahlukileyo ngolwalamano lwakho nomama?

Objective 3
To explore the emotional experiences of South African fathers and their relationship with the mother during the high-risk pregnancy.

7. Lwalubonakala njani unxibelelwano lwakho nosana lwakho olusanda kuzalwa?
   - Ungathi kunzima ukuzinza kunye nosana lwakho olusandul 'ukuzalwa?
   - Zeziphi ezinye zezinto ezazinemvakalelo yokudlala ngokuzalwa kwangaphambili kunokuba bekulindelwe?
   - Ungayichaza njani indlela ovakalelwe ngayo xa wawunomntwana kwangoko kunokuba bekulindelwe?
8. Ngaba ukufumanise kulula ukunxibelelana naziphi na iimvakalelo ezinzima malunga noku?

9. Ngaba ikhona enye into onqwenela ukuyongeza?

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FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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Appendix B: Information sheet

Research Title: Lived experience of a sample of South African fathers having a premature baby

What the study is about: This study is conducted by Jonathan Nell, a MA Research student at the University of the Western Cape. You are invited to participate in this study because you are a South African father who had a premature baby. This study aims to understand what your experience was with having a premature baby, therefore you would be perfect to join this study.

What are the kind of questions that I will be asked? The study uses semi-structured questions, which is a predetermined set of questions aimed at understanding your experience with having a premature baby. The interview will be conducted in a private and safe space in order to engage in an in-depth conversation regarding this experience. The interview will be approximately 30 minutes short.

The kind of questions asked are:

1. What was your experience of having a premature baby?
2. What would you say are the main stressful aspects of having a premature infant?
3. How did you make sense of this experience?
4. How did this experience affect you as a man?
5. How was your relationship with the mother affected?
6. What did your newly-found relationship look like with your newborn baby?
7. What was some of the emotional factors at play with having a premature infant?
8. Did you find it easy to communicate any difficult feelings regarding this?
9. Is there anything else you would like to add?
10. Is there anything you would like to ask me?

How private will this interview be? The interview process will be strictly private in a safe and secure space that allows the interviewee to participate more meaningfully and freely. The researcher will protect the identity of the interviewee at all costs and the anonymity of participants is ensured. This will be done through no dissemination of the confidential information with anyone besides the supervisors of the study. With the permission of the interviewee, the interview will be audiotaped and

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transcribed for further analysis. The recordings and transcriptions will be kept on a password protected device where only the researcher will have access. Lastly, the identity of the participants will not be disclosed during the dissemination of the results in the form of a full written thesis for degree purpose, publication, conference.

Are there any risks associated with participating? There are no apparent risks associated in participating in this research as the identity of the participants are strictly confidential. Participants are also not obliged to by initial participation to complete. Participation in this research is strictly voluntary, which means that if at any point participants want to withdraw from the study for any particular reason, they can. If, for any unknown reason, the study evokes any unprocessed emotional material, participants will be referred to the below FREE counselling services:

South African Depression and Anxiety Group (SADAG)

Form of counselling: Telephonic counselling

Contact: 080 056 7567

Whats app: 076 882 2775

Lifeline Counselling Services (Cape Town)

Form of counselling: Telephonic and face to face

Contact: 063 709 2620

What benefits are associated with participating in this study? In participating in this study you are helping to contribute to knowledge in an area that is under studied in South Africa. Not much is known about fathers' experience with having a premature baby in the unique context of South Africa. By participating, more research can be conducted in the future on fathers' experience with having a premature baby.

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For any further questions, please contact:

Researcher:

Jonathan Nell

084 299 0116

3334314@myuwc.ac.za

Department of Psychology. University of the Western Cape.

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Supervisor:

Professor Michelle Andipatin

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Deputy Dean of Research

Faculty of Community and Health Sciences/ UWC

Co-supervisor:

Mr. Kyle Jackson

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Registered Research Psychologist/Lecturer

Department of Psychology

University of the Western Cape

Head of Department:

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HOD of the Psychology Department

University of the Western Cape

Dean of CHS:

Professor Anthea Rhoda

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Dean of the Faculty of Community and Health Science

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Appendix E: Inligtings blad (Afrikaans)

Inligtingsblad

Navorsingstitel: Geleefde ervaring van ʼn steekproef, oftewel monster van Suid-Afrikaanse vaders wat 'n vroeggebore baba het.

