



**UNIVERSITY of the  
WESTERN CAPE**

Faculty of Community and Health Sciences

**Exploring the Coping Strategies of Mothers with Preterm Babies Admitted to  
a Neonatal Care Unit in one hospital in Cape Town**



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A thesis submitted in partial fulfillment of the requirement for the award of a Master's degree  
in Nursing Science in the Department of Nursing, University of the Western Cape.

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## Declaration

I declare that the thesis entitled “*Exploring the Coping Strategies of Mothers with Preterm Babies Admitted to a Neonatal Care Unit in one hospital in Cape Town*” is my own work, that it has not been submitted for any degree or any examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Delphine Sih Awah

2016

Signed:



UNIVERSITY of the  
WESTERN

Date : 30<sup>th</sup> November 2016

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## **Dedication**

To my parents, Mr and Mrs Awah, my children Joel and Joelene Beng, and posthumously to my beloved uncles; Achuo Thaddeus Abang, Col. Bob Thomas Ebua and Dr Martha Nsen Cheo.



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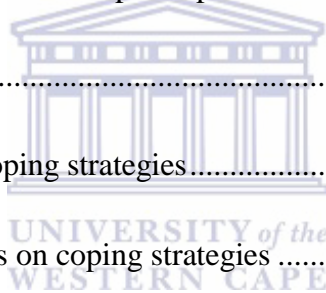


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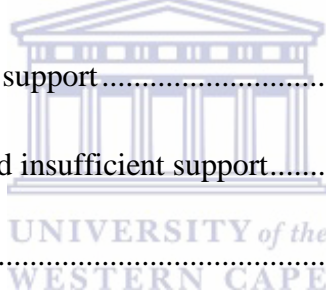




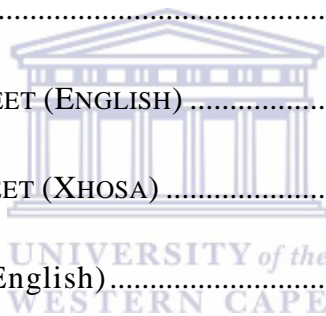
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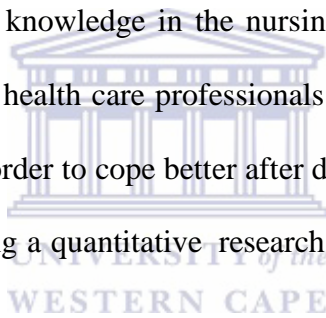
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## Abstract

Most pregnant women have uncomplicated pregnancies. In South Africa mothers with uncomplicated pregnancies are able to deliver at community-based health facilities called Midwife Obstetric Units. However, due to complications that occur during pregnancy, including preterm labour, some women deliver their babies in a secondary or tertiary hospital. During this time, the neonates have to be admitted to the neonatal care unit, which becomes stressful and challenging to their mothers. This is usually due to the daunting hospital environment, the different equipment used to care for their babies and the neonatal care unit routine. The aim of this research was to explore and describe the coping strategies and support needs of mothers with preterm babies admitted to a neonatal care unit in one hospital in Cape Town. This research adopted a qualitative research approach and an exploratory and descriptive design to elicit information from participants. A purposive sampling strategy was used for participant selection. The researcher and the trained data collector conducted one-to-one interviews with the participant which took place in a private room. A semi-structured interview technique was used for data collection. The interview guide was composed of open-ended questions which were followed by probes for clarity and in-depth understanding of the phenomenon. Interviews were conducted in the English and Xhosa languages. English-speaking participants were interviewed by the researcher while one non-English-speaking participant was interviewed by a trained data collector. In this research, 12 mothers were recruited and 11 of them participated. Participants were aged 19 years and older, had delivered preterm babies, and their babies had been admitted to the neonatal care unit for at least three days during the time of data collection. Data were analysed manually using an inductive thematic analysis approach. Results were deductively interpreted and supported by the Brief COPE model. The themes that emerged from the data analysis included: praying, attachment to the baby, acceptance of the situation, support requests, support from one's

social circle and lack and insufficient support. The first three themes are related to coping strategies the subthemes described under praying included: Praying for God's strength and grace and for baby's survival as well as thanksgiving to God for babies' health and preferred gender, attachment to baby included: Bonding with baby and Seeing the baby, acceptance of the situation included: Perseverance in the situation and mother's awareness of her responsibility. With regards to support needs the subthemes that emerged under Support request included freedom to go in and out of hospital, Group session as well as counselling and comfort, Support received from one's social circle included: Support received from HCPs, Support received from relatives and Group support, Lack of and insufficient support included: Health Care professional's attitude and Insufficient Education from HCPs. This research will add to the body of knowledge in the nursing and health field in general. The research findings will inform the health care professionals with regards to the support needs of mothers of preterm babies, in order to cope better after delivery. Another research study of this type could be conducted using a quantitative research approach to gain generalisability.



## Keywords

- Coping strategies
- Mothers with preterm babies
- Neonatal care unit
- Support needs
- Preterm babies
- Preterm delivery
- Pregnancy
- Traumatic experience



# Chapter One

## 1 Background information to the study

### 1.1 Introduction

Chapter one introduces the topic that this research is based on. In this chapter, the overview of preterm delivery is highlighted. Preterm delivery has been shown to have an impact on babies born preterm, their mothers and the society as a whole, which is briefly discussed in this chapter. The concept of coping and how mothers demonstrate coping after preterm delivery is mentioned. This chapter goes on to outline the problem statement that this research addressed, the research purpose and objectives, which are supported by a rationale for conducting this research. The significance of this study is outlined. Adding to the above, some terms used in this research are defined, followed by the structure outline of the full thesis and then a conclusion.

Below the overview of preterm delivery and its definition as well as its causes are outlined.

#### 1.1.1 Overview of preterm delivery

Most pregnancies run a normal course, ending in a healthy mother-infant dyad. However, the occurrence of preterm deliveries is increasing slightly worldwide, and grew from about 9.6% of all babies born preterm in 2005 (Beck et al., 2010) to about 10% in 2010 (World Health Organization [WHO], 2012). Preterm delivery can be challenging for the mothers, their babies and their families (WHO, 2012). As reported by Kendall-Tackett (2009), preterm delivery is a health crisis, it can be a potentially life-threatening condition, or can have a significant negative impact on mothers' psychological wellbeing. According to the WHO (2012) preterm delivery is defined as all deliveries that occur before 37 completed weeks of gestation. The WHO (2012) added that based on gestational age and birth weight, preterm



delivery can be placed into three broad categories, namely extremely preterm, very preterm and moderately preterm.

Babies born preterm are often admitted to a neonatal care unit because they are vulnerable to temperature fluctuations, hypoglycaemia, infections, hypoxia and feeding difficulties (Celik, Demirel, Canpolat & Dilmen, 2013). Preterm babies require high-technology equipment and skilled health personnel to provide care, which can be costly to the family, the health system as well as society in general (WHO, 2012; Beck et al., 2010; Kendall-Tackett, 2009; Spielman & Ben-Ari, 2009; Aagaard & Hall, 2008). As reported by Lloyd and De Witt (2013), the WHO (2012) and Hoffenkamp et al. (2012), survival of preterm babies often depends on the degree of mother-baby bonding, mothers' coping ability, availability of appropriate equipment for neonatal care as well as competent neonatal care personnel. In addition, mothers of preterm babies require more support in order to cope with and care for their babies (Van der Hoeven, Kruger & Greeff, 2012).

Even though preterm babies are usually admitted for monitoring and special health care, mothers of these babies often face several daunting challenges, such as interrupted mother-baby bonding, depression, anxiety, and fear of losing their babies (Van der Hoeven et al., 2012; Kendall-Tackett, 2009). Research reveals that hospitalization of any sort can be traumatic (Franck et al., 2015; Macías, 2015). A study by Holditch-Davis et al. (2003) specified that parents become traumatized when their children are hospitalized. Thus Hospitalization coupled with preterm delivery can be even more traumatic, which can lead to a decrease in maternal self-belief and maternal confidence, as well as causing mothers to feel helpless, which can eventually lead to inability of the mother to care for her preterm baby (Korja, Latva & Lehtonen, 2012).

Preventing preterm mortality is very important and a public health issue targeted worldwide to help reduce global infant mortality (Callaghan et al., 2006). Current literature shows that

preventing preterm delivery is imperative although it remains a challenge, since about 50% of preterm delivery cases happen without a known cause (Moss, 2006).

Preterm delivery is caused by a multitude of factors. Maternal illnesses, foetal abnormalities, poor socio-economic status, multiple gestation, lifestyle and advanced or decreased maternal age might play a leading role in causing women to deliver before the normal gestational age (Van den Broek, Jean-Baptiste & Neilson, 2014; WHO, 2012; Kendall-Tackett, 2009; Haram Mortensen & Wollen, 2003). Therefore focusing on how mothers cope after the traumatic event of preterm delivery is very important. This is because healthcare providers (HCPs) will encourage positive coping and modify maladaptive coping mechanisms of mothers of preterm babies. In this way, mothers will be able to bond well with and care for their babies better in the hospital and at home after discharge, which will promote chances of good growth, development and survival of the baby (Obeidat, Bond & Callister, 2009).

The care and management of preterm babies is of a significant standard. The common physical care offered to preterm babies after delivery and admission comprises thermal care, nutritional support, infection prevention and treatment as well as neonatal resuscitation (WHO, 2012). However, mortality and morbidity rates amongst these babies are still high (Kendall-Tackett, 2009). Therefore other facets such as mothers' coping strategies and support needs after preterm delivery are worth exploring in order to combat infant mortality and morbidity. Mothers are the backbone of the comfort that babies can receive, most especially preterm babies. The efforts of mothers and their babies to bond provide stability and comfort to babies, which allow growth and development in the baby as well as good health in the mother.