Waaroor die studie handel: Hierdie studie word uitgevoer deur Jonathan Nell, ʼn MA-sielkunde-student aan die Universiteit van Wes-Kaapland. U word uitgenooi om aan hierdie studie deel te neem, omdat u ʼn Suid-Afrikaanse vader is wat ʼn vroeggebore baba gehad het. Hierdie studie het ten doel om te verstaan wat u ervaring was met die geboorte van ʼn vroeggebore baba, en daarom sou u ideaal wees om aan hierdie studie deel te neem.

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Wat is die soort vrae wat ek sal vra? Die studie gebruik semi-gestruktureerde vrae, wat ʼn voorafbepaalde stel vrae is wat daarop gemik is om u ervaring met die vroeggebore baba te verstaan. Die onderhoud sal in ʼn privaat en veilige ruimte gevoer word om ʼn diepgaande gesprek oor hierdie ervaring te voer. Die onderhoud sal ongeveer 45-60 minute duur.

Ice breaker questions:

- ***Naam, oudedom/geslag van baba?***
- ***Hoe gereeld sien vader vir baba? Woon vader met baba (en ma), of apart?***
- ***Overall ondervinding om n vader te wees (eerste-keer vader, of alreeds n vader?***
- ***Hoeveel ander kinders het vader, indien alreeds n vader?***

Onderhoudsvrae:

1. Wat was u ervaring met die geboorte van ʼn vroeggebore baba?
1. Hoe het jy gevoel met die geboorte van jou vroegebore baba?
2. Wat sou u sê is die belangrikste spanningsaspekte van die geboorte van ʼn vroeggebore baba?
2. Kan jy my vertel wat sommige van die moeilike gevoelens was gedurende die geboorte?
3. Hoe het u sin gemaak uit hierdie ervaring?
3. Waaraan het jy gedink toe jou baba gebore word?

Hoe privaat sal hierdie onderhoud wees? Die onderhoudproses sal streng aanlyn en privaat wees in ʼn veilige ruimte, gekies deur die deelnemer, wat die ondervraagde in staat stel om meer sinvol en vrylik deel te neem. Die navorser sal die identiteit van die ondervraagde ten alle koste beskerm en die anonimiteit van die deelnemers word verseker deur die gebruik van skuilname. Die privaatheid van die deelnemers word verseker deur nie die vertroulike inligting met enigiemand behalwe die studieleiers van die studie te versprei nie. Met die toestemming van die ondervraagde , sal die onderhoud op band opgeneem en getranskribeer word vir ontleding. Die opnames en transkripsies

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word op 'n wagwoordbeskermde toestel gehou waartoe slegs die navorser toegang het. Laastens sal die identiteit van die deelnemers nie bekend gemaak word tydens die verspreiding van die uitslae in die vorm van 'n ongepubliseerde proefskrif vir graaddoeleindes, tydskrifpublikasie of op enige akademiese konferensie nie.

Is daar enige risiko's verbonde aan deelname? Daar is geen oënskynlike risiko's verbonde aan die deelname van hierdie navorsing nie, aangesien die identiteit van die deelnemers streng vertroulik is. Deelnemers is ook nie verplig om dit deur aanvanklike deelname te voltooi nie. Deelname aan hierdie navorsing is streng vrywillig, wat beteken dat indien, by enige punt, deelnemers van die studie wil onttrek vir 'n spesifieke rede, hulle so kan doen. As die studie om een of ander onbekende rede enige onverwerkte emosionele reaksies ontlok wat moontlik sielkundige hulp benodig, sal die deelnemers verwys word na die onderstaande GRATIS beradingsdienste:

South African Depression and Anxiety Group (SADAG)

Vorm van berading: Telefoniese berading

Kontak: 080 056 7567

WhatsApp: 076 882 2775

Lifeline Counselling Services (Cape Town)