Despite the care provided after preterm delivery, preterm delivery has a significant impact on the lives of the babies, their mothers and significant others, as well as the health system of the

country. It brings with it a huge amount of cost into the lives of individuals and the health system and places them in financial constraints. How preterm delivery affects lives and the system of health care is highlighted below.

### **1.1.2 Impact of preterm delivery**

An increasing number of deaths in those aged under five years are due to prematurity as a result of preterm delivery (Lawn, Shibuya, & Stein, 2005). However, birth asphyxia, infections, low birth weight, and congenital abnormalities are other causes of deaths in children under five years old (Lloyd & De Witt, 2013). It is reported by Roos et al. (2016) that about 2.7 million neonates are reported dead every year in low and middle-income countries of the world. This could be very painful to the mothers who are affected by these deaths.

A great deal of neonatal deaths could be prevented with high-quality care as well as well-timed interventions, and these could be maintained before and during pregnancy, as well as after delivery of the baby (Roos et al., 2016). However, this does not take place for many reasons, including irresponsibility on the part of the HCP tasked with the responsibility of obstetric care delivery. Mothers are often ignorant during pregnancy and fail to fulfill required tasks (such as attending antenatal care, taking all prescribed medication such as folic acids and ferrous sulphate) in preparation for the coming of their baby (Lloyd & De Witt, 2013). Upadhyay et al. (2014) mentioned that medical reasons are not the only factors that can lead to the death of a baby, but that administrative staff members who are responsible for communication between different obstetric care units or facility personnel could fail to carry out their job properly, leading to fatal mistakes. Possible errors of the HCP may include late referrals of cases in connection with preterm labour, which can lead to delay in treatment and subsequent death of the mother and/or baby. Again, HCPs may fail to diagnose preterm

labour, which may lead to wrong maternal management and subsequent loss of the mother and / or baby.

Maternal delay in booking and poor attendance of antenatal care (ANC) may lead to failure in the diagnosis of illnesses and prompt management. This puts the mother and baby at risk and prevents them from receiving timeous disease treatment, with subsequent morbidity and death (Upadhyay et al., 2014). A delay in booking an ambulance for transfer of a mother who is in preterm labour or failure to communicate written information to a receiving facility or unit by administrative staff may lead to loss of the mother and / or baby (Upadhyay et al., 2014; Lloyd & De Witt, 2013). All of the above mistakes could hugely affect the wellbeing of the mother of the preterm baby, which as a consequence could affect the wellbeing of the baby, which can lead to failure to thrive and subsequent death.

Preterm babies are reported to be at risk of having poorly developed brains and lungs, and as a result may suffer consequences such as neurodevelopmental, behavioural and respiratory problems (Haldipur et al., 2011; Beck et al., 2010; Moss, 2006). Preterm delivery contributes substantially to global infant mortality and morbidity, and is the second leading cause of death in children younger than five years after pneumonia (WHO, 2012; Kendall-Tackett, 2009; Williamson et al., 2008). The neurodevelopmental problems that may occur in preterm babies include cerebral palsy, mental retardation, and sensory impairments. The preterm babies may develop neuro-behavioural problems, including attention deficit, poor visual processing, poor academic progress, retinopathy of prematurity disease, as well as learning disabilities (Benzies et al., 2013; WHO, 2012; Beck et al., 2010). The long term impact of preterm birth can be noted at school-going age, such children who were born preterm may battle with academic work, vision, and may end up in special schools, which is a burden to the family, health system and society as a whole (Aarnoudse-Moens et al., 2009).

In addition, it is reported that mother-baby separation due to preterm delivery can have an impact on the social, emotional, behavioural and cognitive skills of the baby (Korja et al., 2012). The respiratory problems that may occur in preterm babies include broncho-pulmonary dysplasia, lung impairment and insufficient pulmonary surfactant, which are noted to cause early neonatal death (Benzies et al., 2013; WHO, 2012; Beck et al., 2010). Many of these babies may grow up with lung problems and are unable to perform certain physical exercises as they get very tired due to lung insufficiency. Not only has preterm delivery affected the baby born before term, it moreover affects the individual mother who delivered a preterm baby.

In a study conducted by McIntosh, Stern, and Ferguson (2004), optimism, coping and psychological distress were assessed in mothers with regard to their reaction to the neonatal intensive care unit (NICU). Results showed that mothers used cognitive ventilation strategy as a way of coping with the stress. Research mentioned that venting increases anger and is not the best way to overcome stress, because it can lead to post-traumatic stress disorder (Shaw et al., 2013). Therefore the negative coping strategies could have a serious effect on the mother, such as reduction in the bonding between the mother and baby. Mothers may similarly lose their self-esteem, which may affect their ability to care for their babies, and hence not meeting motherhood expectations.

Due to complications that occur during pregnancy, including preterm labour, some women deliver their babies in a secondary or tertiary hospital, ending up with the baby being admitted in a neonatal care unit. Mothers of preterm babies are challenged by the fact that they delivered their babies earlier than they expected. This is confirmed by Swanson et al. (2012), who mentioned that delivering a preterm baby is indisputably a more worrying experience. Coupled with the stress of having a preterm baby, the neonatal care unit is physically and psychologically traumatising to mothers due to the presence of unfamiliar

sound pitches from different types of healthcare equipment, including the ventilator, cardiac monitor, feeding pump, and oxygen saturation monitoring machine (Russell et al., 2014). Furthermore, the routine activities of the neonatal unit, the tiny appearance of the preterm babies as well as the presence of sicker babies add to the already existing trauma of mothers of preterm babies (Trajkovski et al., 2012).

Therefore the delivery of a preterm baby could lead to maternal stress and anxiety which may subsequently lead to ‘postnatal blues’ or severe depression (Kendall-Tackett, 2009). The state of anxiety and stress may become worse when the baby’s condition becomes worse, which may lead mothers to develop an acute stress disorder. This could be as a result of not being able to hold, touch or care for their preterm babies after delivery (Kendall-Tackett, 2009). Again, the duration of stay in hospital is higher for preterm babies than for their full-term counterparts, and this interrupts the mother-baby bond, thus adding to already increased maternal stress (WHO, 2012; Hoffenkamp et al., 2012).

Furthermore, because preterm delivery happens suddenly, it affects maternal self-belief, attitudes and values, making mothers feel helpless, unsure and anxious (Korja et al., 2012). It has been documented that mothers of preterm babies experience feelings of isolation, uncertainty, unawareness, fear, anxiety, guilt, ambivalence, helplessness and anger after delivery (Goutaudier et al., 2011). Another study revealed that mothers of preterm babies only blurredly recalled the event of delivery and expressed their anticipation of seeing and touching their babies – with contrasting emotions when they touch or see their babies for the first time (Arnold et al., 2013). Therefore preterm delivery sets a mother backwards health-wise and therefore requires much attention from HCPs, family and the entire State.

Research shows that preterm delivery may significantly affect other individuals such as the preterm baby’s father, grandparents or siblings who may render support to affected mothers (Hebert, 2014). However, the mothers of the preterm babies are usually the most affected and

are thus considered a target group through which to approach preterm delivery concerns in order to render benefits to the mother and her baby (Arzani et al., 2015). This is because mothers and their preterm babies are at risk of developing short- and long-term complications after preterm delivery (Cnattingius et al., 2013; Morken, 2010).

It is reported that infant mortality and morbidity rates decrease with advanced gestational age (WHO, 2012). Therefore extremely preterm babies with a very low gestational age are more susceptible as compared to the other categories of preterm babies. Research shows that the more susceptible the preterm baby, the more chance there is that they will stay longer in hospital in the neonatal care unit and vice versa (Lau et al., 2015). This is directly affecting the cost of care, since much will be invested in ensuring the survival of preterm babies, ranging from the equipment and drugs used to the HCPs who are tasked to deliver neonatal care.

Preterm delivery imposes significant financial costs to the family to whom the baby is born, the community and the State as a whole. In the mid-2000s, Beck et al. (2005) revealed that medical exigencies as well as the educational needs of preterm babies were very costly for their parents, families and the entire country. They similarly indicated that normal productivity in a country may not be achieved in the presence of an abnormally high preterm birth rate in that country. According to WHO Born Too Soon Report, (2012), the yearly societal cost of care for preterm babies was estimated to be \$2.6million for the USA, which is equivalent to approximately R37 million in South Africa (Howson, Kinney, McDougall & Lawn, 2013). In the late 2000s, Petraglia and Visser (2009) estimated that the daily cost of hospitalisation in a neonatal unit is \$1000 in the USA, which is equivalent to approximately R14 384.02 in SA. Mothers of preterm babies have to cope with the entire package of stress brought about by having a preterm baby, as mentioned below.



### **1.1.3 Mothers' ability to cope with preterm delivery**

The ability of mothers to adapt to changing states of responsibilities in their individual lives in order to be emotionally, physically and mentally stable can be mentioned as coping (Schappin et al., 2013). When people are stressed, they tend to do something on their own in order to deal with the stressful situation. Therefore, what mothers do to help them cope with changes in the responsibilities in their lives could be termed as coping strategies. Different individuals cope differently; therefore some of the coping strategies used are positive, while others are negative. Positive or negative coping depends on how the individual mother perceives the event of preterm delivery.

Even though some mothers perceive preterm delivery to be normal, most mothers who deliver preterm babies do not smile at the event (Gray et al., 2012). Positive coping could be encouraged by implementing certain activities, such as accommodating individual cultures during healthcare practices and making the neonatal care environment friendlier. It is very important that mothers of preterm babies cope positively in order to enhance maternal ability to care for their preterm babies independently, thus ensuring good infant growth and development (Flacking et al., 2012).