Vorm van berading: Telefonies en van aangesig tot aangesig (in persoon)

Kontak: 063 709 2620

Watter voordele hou daaraan verbonde om aan hierdie studie deel te neem? As u aan hierdie studie deelneem, help u om by te dra tot kennis op 'n gebied wat in Suid-Afrika bestudeer word. Daar is nie veel bekend oor vaders se ervaring met die geboorte van 'nvroeggebore baba in die unieke konteks en geskiedenis van Suid-Afrika nie. Deur deel te neem, kan daar in die toekoms meer navorsing gedoen word oor vaders se ervaring met die vroeggebore baba. Hierdie studie kan help om doelstellings vir sielkundige intervensies te identifiseer wat daarop gerig is om vaders in hierdie verband te help.

Vir verdere vrae, kontak gerus:

Navorser:
Jonathan Nell
084 299 0116
3334314@myuwc.ac.za
Student Navorsings Sielkundige
Department van Sielkunde
Universiteit van Weskaapland

Toesighouer:
Profesor Michelle Andipatin
mandipatin@uwc.ac.za
Adjunk Dean van Navorsing
Fakulteit van Gemeenskaps en Gesondheids Studies/ UWK

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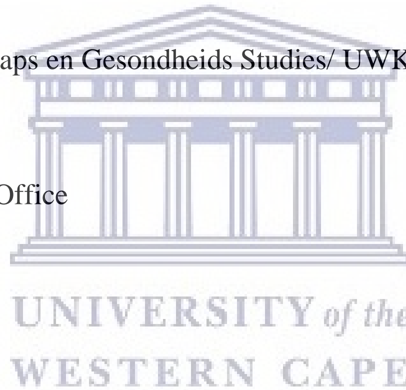
Medestudieleier:
Mnr. Kyle Jackson
kmjackson@uwc.ac.za
Geregistreerde Navorsings Sielkindige/Lektor
Department van Sielkunde
Universiteit van Weskaapland

Hoof van Departement:
Prof Anita Padmanabhanunni
apadma@uwc.ac.za
Department van Sielkunde
Universiteit van Weskaapland

Dekaan van CHS:
Profesor Anthea Rhoda
Chs-deansoffice@uwc.ac.za
Dean van Fakulteit van Gemeenskaps en Gesondheids Studies/ UWK
Universiteit van Weskaapland

Research Ethics
BMREC, Research Development Office
021 959 4111
Research-ethics@uwc.ac.za
University of the Western Cape



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Appendix F: Information sheet (isiXhosa)

Iphepha lolwazi

Isihloko sophando: Ukuvavanya amava obomi besampulu yootata baseMzantsi Afrika ababenomntwana ongaphambi kwexesha.

Isifundo malunga nantoni na: Olu phando luqhutywa nguJonathan Nell, umfundi woPhando lwe-MA kwiYunivesithi yaseNtshona Koloni. Uyamenywa ukuba uthathe inxaxheba kolu phando kuba ungutata waseMzantsi Afrika owayenomntwana owazalwa ngaphambi kwexesha. Olu phononongo lujolise ekuqondeni ukuba lingawaphi amava akho malunga nokuba umntwana azalwe ngaphambili kunokuba bekulindelwe.

Ngaba loluphi uhlobo lwemibuzo endiza kubuzwa ngayo? Isifundo sisebenzisa imibuzo ejolise ekuqondeni amava akho malunga nokuba umntwana azalwe ngaphambili kunokuba bekulindelwe. Udliwanondlebe luya kubanjwa kwindawo yabucala ekhuselekileyo ukuze ube nengxoxo enzulu malunga namava akho. Udliwanondlebe luya kuba malunga nemizuzu engama-30 ngokufutshane.

Uhlobo lwemibuzo ebuzwayo yile:

Imibuzo eqhekeza umkhenkce:

4. Igama, isini / isini, ubudala bomntwana
5. Umona kangaphi umntwana? Ngaba uhlala nomntwana (kunye nomama), okanye ngokwahlukileyo?
6. Ngamava apheleleyo wokuba ngutata (utata wokuqala, okanye utata okhoyo?
7. Bangaphi abanye abantwana onabo, ukuba utata sele enaye?