It is reported by Ntswane-Lebang and Khoza (2010) and Shaw et al. (2013) that mothers use different ways to cope after giving birth to preterm babies, during admission and after discharge. Ntswane-Lebang and Khoza (2010) besides reported that these mothers demonstrate a feeling of helplessness and guilt. Furthermore, Watson (2011) and Jackson, Ternstedt and Schollin (2003) identified that while some mothers gradually adapt to the situation of preterm delivery after some days or weeks, other mothers find it difficult to do so and become unfit to care for their babies. According to Ringland (2008) mothers of preterm babies use support from HCPs and relatives as a strategy to cope with their babies' uncertain survival state and the potential for long-term complications which are heart-



breaking to the mother. It is noted that maternal coping strategies as well as their support needs have been insufficiently explored, and to date little is known on the coping strategies of mothers with preterm babies in the neonatal unit in Cape Town. Earlier studies have explored maternal stress after preterm delivery without looking at what these mothers do to withstand the stress, leaving a dearth of information (Watson 2010; Jackson et al., 2003). Hence the current research aimed to bridge the gap by exploring and describing the coping strategies used by mothers of preterm babies admitted in a neonatal care unit in one hospital in Cape Town.

Limited time and resources are factors identified to impact on a research process, and for this reason one hospital in Cape Town has been chosen to deal with and conclude this research. It has been shown that mothers of preterm babies need special support as well as positive coping strategies to ensure their babies' survival (WHO, 2012). Therefore it is important to have an understanding of how mothers cope with preterm delivery events, so that appropriate assistance could be given to the mothers who fail to cope positively. These research findings will be reported via the management to the HCPs who deliver neonatal services in the neonatal care unit in the setting where this research was conducted. The availability of the report will be made known to the HCPs by the researcher.

## **1.2 Problem statement**

Preterm delivery is stressful and requires adjustment to the changing state of responsibility in the lives of the mothers, who face a number of challenges related to the health of their babies. These mothers have to develop coping strategies in order to deal with the stressful situation (Shosha & Kalaldehy, 2012). It is reported that mothers of preterm babies need special support as well as positive coping strategies to ensure their babies' survival (WHO, 2012). To date little is known of the coping strategies of mothers with preterm babies in the neonatal care units in Cape Town. Considering that preterm deliveries are reported in South Africa (SA),

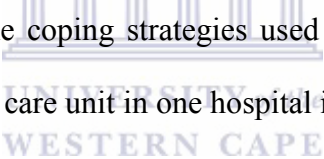
health care professionals need to understand how these mothers cope and their support needs. This will enable the HCP to provide the required support. Anecdotal evidence suggests that mothers who have delivered preterm babies find it difficult to cope with the situation and require support.

### **1.3 Purpose of the research**

The purpose of this research was to **gain an understanding of** the coping strategies used by mothers whose preterm babies were admitted in a neonatal care unit in one hospital in Cape Town.

### **1.4 Objectives of the research**

The objectives of this research were:

- 
- To explore and describe the coping strategies used by mothers whose preterm babies were admitted in a neonatal care unit in one hospital in Cape Town.
  - To explore and describe the support needs of mothers whose preterm babies were admitted in a neonatal care unit in one hospital in Cape Town.

### **1.5 Significance of the research**

This research intends to provide information that could assist in the development of guidelines on appropriate support mechanisms, care protocols, planning, and assistance for mothers of preterm babies. Findings of this research may provide baseline information that will indicate whether more research is needed to develop a more mother-baby-friendly healthcare facility, especially related to preterm delivery. Furthermore this research may enable stakeholders to assess the adequacy or efficacy of support rendered to mothers in the setting.

## 1.6 Motivation for the study

In practice in one of the health institutions in the Western Cape, the researcher observed a situation where a 28-year-old mother delivered a preterm baby and was unable to see her baby due to direct admission to the NICU. The mother was left confused and forlorn, not knowing what to expect. This experience lingered, prompting an interest in understanding the coping strategy and support needs of mothers who are in a similar situation. It is very important that this research be conducted because it focuses on the mothers of preterm babies, mothers being those most affected by the sudden delivery – more so than the fathers or anyone else. Mothers are the influential source of aspects needed for a baby's survival, including food and warmth, the most important aspects needed for basic living for the preterm baby.



## 1.7 Operational definitions

*Coping strategies.* In this research, coping strategies are the various activities used by mothers whose preterm babies are admitted in the neonatal care unit, to manage the preterm delivery-related stress that they are experiencing.

*Neonatal care unit.* In this research, this is used to mean a unit in a public hospital used to admit newborn and preterm babies who are sick and require the use of equipment such as the incubator, phototherapy machine, nutritional or intravenous therapy machine.

*Preterm delivery.* In this research, preterm delivery is used to mean delivery that occurred before 37 completed weeks of gestation at the selected research setting.

*Preterm baby.* In this research, preterm baby is used to mean any baby born before 37 completed weeks of gestation.

*Support.* In this research, support is used to mean the kind of assistance (financial, physical, psychological, emotional and social) given to a mother during her preterm baby's admission in the neonatal care unit.

## **1.8 Structure of the thesis**

The layout of this thesis includes five chapters. Chapter one provided the introduction of the research, problem statement, motivation for conducting this research, research aims and objectives, significance of the research, definitions and a brief description of the conceptual model that was employed in this research. It highlights a brief description of the methodology that was followed in this research as well as some of the operational definitions used in this research. This chapter ends with a transitory conclusion.

In Chapter two the literature reviewed and linked to this research is presented, which includes the concept of preterm delivery, global statistics with regard to preterm delivery, current studies in line with this research and identification of gaps. The conceptual framework as applied in this research is discussed in this chapter. Coping assessment models are discussed, with emphasis on aspects of the Brief COPE model and its application to this research. This chapter ends with a brief conclusion.

The research methodology follows in chapter three, which deals with the research approach and design, data collection and analysis, trustworthiness and rigour maintained in this research, ethic principles that were applied as well as a brief conclusion.

Chapter four presents the results obtained from the interviews conducted in this research study. Themes and categories with respect to both research objectives are presented in this chapter. Patients' own words as used in the interviews are used as direct quotes to explain facts. Finally a conclusion is provided.

The last chapter (five) discusses the results as related to the literature. This chapter moreover mentions identified limitations, and provides some recommendations for future attention and a conclusion to the entire research project.

## **1.9 Summary of chapter one**

Chapter one of this thesis provided a background to the research and a brief structure of the thesis. The research aim and objectives, problem statement, motivation for conducting the research, significance of the research and operational definitions were presented in this chapter. Current knowledge about the current research topic follows in a review of the literature in Chapter two.



## Chapter Two

### 2 Literature review and conceptual framework

#### 2.1 Introduction

The affliction of preterm delivery is more prevalent in developing countries than the developed ones (Steer, 2005). The reviewed literature relates to exploration and description of the coping strategies of mothers with preterm babies admitted in the neonatal care unit in a hospital in Cape Town. It relates to exploration and description of the support needs of mothers of preterm babies admitted in a neonatal care unit in a hospital in Cape Town. Literature reviewed will help to have a better understanding of the set objectives of this research. Articles reviewed included studies that were conducted on neonates and their admission in a neonatal care unit and in a hospital environment.

Literature reviewed included those published and unpublished sources written in the English language. The sources of literature included EBSCO: Medline, CINAHL, Africa Wide, PsycInfo and Scopus electronic databases. Further searches were done on Google Scholar and google.co.za. The following key words were used to conduct the literature search: Coping\*) AND (mother\* OR woman OR women) AND (preterm baby\* OR preterm infant\* OR premature OR neonate) (hospital\* OR academic hospital\* OR teaching Experience hospital\*). Articles that met the inclusion criteria (articles that were conducted on neonates and their admission in a neonatal care unit and in a hospital environment) were reviewed. Some researchers used qualitative methods while others used quantitative and mixed methods. However, it was noted that most of the researchers used a quantitative approach. For the conceptual framework the following terms were entered to search for information: 'the Brief COPE model', stress and coping.

## 2.2 Preterm delivery

Preterm delivery is defined as the delivery of a baby before 37 completed weeks of gestation and often with a low birth weight (WHO, 2012; Kendall-Tackett, 2009; Meloni et al., 2009). It has been documented that preterm delivery is a key cause of neonatal mortality and morbidity and has long-term consequences for the health of the mother and of the baby (Beck et al., 2010). Preterm delivery can be grouped into three different categories: extremely preterm, very preterm, and moderately preterm (Paterson & Redpath, 2013; WHO, 2012; Moss, 2006).

Extremely preterm babies are those born at a gestational age of less than 28 completed weeks. These preterm babies usually weigh less than 1000g at birth. This group of preterm babies is the most vulnerable to infections and injury; however it is the least delivered worldwide (Paterson & Redpath, 2013; WHO, 2012). About 90% of preterm babies in this category die within the first four weeks of life in low-income countries, while 10% die in high-income countries (Paterson & Redpath, 2013; WHO, 2012).

Very preterm babies include babies born at a gestational age between 28 and 32 completed weeks, usually weighing less than 1500g at birth. This category of preterm babies is the second highest delivered amongst preterm deliveries. Very preterm babies are more vulnerable than the moderately preterm babies, but less vulnerable than extremely preterm babies (Paterson & Redpath, 2013; WHO, 2012).

Moderately preterm babies include babies that are born at a gestational age between 32 and 37 completed weeks, usually weighing less than 2000g at birth. Babies in this category are the most commonly delivered amongst preterm babies and have a higher chance of survival than both very preterm and extremely preterm babies (Paterson & Redpath, 2013; WHO, 2012). The cause of preterm delivery in some cases is unknown, and it leads the causes of

infant mortality (Blencowe et al., 2013). Preterm delivery is more so known by its high cost imposition upon the family involved, the healthcare system as well as the society as a whole (Paterson & Redpath, 2013; WHO, 2012). Furthermore, preterm delivery is known to cause diseases and other conditions such as depression, postnatal blues, stress and anxiety in the mothers. Preterm delivery can cause disheartening health conditions in the lives of preterm babies such as retinopathy of prematurity, neurodevelopmental and neurobehavioural problems (Benzies et al., 2013; Korja et al., 2012; WHO, 2012; Haldipur et al., 2011; Morken, 2010).

Thus in the year 2000 the WHO placed an urgent call via the United Nations Millennium Development Goal (MDG) 4 to reduce infant mortality by two-thirds by the year 2015. This call staged preterm delivery as a matter of importance and focus and as a complex public health problem that must be attacked in different ways in order to meet MDG 4. This drive is supported by the statement by Morken (2010) that there is a need for both larger research studies as well as an approach that centres more on preterm delivery as a public health problem. Requejo et al., (2015) mentioned that irrespective of the efforts applied by countries that signed the document to pursue reduction of maternal and child mortality by two-thirds by 2015, this target was never met. Again, Research by Requejo et al. (2015) mentioned that with unceasing serious interventions applied going forward, the target of reducing maternal and child mortality may be reached in time beyond 2015, as indicated in the Sustainable Development Goals (SDGs). Goal 3 of the SDGs still highlights the need to improve maternal and neonate positive outcomes, by reducing maternal mortality and preventable deaths amongst new-borns and children under five years (Hoope-Bender, 2014).



### **2.3 Global prevalence of preterm delivery**

Preterm delivery, according to Blencowe et al. (2013), is the leading cause of infant mortality. Its global prevalence has increased slightly from about 9.6% of all births in 2005 (Beck et al., 2010) to about 10% of all births in 2010 (World Health Organization [WHO], 2012). It is reported that approximately 15 million preterm babies are born globally every year (WHO, 2012). It is moreover reported that the rate of preterm delivery varies from country to country, with the highest rate (11.8%) occurring in low-income countries including Malawi, Democratic Republic of the Congo and Comoros. High-income countries such as the United States of America (USA), United Kingdom and Turkey account for about 9.4% of preterm births (WHO, 2012). However, the USA accounts for the highest number of preterm births in the developed countries, with about 42% of such births (Blencowe et al., 2013).

### **2.4 Preterm delivery in developing African countries**

Over 60% of the global preterm deliveries occur in sub-Saharan Africa and South Asia, regions which are reported to be behind with regard to the care of preterm babies, hence having a low survival rate (WHO, 2012). Consequently, it is on these continents that more than 80% of the total number (1.1 million) of babies born die due to complications of preterm delivery (WHO, 2012). Furthermore, in the developing countries neonatal deaths are attributed to the inadequacy and sometimes lack of amenities, such as maternity health facilities, favourable social conditions and adequate care before pregnancy, and during the antenatal, intra-natal and postnatal periods (Liu et al., 2015). Particularly in sub-Saharan Africa, deaths of neonates result from preterm delivery, neonatal sepsis and birth asphyxia (Kinney et al., 2010). According to the United Nations Secretary General Ban Ki-Moon, many of the preterm babies who survive face a lifetime of disability, which adds to the burden on the families, health care sector, and society at large (WHO, 2012).

## 2.5 Preterm delivery in SA

About 15 million preterm babies are born worldwide each year, of whom 84 000 are born in SA (Save the Children, 2012). The total number of live births in SA was 1 084 397 in 2013, of which more than 8% were preterm births (Statistics SA, 2013). It is reported that about 10% of the total number of preterm babies born in SA die within the first few days of their lives, even though most of the deliveries are conducted in health facilities. It is being reported that 40% of neonatal deaths in SA are due to preterm delivery (Lloyd & de Witt, 2013). Again research shows that the main causes of perinatal mortality in the rural areas, cities and metropolitan areas of SA include birth asphyxia, birth trauma, spontaneous preterm delivery, prenatal bleeding, complications of gestational hypertension, complications of preterm delivery and neonatal hypoxia (Lloyd & de Witt, 2013). In addition, other factors related to the mother, such as maternal lateness to book for antenatal care (ANC), inconsistent or no ANC attendance despite the available services have been reported to affect the outcome of pregnancy in SA.

According to Lloyd & De Witt, (2013) the Saving Babies (2001-2011) report revealed that the healthcare team has been pointed out as contributing to the mortality of babies, including preterm babies, due to delay in referring a woman in prolonged labour and responding inappropriately to problems identified during antenatal visits. Another group of people indirectly responsible for the death of preterm babies, according to the Saving Babies (2001-2011) report, are the administrators, in that they fail to provide timeous transport amenities to healthcare facilities when required to urgently transport a patient to a higher level of care, such as from a primary or secondary level to a tertiary level facility (Lloyd. & De Witt, 2013).

Furthermore Chola et al. (2015) mention that, before 2015 the South African Department of Health (DoH) had a period of focusing on how to deal with preventable factors that take the lives of preterm babies. They highlighted that the DoH implemented strategies to meet MDGs 4 and 5, to respectively reduce child and maternal mortality by two-thirds by 2015; these strategies included strengthening the health system and vigorously responding to HIV infections in SA. Other strategies include free healthcare services for all pregnant women and children, with deliveries taking place in health facilities, and adoption and education of women on WHO guidelines for exclusive breastfeeding. Routine pneumococcal and rotavirus vaccination and child support grants have been regarded as strategies implemented to mitigate infant and maternal mortality in SA. However challenges remain in curbing the preterm delivery predicament, thus preventing the attainment of the MDG target.

More efforts are needed to achieve the 2030 SDG target for goal 3 that relates to good health. Chola et al. (2015) reported that SA archives the highest child mortality rate amongst developing countries; therefore it is vital to understand aspects of infant care that are happening at the maternal dimension. This research aims to explore maternal coping strategies and their support needs following a preterm delivery. Mothers need to be able to cope positively in order to be able to deal effectively with traumatic situations such as preterm delivery, allowing good mother-baby bonding.

In Cape Town where this research was conducted preterm deliveries are reported in both public and private hospitals. The public hospitals are at different levels of service, namely primary, secondary and tertiary levels. Preterm deliveries take place in the secondary and tertiary levels facilities. In the Cape Town purlieu, the tertiary hospitals that offer maternal obstetric services include Tygerberg Hospital (TBH) and Groote Schuur Hospital (GSH). The secondary hospitals that offer maternal obstetric services in this area include New Somerset Hospital (NSH) and Karl Bremer Hospital (KBH). The primary level comprises maternal

obstetric units (MOUs) such as Elsie's River MOU, Delft MOU, and Bishop Levis MOU, to name but a few. These MOUs attend to pregnant women with low-risk pregnancies. However, women who arrive at these primary level units with high-risk pregnancy conditions such as preterm labour are referred to the higher level for attention. The private sector belongs to recognised corporate healthcare groups and includes the Netcare, Mediclinic, Life Healthcare and Melomed hospitals.

Preterm babies born at KBH and NSH are usually referred to TBH and GSH respectively in case of any serious complications that cannot be managed at these secondary hospitals. KBH has a good kangaroo mother care (KMC) unit, such that some stable babies who only need KMC are transferred from TBH to KBH for KMC. The researcher could not find data on the recent statistics on preterm delivery in Cape Town.

## **2.6 Impact of preterm delivery**

Having given an overview of preterm delivery, it is important to explore how it affects the lives of mothers and their preterm babies. This research explores how mothers cope with preterm delivery as well as what mothers perceive as their support needs in order to cope positively, which is the core upon which this study is based. Babies born preterm may suffer consequences such as cerebral palsy, sensory disorders, learning disabilities and respiratory illnesses which can sometimes extend into later life (Beck et al., 2010). Preterm delivery contributes substantially to global infant mortality and morbidity (Williamson et al., 2008). It is reported to be the second leading cause of death in children younger than five years, after pneumonia (WHO, 2012; Kendall-Tackett, 2009). These effects of preterm delivery on the babies can have a negative effect on the mothers' coping abilities, which can in turn affect the way the mother looks after the baby, leading to poor growth and development and even the death of the child. The negative effects of preterm delivery have been reported to extend to

the mothers. In a study conducted by McIntosh et al. (2004), optimism, coping and psychological distress were assessed in mothers with regard to their reaction to the NICU. Results showed that mothers used cognitive, ventilation and active coping strategies. One can note that some of the coping strategies are negative coping strategies which require intervention.

## **2.7 Maternal stress related to preterm delivery**

Research has shown that stress in mothers of preterm babies is higher when their baby is admitted to the neonatal care unit (Fowlie & McHaffie, 2004). This sometimes results in postnatal blues, post-traumatic stress disorder and depression in mothers (Sawyer et al., 2013; Shaw et al., 2013; Watson, 2011). Coping with preterm delivery can be mentioned as actions that an individual mother can execute in order for her to bear the stressful situation inflicted by preterm delivery. The neonatal care unit deals with sick neonates, hence posing challenging situations that demand the use of advanced technology such as sophisticated machines. The busy nature of the unit and sometimes the practice of invasive procedures become challenging aspects of the neonatal care unit. These may lead mothers into an overwhelming state that is psychologically demanding, hence causing stress and anxiety (Athanasopoulou & Fox, 2014).

Due to advanced technology many preterm babies today are able to see more days of their lives than in the past, where many of the preterm babies died before or within the first few hours of life. However, a high mortality rate, high morbidity rate and long hospital stay for preterm babies have been reported by Lawn et al. (2005). Research has shown that these aspects place high pressure on the mothers who wait anxiously for their baby's condition to get better in the neonatal unit (Lawn et al., 2005).