Imibuzo Yodliwano-ndlebe:

1. Linjani ixesha lakho ukuba nomntwana wakho ngaphambili kunokuba bekulindelwe?

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Wavakalelwa njani xa wawunomntwana wakho?

2. Ungathi zeziphi ezona zinto zixinzelelekileyo zokuba nomntwana kwangoko kunokuba bekulindelwe?

• Ungandixelela ukuba zeziphi ezinye iimvakalelo owawukhe wahlangabezana nazo?

3. Ubuyenza njani le nto?

• Ndixelele ngezinye zeengcinga owawunazo xa wawunomntwana wakho ngaphambili kunokuba bekulindelwe?

Luya kuba lubucala njani olu dliwanondlebe? Udliwanondlebe luza kuba kwi-intanethi kwigumbi elithuleyo zombini ezo ndlebe nodliwano-ndlebe. Umphandi uya kukhusela isazisi sakho ngazo zonke iindleko kwaye ukungaziwa kwakho kuyaqinisekiswa. Olu lwazi aluzokwabelana naye nabani na kodwa ngabaphathi babafundi. Ngemvume yakho, udliwanondlebe luya kurekhodwa lwevidiyo. Ushicilelo kunye nokukhutshelwa kuya kugcinwa kwifayile ekhuselweyo yephasiwedi apho kuphela umphandi enokufikelela. Okokugqibela, isazisi sakho asizukuchazwa ngexesha lokuhanjiswa kweziphumo ngohlobo olupheleleyo lwe-thesis ebhalwayo, idrafti, ingqungquthela.

Ngaba kukho nayiphi na imingcipheko enxulumene nokuthatha inxaxheba? Kukho umngcipheko onxulumene nokuthatha inxaxheba kolu phando. Nangona kunjalo, iinzame ezinje ngeenkonzo zesimahla zokufumana iingcebiso zenziwa zifumaneke ukunciphisa umngcipheko onxulumene nokuthatha inxaxheba kuphando. Akunyanzelekanga ukuba uthathe inxaxheba ngokuzeleyo. Ukuthatha inxaxheba kolu phando kungokuzithandela ngokungqongqo, okuthetha ukuba ukuba nangaliphi na ixesha ufuna ukurhoxa esifundweni nasiphi na isizathu esithile, unako. Ukuba, nangasiphi na isizathu, uphononongo luvuselela naziphi na iimpendulo zemvakalelo ezingafunyanwanga, uya kuthunyelwa kwezi nkonzo zoncedo zilulekayo zingezantsi:

Iqela loxinzelelo kunye nexhala loMzantsi Afrika (SADAG)

Uhlobo lwengcebiso: Ngcebiso ngomnxeba

Unxibelelwano: 080 056 7567

I-WhatsApp: 076 882 2775

Iinkonzo zeNgcebiso ngeLifeline (eKapa)

Uhlobo lwengcebiso: Ngomnxeba kunye nobuso ngobuso

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Nxibelelana: 063 709 2620

Zeziphi izibonelelo ezihambelana nokuthatha inxaxheba kolu phando? Ngokuthatha inxaxheba kolu phando unceda ukufaka isandla kulwazi kwindawo efundelwa apha eMzantsi Afrika. Akukho nto ingako yaziwayo malunga namava katata ngokuba nomntwana ongaphambi kwexesha kwimeko ekhethekileyo apha eMzantsi Afrika. Ngokuthatha inxaxheba, uphando olungaphezulu lunokwenziwa kwikamva lamava wootata ngokuba nomntwana ongaphambi kwexesha.

Eminye imibuzo, nceda unxibelelane:

Umphandi:

UJonathan Nell

084 299 0116

3334314@myuwc.ac.za

ISebe lezeengqondo

IYunivesithi yeNtshona Koloni.