A high level of care is generally instituted for every baby born preterm, and mothers find it difficult to cope with the situation (Russell et al., 2014). This is partly because during the baby's admission to the neonatal care unit every mother desires the survival of her baby – with them knowing or not knowing the medical condition and likelihood of survival of their preterm baby. Sometimes the medical experts give continuous care to the sick neonates, even though they do not foresee their survival. This prolonged care could be because medical practitioners do not have enough evidence to show why health care must be ceased, or the family of the baby does not want health care to be terminated (Wilson et al., 2013). This leads to more stress in the mothers of preterm babies, as they wait for their baby's condition to improve, to no avail. In addition, neonatal complications, and the rate and length of stay in neonatal care units are significantly higher in preterm babies compared to term babies, which further causes distress in mothers (Carter et al., 2012).

## **2.8 Coping with preterm delivery**

Mothers of preterm babies may cope positively or not, depending on how they perceive their delivery, and how they are taken care of during and after delivery and while their baby is admitted to the neonatal care unit in the hospital. Mothers' coping may depend on the condition of their babies, and how they are attached to their babies while being admitted. Again the mothers' relationship with healthcare professionals as well as with significant others such as family members, husbands and their in-laws may affect their ability to cope after preterm delivery (Adama, Bayes & Sundin, 2016).

Positive coping involves behaviour that a mother will use in order to manage the stressful preterm event and subsequent admission of the neonate better. Such behaviour may include the ability of the mother to use the most available form of help to attain her basic requirements such as food, hygiene, mobility, sleep and rest, as well as those of the baby like

healing and growth. When mothers cope positively they may have interest in caring for their babies and for themselves. These mothers will cooperate and have positive attitudes towards the HCPs with regard to the care of their babies, hence having a positive impact on the health of their babies (Wilson, 2013).

Negative coping is the kind that leads to frustration in the mother, such that nothing is meaningful to her. Signs of negative coping include anger in the mother, which is usually extended to other persons such as the HCP and other persons around her. Negative coping could make the mother unable to cooperate with the HCP, which thence affects the wellbeing of their baby. Negative coping may cause mothers to abandon their babies in hospital. It can render these mothers of preterm babies unable to carry out basic functions with regard to caring for their preterm baby as well as for themselves (Wilson, 2013). Negative coping can make the mother of a preterm baby miserable and may affect her general body weight as well as that of the already underweight preterm baby, therefore causing more tension since weight management is a serious concern in the survival and growth of the preterm baby.

It is thus important to know how these mothers cope after preterm delivery in order to enhance positive coping strategies if they are not coping well. Helping mothers to cope well could be impossible to carry out if HCPs do not know what these mothers are feeling. This could have an effect on attaining the SDG 3 targets, with a bleak future for the state of the population. It is important to know what the mothers of preterm babies need during the period of preterm delivery, because this promotes a feeling of comfort, hence inducing good coping abilities, which is subsequently good for the baby's growth and development (Shaw et al., 2013).

Mothers of preterm babies use different strategies to cope with preterm delivery, admission and discharge (Natwane-Lebang & Khoza, 2010). The coping time frame varies from mother to mother. While some mothers gradually adapt to the situation after some days or some weeks, other mothers find it difficult to do so; this may be the result of their babies' fragile health condition or their own inability to cope with the stressful event (Watson, 2011).

Various coping strategies used by mothers of preterm babies have been documented, and these include mothers participating in the care of their child, gathering information about preterm delivery and care, involving friends in the care process, and engaging with other parents of preterm babies in talks about the preterm event (Smith et al., 2012; Goutaudier et al., 2011). Moving away from the baby has been reported as a coping strategy used by mothers of preterm babies (Smith et al., 2012). Other studies have documented coping strategies such as confrontative coping, escape avoidance, planful problem solving and positive reappraisal (Madu & Roos, 2006). Seeking social support and self-control have been identified as coping strategies by Madu and Roos (2006). On the one hand, when preterm babies are miserable, restless and easily irritated mothers tend to demonstrate negative coping; on the other hand, when their babies are calmer and easily adapting to changing conditions these mothers demonstrate positive coping strategies (Burnham, Feeley & Sherrard, 2013).

Cleveland and Horner (2012) carried out a study to better understand the experiences of Mexican mothers whose preterm babies were admitted in a neonatal care unit. Results showed that these mothers developed coping strategies which included balancing responsibilities, being emotionally connected with their babies and watching over their babies. When stress in mothers is high, they tend to cope negatively. However, a study by Turan, Basbakkal and Özbek (2008), aimed at determining the effect of stress-reducing nursing interventions on the stress levels of mothers and fathers of preterm infants in a



neonatal care unit showed that a kind of soothing nursing care in the unit can decrease the stress, which can eventually promote positive coping. It is believed that mothers would be prepared to cope better if better equipped with information about the babies' health, development and potential health challenges (Burnham et al., 2013).

The researcher could not find any study on coping strategies of mothers of preterm babies in any of the Cape Town hospitals, and therefore set out to explore these using one hospital that provides neonatal services to an area in the city.

## **2.9 Mothers' support needs after preterm delivery**

Having explored some literature on the coping strategies of mothers of preterm babies, it is worth exploring support needs as perceived by mothers of preterm babies. This information will assist HCPs to know exactly what kind of help they can provide to a mother after delivering a preterm baby. This will further promote positive coping, which could guarantee proper care given to a preterm baby by the mother. With positive coping strategies adopted by the mothers, survival of the preterm baby could be ensured, because mothers will be more concentrated and focused on the care of their babies.

According to research, mothers of preterm babies use support from various sources, such as HCPs as well as their families, which eventually enables them, cope with the stress brought about by preterm delivery (Lindberg & Ohrling, 2007). Studies have shown that assuring mothers with regard to the condition of their babies as well as providing proper information regarding the needs of their preterm babies are some aspects that mothers consider to be supportive to them during the period of preterm delivery and admission (Linberg & Ohrling, 2007). Similarly, Lubbe (2005) added that apart from information needs, mothers of preterm babies considered communication as a support need after preterm delivery. The author identified mothers who considered emotional support needs, learning support

needs, discharge needs, as well as individually preferred needs to be amongst the support needs required during preterm delivery (Lubbe, 2005). In another study staff professionalism and staff empathy were amongst the preferred support needs of mothers after preterm delivery (Sawyer et al., 2013). Previous studies explored different aspects related to preterm delivery, and while some studies have explored mothers' coping strategies after preterm delivery in other settings, such as those by Smith et al. (2012), Goutaudier et al. (2011) and Madu and Roos (2006), no studies were found on this research topic in the Cape Town context. This therefore indicated a gap and supported the intent to conduct this research. Thus, this research attempts to explore the coping strategies used by mothers with preterm babies admitted to a neonatal care unit in one hospital in Cape Town.

The Brief COPE model and its applications have been utilised in this research as a conceptual framework, as explained below. The framework is explained in this chapter and will be used in Chapter five to interpret the results of this research. The different coping assessment theories are explained, but the focus is on the Brief COPE model, upon which this research is based. The use of a conceptual framework in nursing research is vital, since a framework allows the researcher to be able to describe what nursing has to offer, to whom and when the aspect of nursing has to be offered, thereby relating the researcher to the research (Creswell & Clark, 2011). With insight about a particular theory, healthcare givers could be assisted to provide good care through health promotion which can improve the health of the patient and family as well as the entire community. The outcome of this research may assist the HCPs to provide appropriate assistance to the mothers of preterm babies, hence providing good care to the preterm babies. Good health care is achieved with the use of logical steps in holistic care through assessment, diagnosis, intervention, and evaluation.

## 2.10 Coping assessment models

Some of the coping assessment models that the researcher came across included the Crisis Intervention Model, the Full COPE model and the Brief COPE model. With regards to the Crisis Intervention Model, it views three elements as being able to provoke a crisis: a precipitating event, a perception of the event that leads to distress and diminished functioning when the distress is not alleviated (Puleo & McGlothlin, 2010). It moreover presents five elements that can be applied by helpers in a crisis in order to alleviate suffering: making contact with victims, examining dimensions of the problem, exploring possible solutions, assisting in taking concrete action, and follow-up to check progress (Puleo & McGlothlin, 2010). This can be applied in this research since preterm delivery can provoke stress and disequilibrium in a mother. However, the researcher was not interested in assessing the whole event of preterm delivery but rather was interested to know how mothers of preterm babies coped after delivering a preterm baby who was admitted to the neonatal care unit.

With regards to the Full COPE model, it is very cumbersome and most of the items of coping found in this model could be found in the Brief COPE. The Full COPE model was developed to assess coping in an expansive manner by looking at a wide range of coping responses. The COPE Inventory encompasses coping responses that are both functional and dysfunctional, and is composed of 60 concepts that are used to determine how individuals cope with stressful situations such as preterm delivery. Besides being cumbersome, the Full COPE imposes impatience during data interpretation and discussion when there is limited time to complete the study, as mentioned by Lazarus and Folkman (as cited in Muller & Spitz, 2002). Based on the above reasons and to save time, the Brief COPE model was preferred as a conceptual framework for this study, as discussed below.

## 2.11 Conceptual framework

A conceptual framework is a network or a plane of interlinked concepts that cooperatively provide a comprehensive understanding of a phenomenon or phenomena (Jabareen, 2009; Powers & Knapp, 2006). According to Madu and Roos (2006) coping and adaptation are important aspects of an individual's ability to survive stressful events such as preterm birth. Folkman and Lazarus (1984) (as cited in Lim, Bogossian & Ahern, 2010), explained that coping works with two cognitive appraisals carried out by a person in relation to perception of the threat as well as his or her available resources to deal with it.