Umphathi:

Unjingalwazi uMichelle Andipatin

mandipatin@uwc.ac.za

USekela Mphathi woPhando

Icandelo leNzululwazi yoLuntu kunye lezeNzululwazi zezeMpilo / i-UWC

Isuphavayiza:

Mnu Kyle Jackson

kmjackson@uwc.ac.za

Ugqirha obhalisiweyo weSayensi yezeengqondo / uMhlohli

ISebe lezeengqondo

IYunivesithi yeNtshona Koloni

INtloko yeSebe:

Prof Anita Padmanabhanunni

apadma@uwc.ac.za

IHOD yeCandelo lezeMpilo yezeengqondo

IYunivesithi yeNtshona Koloni

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UDean of CHS:

Unjingalwazi Anthea Rhoda

Chs-deansoffice@uwc.ac.za

UDean wecandelo loLuntu lwezeNzululwazi kunye nezeMpilo

IYunivesithi yeNtshona Koloni

Iindlela Zokuziphatha zoPhando

BMREC, Research Development Office
Research-ethics@uwc.ac.za

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Appendix C: Consent form

Research Title: Lived experience of a sample of South African fathers having a premature baby

The current study has been explained and clarified to me in a thorough way and in a language that I understand. I am aware of the contribution of this study and is willing to participate fully. I understand that my participation in this study is strictly voluntary and that I can withdraw out of my own free will. I understand that my identity and all information stemming from my participation will be strictly confidential and will not be violated by the ethical code of this research.

Therefore, with the above understanding:

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I give my full consent to participate ☐

I do not give my consent to participate ☐

I give my consent to be video/audiotaped ☐

I do not give my consent to be video/audiotaped ☐

Participant name: ______________________________

Participant Signature: ______________________________

Date: ____________________

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Appendix H: Vrywarings vorm (Afrikaans)

Vrywaringsvorm

Navorsingstitel: Geleefde ervaring van 'n steekproef, oftewel monster van Suid-Afrikaanse vaders wat 'n vroeggebore baba het.

Die huidige studie is op 'n deeglike manier aan my verduidelik en uitgeklaar in 'n taal wat ek verstaan. Ek is bewus van die bydrae van hierdie studie en is bereid om ten volle deel te neem. Ek verstaan dat my deelname aan hierdie studie streng vrywillig is en dat ek uit my eie wil kan onttrek. Ek verstaan dat my identiteit en alle inligting wat spruit uit my deelname streng vertroulik sal wees en nie deur die etiese kode van hierdie navorsing oortree sal word nie.

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Daarom, met bogenoemde begrip:

Ek gee my volle toestemming om deel te neem ☐

Ek gee nie my toestemming om deel te neem nie ☐

Ek gee toestemming na klank/video opname ☐

Ek gee nie toestemming na klank/video opname ☐

Naam van deelnemer: ________________________________

Handtekening van deelnemer: ________________________________

Datum:___________________________

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Appendix I: Consent form (isiXhosa)

Ifomu yemvume

Isihloko sophando: Ukuvavanya amava obomi besampulu yootata baseMzantsi Afrika ababenomntwana ongaphambi kwexesha.

Olu phando luye lwacaciswa kwaye lacaciswa kum ngokucacileyo nangolwimi endiluqondayo. Ndiyazi igalelo lolu phando kwaye ndizimisele ukuthatha inxaxheba ngokupheleleyo. Ndiyaqonda ukuba ukuthatha kwam inxaxheba kolu phando kukuzithandela kwaye ndingarhoxa ngaphandle kwenkululeko yokuzikhethela. Ndiyaqonda ukuba ulwazi lwam kunye nayo yonke ingcaciso iya kuba yimfihlo kwaye ayizophulwa.

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Ke ngoko, ngokuqonda okuthe kratya:

ndiyavuma ukuthatha inxaxheba. ☐

Andivumi ukuthatha inxaxheba. ☐

Ndiyavuma ukukhutshwa iividiyo / audiotaped ☐

Andivumi ukubonwa / kuvavanywa ☐

Igama lomthathi-nxaxheba: ________________________________

Utyikityo lomthathi-nxaxheba: ________________________________

Umhla: ________________________________

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Exploring the lived experiences of a sample of

South African fathers

who had a premature baby.