Furthermore Lazarus and Folkman (1984), (as cited in Lim, Bogossian & Ahern, 2010), stated that there are two types of coping mechanism, namely problem-focused and emotion-focused coping mechanisms. While the former involves the individual's ability to deal with the cause of the stressor, the latter involves the ways in which the individual manages the stressor (Lim et al., 2010). Individuals use different strategies to cope with stress. For instance, Madu and Ross, (2006) indicated that the type of coping strategies used by different individuals determine how well they can cope in a stressful event. Therefore, knowing how mothers of preterm babies cope with preterm birth will assist in providing appropriate care to mothers, who in turn provide appropriate care to their preterm babies, thus increasing the probability of reducing maternal and infant mortality.

A dearth of knowledge on how mothers cope after they deliver preterm babies in a hospital in Cape Town was identified during literature appraisal. Therefore the researcher's interest was in exploring and describing this area of research. This research used the Brief COPE model discussed below to determine coping strategies used and support needs as perceived by mothers after preterm delivery in a hospital. The Brief COPE model is a derivative of the Full COPE Inventory.

## **2.12 The Brief COPE model**

The Brief COPE model was used as a conceptual framework to guide this study and to interpret the results that were obtained from the qualitative interviews in order to answer the research objectives. The Brief COPE model was chosen because it is designed to assess coping in a naturally occurring environment. Many studies have used the Brief COPE model to interpret coping results. For example, a study by Carter et al. (2012) studied post-earthquake birth evaluation in Italy and interpreted findings using this model, while Su et al. (2015) used the Brief COPE model to look at the coping strategies of people living with HIV in China. This model suited the structure of this research and could answer the research objectives. The researcher was interested in mothers using their own words to verbalise how they coped, so that their true feelings could be compared to the items in the Brief COPE model.

### **2.12.1 Origin of the Brief COPE model**

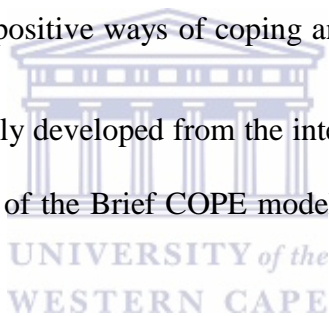
The Brief COPE model is the shortened version of the Full COPE Inventory. It is built from acknowledged models such as Lazarus' transactional model of stress, and Carver and Scheier's behavioural self-regulation model. The model was developed to overcome the burden of the Full COPE model as well as the impatience experienced by participants during studies conducted to assess coping strategies (Lazarus & Folkman, 1994, cited in Muller & Spitz, 2003). The Brief COPE model seeks to promote a coping assessment in a naturally occurring setting (Carver, 1997) hence it could be used to assess coping in mothers of preterm babies as it occurs in a neonatal care unit to which the neonates are admitted.

### **2.12.2 Application of the Brief COPE model to the study**

According to Muller and Spitz (2003) the Brief COPE model consists of 14 items for assessing different coping dimensions. These items include: active coping, planning,

instrumental support, emotional support, venting, behavioural disengagement, self-distraction, self-blame, positive reframing, humour, denial, acceptance, religion, and substance use. Each item is represented by two sub-items of coping behaviours and thoughts that are seen in individuals to manage the stressful situation that they are experiencing. In this study, the researcher used the items in the Brief COPE model to compare coping strategies obtained from the interviews with participants who were mothers of preterm babies hospitalised in a secondary hospital. However, not all of the listed aspects of the Brief COPE model were utilised in this study, as seen in the results and discussion sections. The researcher was interested in the coping strategies of mothers, irrespective of how much or how often the strategy has been used by a particular mother. Acquiring insight on how these mothers cope will lead to the promotion of positive ways of coping and preventing negative ones.

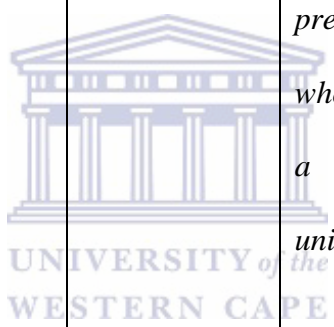
The themes which were inductively developed from the interviews were compared in relation to the concepts and sub concepts of the Brief COPE model. The result of this comparison is given in table 1 below.



**Table 1: Illustration of aspects of the Brief Cope model that related to this research**

<b>Objective</b>	<b>Aspect of the framework</b>	<b>Data collection method</b>	<b>Interview guide</b>
To explore and describe the coping strategies	Religion, acceptance, positive	Semi-structured interview	<i>Please can you tell me what helps you to feel better with</i>

preterm babies admitted to the neonatal care unit	reframing, self-distraction	technique	<i>the situation of giving birth to a premature baby?</i>
To explore and describe the support needs of mothers of preterm babies in the Neonatal Care Unit	Instrumental and emotional support	Semi-structured interview technique	<i>Can you tell me what you need to help you cope better after giving birth to a premature baby who is admitted in a neonatal care unit?</i>



### 2.12.3 A critique of the Brief COPE model

The Brief COPE model is advantageous in various ways: it can be used to assess traits of coping, which includes mechanisms people use to cope with stress in everyday life. It can also be used in the assessment of state coping, which includes the mechanism people use to cope with stress in a particular situation – as is the case with mothers of preterm babies. Again, it has been widely used as permitted by Carver (1997) in several health-related

studies, such as studies on breast cancer patients, on people recovering from a natural hazard (such as floods, hurricane damage) and studies dealing with people looking after very ill persons (such as patients affected by cancer, with degenerative illnesses such as dementia and Alzheimer's disease, and those affected by preterm delivery). For the purpose of this study, it is used to determine the stress-coping dimensions and support needs of mothers of preterm babies with regard to preterm delivery and hospitalization of their babies.

Miyazaki et al. (2008) criticized the Brief COPE theory as inappropriate to assess coping in a sample with different cultural backgrounds. To counteract this weakness, the research applied a qualitative approach, and used the model for interpretation as opposed to using it for data collection, providing the opportunity to get information from the mothers of preterm babies themselves and within the cultural context of the participants. This was important, as the population in this study has a completely different cultural background compared to the population used in the development of the model. This research is interested in how mothers of preterm babies cope with the preterm event despite their backgrounds and origins.

### **2.13 Summary of chapter two**

The current literature reveals that some mothers of preterm babies use coping strategies that are harmful and may affect the mother as well as the wellbeing of the baby. There is limited available literature on the coping strategies of mothers who delivered preterm babies in a hospital in Cape Town. It is unclear how these mothers cope after preterm delivery, and therefore exploring maternal coping strategies and their preferred support needs remains a point of interest to the researcher, because of the huge infant mortality caused by preterm delivery worldwide. The global prevalence of preterm delivery, prevalence in the developing African countries and South Africa, as well as its impact was discussed in this chapter. Also maternal stress related to preterm delivery as well as coping strategies and support needs after



Preterm delivery were reviewed and discussed in this chapter. Some coping assessment models were mentioned and emphasis was placed on Brief COPE model which was used in this research. The framework used in this research was the Brief COPE model. In this chapter some aspects of the crisis intervention model, Full COPE model as well as Brief COPE model have been discussed. A derivation of the COPE model, components of the Brief COPE model, its limitations and how it is applied in this study have been discussed. The next chapter discusses the methodology that was applied in this research process.



## **Chapter three**

### **3 Research methodology**

#### **3.1 Introduction**

A research methodology is the application of all the steps and procedures for collecting, analyzing and interpreting data in a research investigation by a researcher, carried out in a logical and systematic way (Creswell, 2014). The purpose of this study was to explore and describe the coping strategies used by mothers whose preterm babies were admitted to a neonatal care unit in one hospital in Cape Town, as well as their support needs. This chapter seeks to describe the methodology that was followed in this research. Some aspects of research will be mentioned at the beginning, such as the qualitative research approach, research design, and exploratory and descriptive research design. Then aspects such as research setting, research population, sampling method, inclusion and exclusion criteria are outlined, followed by discussion of the research sample size and data collection process. Ethical considerations with regard to research on participants, data collection, the data analysis process, pilot study and study limitations are discussed in this chapter. Finally a conclusion is provided in terms of what was covered in this chapter.

#### **3.2 Qualitative research approach**

A qualitative research paradigm has definite research methods which can be used in carrying out scientific investigations. It focuses on a subjectivist approach to a study of social phenomena and attaches importance to a range of research techniques. It focuses on qualitative analysis of data collected by means of personal interviews, participant observations, individuals' stories and personal constructs and document analysis (Creswell, 2013). Guba and Lincoln (1994), on the other hand, argue that human behaviour, unlike that

of physical objects, cannot be understood without reference to the meaning and purposes attached by human actors to their activities. Qualitative research is concerned with social reality that is viewed and interpreted by the individual ideological positions. Therefore, knowledge is personally experienced rather than acquired or imposed from outside.

A qualitative research approach in its bigger sense refers to research that prompts participant's accounts of meaning, experiences or perceptions; it produces descriptive data in the participants' own written or spoken words (Ritchie, Lewis, Nicholls & Ormston, 2014). The tenacity of descriptive research is to observe, explore, describe, and document aspects of a situation as it naturally happens (Ritchie et al., 2014; Polit & Beck, 2008). In descriptive studies, researchers have little or no ability to control, and subjects are examined as they are in their likely settings: for example, mothers of preterm babies experiencing their babies' admission to a neonatal care unit (Ritchie et al., 2014). Qualitative research seeks illumination, understanding and extrapolation to similar situations, while quantitative research seeks causal determination, prediction and generalisation of research findings (Creswell & Clark, 2011). Thus, a qualitative research approach is an unrestricted research approach that enables the researcher to discover unforeseen aspects or to understand the meaning that individuals attribute to what they experience, specifically within aspects of their lives being researched in a specific area (Creswell, 2014).

A qualitative research approach suited this research because it allowed participants to produce descriptive data in their own spoken words. Hence, the researcher could explore deeply how the participants coped with the delivery and admission of their preterm babies, as well as the support needs as perceived by the mothers themselves. Most previously published literature on mothers' stress and coping has used a quantitative research approach (Heidari, Hasanpour & Fooladi, 2013). A qualitative research approach was used in this study therefore to uncover answers to the research objectives that could not be uncovered by a quantitative

research approach.

### 3.3 Research design

To sufficiently address the coping strategies used by mothers after delivering a preterm baby and bridge the gap of untold information, a qualitative approach suited this research. Qualitative research is made up of a number of research designs, and the design that was used in this study was the exploratory and descriptive design. A research design is defined by Creswell (2014) as a type of inquest to a research problem in which the direction and procedures performed are supported by qualitative, quantitative and mixed-method research approaches. This type of inquest follows a plan of action from time of conceptualization of the topic to participant selection, data-gathering methods and data analysis type utilised (Maree, 2016).

This research intended to meet the research objectives stated in the first chapter. The first research objective was *to explore and describe the coping strategies used by mothers whose preterm babies were admitted to a neonatal care unit in one hospital in Cape Town* and the second objective was *to explore and describe the support needs of mothers whose preterm babies were admitted to a neonatal care unit in one hospital in Cape Town*. An exploratory descriptive research design was applied in this research, which allowed in-depth understanding of information in obtaining answers to the research objectives. An exploratory and descriptive research designs are used in public health studies to understand the meaning, processes and context of public health services and experiences (Jack, 2006). This research design addresses the dearth of information regarding mothers' coping strategies after preterm delivery in the Cape Town area.

Polit and Beck (2006) mention that exploratory research is research that starts with the phenomenon of interest – such as coping strategies and support needs of mothers of preterm babies as in this research. In-depth understanding of the phenomenon was achieved using

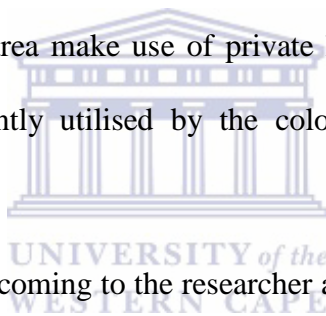
probing questions which preceded simple, understandable, open-ended questions during qualitative interviews. Thus, the researcher began by asking how mothers coped with the situation of preterm delivery as well as mothers' support needs in the environment in which their babies were cared for, and the support from their general social circle. During interview, participants were prompted to voice their own thoughts, which gave the researcher the opportunity to discover more about what they experienced. This research sets out to explore, describe and document the coping strategies and support needs of mothers of preterm babies as they naturally occurred in the lives of mothers at one hospital in Cape Town. Data collection in this qualitative research study was conducted through direct contact with the participants. Therefore, data were gathered using a semi-structured interview guide in which open-ended questions were asked and probes were used to explore more about the participants' ideas, and the phenomenon was described and documented.

### **3.4 Research setting**

A research setting is a place where research is conducted or research data are collected (Brink, Van der Walt, & Van Rensburg, 2012). It is mentioned by Holliday (2002) that a research setting is defined by certain criteria as applied to the research site, described below. This research was conducted in neonatal care unit in a hospital in Cape Town. The hospital is a government, referral, and teaching hospital that operate 24 hours a day. The institution operated under a strict organisational culture with high inter-departmental

collaboration with the health department leading the services in the setting. The research setting was centrally located and easily accessible to the population it serves as well as to the researcher. The research site was placed on the secondary level of the three tiered system (primary, secondary and tertiary) of health care in SA.

The hospital in which this research was conducted offered, amongst other services, neonatal care services. Babies who were delivered in this hospital and required intensive care were referred to the tertiary hospital of the catchment area. Mothers who delivered in this hospital lived in areas averaging six kilometres away from the hospital (research setting). The research setting was mostly utilised by people of the coloured ('mixed') race in SA. The surrounding areas are inhabited by people of the African, coloured and white races. Most people of the white race in the area make use of private hospitals for obstetric care, hence leaving this hospital predominantly utilised by the coloured and African population and sparingly by whites and Indians.



The HCPs in the setting were welcoming to the researcher at the times that the researcher was collecting data. Mothers who delivered preterm babies were available at the setting and were visited at designated times. Access to the setting was not difficult as the researcher met all requirements in order to gain permission to collect data. The operating rules of the neonatal unit were flexible and understandable by the parties that took part in the activities of the unit. A security system was in place in the general hospital, which enabled manageability of the setting by the staff as well as the researcher.

According to the unit manager at the neonatal unit where this research was conducted, the unit was made up of 16 neonatal incubators. The staff members that rendered neonatal services in the unit were about 20 in total. There was one consultant, one medical officer, four registered nurses, eight enrolled nurses and six enrolled nursing assistants. The researcher

met different staff members on different days of data collection and explained the research aim and objectives each day before accessing the research site.

### **3.5 Research population**

According to Polit and Beck (2006) a research population is made of all the individuals or objects with common defining characteristics. In this research, the population included all women who delivered preterm babies and had the preterm babies admitted at the selected hospital. A target population, according to Polit and Beck (2006), is defined as the entire population in which the researcher is interested. Therefore in this research the target population was the population of mothers who delivered preterm babies who were admitted to a neonatal care unit. Furthermore, Polit and Beck (2006) defined the accessible population as cases from the target population that are accessible to the researcher as a pool of subjects. In this research, the accessible population included mothers who were recruited to the research. The ages of the mothers who were interviewed ranged between 19 and 43 years. The target population for this research was mothers who had delivered preterm babies who were admitted for at least three days to the neonatal care unit in one hospital in Cape Town during the data collection period, which lasted up to one month.

Participants were included in this study if they were 18 years and older, and had delivered preterm babies. Only mothers whose preterm babies were admitted to the neonatal care unit for at least three days at the time of the data collection were included. This is because at three days most of these mothers have experienced the complete cycle of the neonatal care unit routine and had the opportunity to meet all the HCPs involved in their care as well as the care of their babies. Mothers were included only if they spoke English, Afrikaans or Xhosa, because these are the three languages most commonly spoken in Cape Town. In the sample, most mothers preferred English and only one preferred Xhosa language.

This research excluded mothers younger than 18 years of age because they could not consent as stipulated by the law. Mothers of term babies were excluded from this research. Mothers were not included in this research if they were diagnosed with any form of postpartum mental disorder or potential substance abuse at the time of data collection. This was because their capacity to understand and take informed decisions and give consent remains controversial (Roberts, 2014).

### **3.6 Sample and sampling method**

Powers and Knapp (2006) define a sample as a part of a whole population that is usually studied in predilection of the whole population, due to considerations such as time and money. Therefore, in this research, a sample included the mothers of preterm babies who were studied rather than all the mothers who delivered preterm babies. Twelve mothers were recruited purposefully, including the mother recruited for piloting the study, and 11 were interviewed in this research. One participant withdrew from the research after verbally accepting and was not interviewed; the reason given was that her husband was not comfortable with her participating in the research. This participant preferred to ask her husband if she could participate, even though she could legally carry out informed decision making. Therefore the group of mothers who were interviewed in this research comprised the sample of this research.

According to Brink, Van der Walt, & Van Rensburg, (2012) sampling is the process whereby a researcher selects a group of people, events, behaviours, or other elements called participants from a bigger entity from information can be obtained regarding a specific phenomenon under research. Purposive sampling, which is a non-random sampling method, was used in this research to recruit participants. Brink, Van der Walt, & Van Rensburg, (2012) define purposive sampling as a non-probability sampling type that is dependent on the



judgement of the researcher of the participants, based on the knowledge they have regarding the phenomenon to be researched. This means that in purposive sampling the researcher believes that the participants represent a good basis of information to address the phenomenon being researched, to acquire answers to the research objectives.

With regard to this research, the interest of the researcher was based on coping strategies used and support needs as experienced by mothers who delivered preterm babies who were admitted to the neonatal unit. Therefore, participants selected for this research were mothers who delivered preterm babies and whose preterm babies were admitted to a neonatal care unit, and met the inclusion criteria. This enabled the researcher to obtain answers to the research objectives as the selected mothers could provide information on coping strategies and support needs after preterm delivery. The participants who met the inclusion criteria (as highlighted in the previous section) were recruited until data saturation was attained.

It has long been established that, in qualitative research the focus is not on generalizability, hence the sample size could not be predicted at the outset of the research. However, as earlier noted by Polit and Hungler (1999), when the sample is homogenous as in this research which dealt with mothers of preterm babies, less than 10 participants may be enough. Based on that, in this study the sample size started from 10 participants. Twelve mothers were recruited and 11 participated. The researcher stopped interviewing at 11 participants because no new information was being obtained from the participants during interviewing – in other words, data saturation had been reached (Powers & Knapp, 2006). This was easily identified because of the concurrent data analysis that took place during the process.

### **3.7 Interview guide**

Qualitative researchers use observation, focus group discussions and interviews to collect data to answer qualitative research questions or address research objectives (De Vos et al., 2005). In this research, data included all of the information that was collected from the participants at the research site. A semi-structured interview guide was used to elicit information from the participants in this study. The interview guide was composed of two simple, understandable open-ended questions, which were followed by probes, as mentioned in the data collection section. This approach of interviews was selected for this research because it allowed the researcher to gain more information from the participants and thus suited the exploratory nature of this research. Participants could explain more about the phenomenon within their own cultural background, hence enabling an in-depth understanding of how mothers of preterm babies coped with the situation of preterm delivery as well as their support needs after preterm delivery in the Cape Town area. This allowed enough data to be collected for an elaborate description of the phenomenon under research.