What will I have to do?

Have a conversation about your experience of having a baby born prematurely. The interview will take place online at your convenience. Your participation will be anonymous and confidential.

We want to know what your perceptions, feelings and thoughts were when you had your premature baby. To do this, we would like to invite you for an interview about the experiences of this event.

We are studying the experiences of South African fathers who had a premature baby. If this is you, we would like to hear from you.

Who can take part?

- Fathers born in South Africa
- Had a baby born prematurely (between 27-37 weeks)
- Baby must 6 months and older
- Must be 18 years or older
- Speak English, Afrikaans or IsiXhosa

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IF YOU ARE INTERESTED, PLEASE CONTACT JONATHAN NELL:

cellphone - 084 299 0116

email - 3334314@myuwc.ac.za

whatsapp - 060 504 7369

Ukuvavanya amava obomi besampulu ye

Ootata base Mzantsi Afrika

owayenomntwana ngaphambi kwexesha.

Ndiza kwenza ntoni?

Yiba nencoko malunga namava akho okuba umntwana azalwe ngaphambi kwexesha. Udliwanondlebe luya kuqhubeka kwi-intanethi ngokulula kwakho. Uthatho-nxaxheba lwakho iya kuba yinto engaziwayo kwaye iyimfihlo.

Sifuna ukwazi ukuba yintoni ukuqonda kwakho, iimvakalelo kunye neengcinga zakho xa wawunomntwana wakho ngaphambi kwexesha. Ukwenza oku, singathanda ukumema udliwanondlebe malunga namava esi siganeko.

Sifunda i amava Ootata base Mzantsi Afrika ebengaphambi kwexesha usana. Ukuba nguwe lo, singathanda i ukuva kuwe.

Ngubani onokuthi athathe inxaxheba?

- -Ootata abazalelwe eMzantsi Afrika
- -Ukuba umntwana azalwe ngaphambi kwexesha (phakathi kweeveki ezingama-27 ukuya kuma-37)
- - Usana kufuneka luneenyanga ezi-6 nangaphezulu
- -Kufuneka ube uneminyaka eli-18 okanye ngaphezulu
- - Thetha isiNgesi, isiBhulu okanye isiXhosa

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IF YOU ARE INTERESTED, PLEASE CONTACT JONATHAN NELL:

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email - 3334314@myuwc.ac.za

whatsapp - 060 504 7369

Om die lewenservaring van 'n monster van

Vaders van Suid-Afrika

wat 'n vroeggebore baba gehad het te ondersoek.

Wat moet ek doen?

Gesels oor u ervaring van voortydige geboorte. Die onderhoud sal op u gemak aanlyn voortgaan. U deelname sal anoniem en vertroulik wees.

Ons wil weet wat u begrip, gevoelens en gedagtes was toe u 'n vroeggebore baba gehad het. Om dit te doen, nooi ons u graag vir 'n onderhoud uit oor hierdie ervaring.

Ons bestudeer die ervarings van Suid-Afrikaanse vaders wat 'n vroeggebore baba gehad het. Indien dit u is, wil ons graag van u hoor.

Wie kan deelneem?

-Vaders wat in Suid-Afrika gebore is
-As u vroeggebore baba tussen 27 en 37 weke gebore was
- Baba moet 6 maande of ouer wees
-Vader moet 18 jaar of ouer wees
- Moet Afrikaans, Engels of IsiXhosa kan praat.

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INDIEN U SOU BELANGSTEL, KONTAK ASSEBLIEF VIR JONATHAN NELL:
selfoon - 084 299 0116
e-pos- 3334314@myuwc.ac.za
whatsapp - 060 504 7369

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Department of Institutional Advancement
University of the Western Cape
Robert Sobukwe Road
Bellville 7535
Republic of South Africa

60 YEARS *of hope, action & knowledge*

07 October 2020

Mr J Nell
Psychology
Faculty of Community and Health Sciences

Ethics Reference Number: BM20/8/12

Project Title: Exploring the lived experiences of a sample of South African fathers who had a premature baby.

Approval Period: 07 October 2020 – 07 October 2023

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
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