### **3.8 Pilot study**

A pilot study is defined by Powers and Knapp (2006) as a preliminary study carried out before the actual study starts, in order to test the data collection tools. They state that the pilot study is usually carried out on a smaller sample of participants who are homogenous to the intended research sample. Before the main research (data collection) started the researcher piloted the interview schedule to determine whether the questions and language used were understandable. The pilot study ensured that the researcher rehearsed the process of interviewing. This trial interview was conducted with two participants who delivered preterm babies who were admitted to the neonatal care unit. These two participants were identified by an HCP who worked in the neonatal unit. This ensured exclusion of mothers

who were under the age of 18 years, as well as those who could have had an additional mental health illness as these were some of the exclusion criteria. The mothers were approached and an introduction to the research was done individually. The mothers wanted to be interviewed on that same day, but at that stage both had only spent two days in the neonatal unit. As the conditions were explained to the mothers, they accepted being interviewed the following day between 10:00am and 11:30am.

The interview with these mothers for the pilot study lasted for about 40-45 minutes each. The interviews were audio-recorded and after the researcher returned home they were transcribed verbatim and qualitatively analysed. No problem was identified with the original interview guide, and therefore the trial study participants were included in the sample of participants in the original study.



### **3.9 Data collection process**

The potential participants were identified by the professional nurses and doctors who were responsible for the care of the preterm babies in the neonatal care unit at that time. The researcher then approached identified participants who were not busy with their babies at the time, to introduce the research topic. The participants were approached individually so that they could feel free to communicate with the researcher. After participants accepted the invitation to participate, both the researcher and the participant set a convenient date and time to conduct the interview. The information sheet was handed to each potential participant, in her preferred language. The participants were informed about the scope of this research, including the potential benefits and risk of their participation. A brief explanation of headings in the information sheet was given to the potential participant at the time of handing over the sheet. The information sheet was again explained in full before commencing the interview, as

this was requested by the participant. The content of the consent form was explained to the participants and they were requested to sign it before participating.

It is important that the researcher plans ways to safeguard research data before commencing the research. The researcher prepared the interview guides in all three languages, notepad and pen were available, and for each participant the researcher had a page where field notes were jotted down during interviewing. A tape recorder was available for recording the participants' verbal information. Interviews were carried out in a private room, during which facts were written down. The information was immediately transferred to a password-locked computer at the researcher's home and deleted from the recorder, which was borrowed from the University where the study was registered. The paperwork was at all times locked up in a safe cupboard in the researcher's room, and the key to the cupboard was kept only by the researcher.

Data were collected by means of semi-structured interview and field notes. For participants who were fluent in English the researcher conducted interviews in English; for those who were not, the researcher used a trained data collector to conduct the interviews in Xhosa. The participant who needed a translator was informed before coming in contact with the trained data collector in order to release anxiety. The trained data collector signed a consent form accepting that she would maintain confidentiality of participants. Of the total sample, only one participant could not speak English. This participant preferred Xhosa and was thus interviewed in Xhosa by the interpreter. The researcher as well as the trained data collector made use of field notes to record what was seen, heard and experienced as well as thought during data collection.

### **3.9.1 Interview**

Data were collected by the researcher and a trained data collector over a period of one month. One-to-one interviews between the researcher and the participant took place in a private

room. In the case of the interview that involved the non-English-speaking participant, the private room was occupied by the researcher, trained data collector and the participant. Each interview session lasted about 40–45 minutes. The interview sessions were commenced by asking the participants about their experiences of having a preterm baby, then their coping strategies and support needs were explored, and the sessions ended by inquiring how ready these participants were to take their babies home.

The interview with the non-English participant took the form of an ‘active interpreter model’ in which the interpreter posed the interview questions to the participant, after which a summary of the entire interview was delivered to the researcher. This active interpreter mode reduced the pitfalls such as time consumption, disinterest and misunderstanding between the interview partakers during the interview (Pitchforth & Van Teijlingen, 2005). All interviews were audio-recorded as permitted by the participants. Open ended questions such as ‘Please can you tell me what helps you to feel better with the situation of giving birth to a premature baby?’ and ‘Can you tell me what you need to help you cope better after giving birth to a premature baby who is admitted to a neonatal care unit?’ were used to obtain information from the research participants. Probes such as ‘Can you tell me more about that?’, ‘What do you mean by that?’, ‘Please can you explain that?’, ‘Please tell me how you felt?’, and ‘What do you think can be done?’ were used to explore details of participants’ ideas and to acquire much information for a comprehensive description of participant coping strategies and support needs. Non-verbal cues observed were recorded as field notes and the notes were kept by the researcher and the interpreter. This ensured that as much information as possible was obtained. The field notes were added to the transcribed audio-recorded information and were analysed.

### **3.9.2 Data analysis and interpretation**

An inductive thematic content manual data analysis was executed by the researcher, which happened concurrently with data collection. In this way the researcher became more engaged

in reading and understanding of the data, which provided a good understanding of the situation under study, which were the coping strategies used by mothers of preterm babies as well as their support needs as perceived by these mothers. All audio-recorded interviews were transcribed verbatim. The Xhosa transcript was translated into English, translated back into Xhosa, and then analysed by the researcher. The back translation was done to ensure that the translated interview carried the same meaning as had been meant by the participant. Verbatim transcription took place immediately after each interview. The inductive data analysis approach in De Vos et al. (2005) was followed, as described below:

- All interview transcripts were labelled using numbers in a chronological upward trend from the one (1) to eleven (11).
- All files were labelled and transcribed verbatim in a chronological manner.
- Before transcription the researcher listened to the audio-recorded information to get familiar with what was being said by the participant, while taking notes. Interviews 1 to 11 were all captured in the computer and numbered line by line for easy tracing during coding.
- The researcher read the transcripts repeatedly to assimilate the information.
- Preliminary coding was done each time the researcher read through the transcripts and similar codes were identified each time. De Vos et al. (2005) define coding as a process whereby data are broken down and put back together in new ways.
- When the researcher had familiarised herself with the data, regularities in participants' views were retrieved and grouped into different codes using highlighters, giving each code a different colour and a defining word, thus reducing the bulk of the data into simpler, easily understandable concepts.
- Main themes and subthemes were obtained and the researcher went back to the data to confirm the themes obtained by reading through the data again.

- The themes were described one after another, and for each theme a quote from a participant's words was mentioned. Literature was searched to confirm the themes obtained.
- The researcher built an understanding of the data to ensure that the information collected was answering the research objectives.
- The coded materials were then interpreted deductively by comparing with the coping aspects of the established Brief COPE model presented in Chapter two of this study.

### **3.10. Trustworthiness of the study**

Trustworthiness in research is concerned with the accuracy and truthfulness of scientific findings (Ritchie et al., 2014). It is the extent to which conclusions drawn effectively represent reality. Rigor is defined as the means whereby one shows integrity and competence in conducting research in relation to ethical principles and policies (Ritchie et al., 2014). The four criteria that were used in this study to ensure trustworthiness were those proposed by Guba (cited in Shenton, 2004), which include credibility, transferability, dependability and confirmability.

#### **3.10.1 Credibility**

Credibility seeks to demonstrate that the research project actually yields data that were originally sought; hence credibility means the authenticity of the findings (Shenton, 2004). In this research, credibility was attained in the following ways: (i) Credibility was ensured through member checking, where at the end of each interview the researcher summarized the entire interview, including the participant responses, for the participant to confirm what she said. There were no discrepancies after each summary for the entire sample. Participants were satisfied that what they had said was correctly represented, and they all maintained their responses. The researcher had prolonged engagement with participants, which was achieved by permitted further visits to the unit; these provided the opportunity for the researcher to

interact with participants. Hence, any unclear issue that could have been identified during data transcription and analysis (which was done concurrently with data collection) could have been resolved. This enabled the collection of data that represented reality as experienced by the individual participants (Shenton, 2004). (ii) A pilot study was conducted in this research, which helped to determine if the interview guide questions were understandable and appropriate for the participants to respond to. The pilot study reinforced the researcher's ability to carry out an effective interview with participants, which helped to build confidence in the research, thereby limiting faults in the data. There was no misunderstanding of questions in the interview guide by the participants, and the researcher had practiced how to approach and interview participants. This enabled the researcher to proceed with the research interviewing process knowing that the research tools, such as the interview guide, information sheets and consent forms, were to yield answers to the stated research objectives. (iii) The researcher used probes and a repetitive questioning style during the interviews with participants. This means that participants were asked the same question after a series of probes, and if they gave the same answer as previously, this confirmed that the response was a true reflection of the participant's coping strategies and support needs after preterm delivery. (iv) The researcher frequently met with her supervisors as well as a writing coach who were assigned by the university, and as such many flaws were identified and immediately corrected as the research was being conducted. During the meetings with the research supervisors as well as the writing coach research results were interpreted and analysed and report writing was well guided, which helped to generate a true reflection of the ideas initially collected from participants – hence maintaining credibility

### **3.10.2 Transferability**

Transferability refers to the extent to which the results of one research in one context can be applied to another context and setting (Elo et al., 2014). Qualitative research tends to be



context-specific; therefore, the results obtained from this research may only apply to the mothers who delivered at the hospital where this research was conducted. Hence, it may not be possible to transfer the insights gained from this research directly to other settings. However, this research might contain information that could be useful to health personnel working with mothers in other healthcare settings in which they experience anxiety about the wellbeing of a newborn preterm baby. The results of this research could be transferred to mothers within a similar research context. Hence in this research the setting and the process have been sufficiently described to ensure a thick description which can be used to measure or have an understanding of a similar context, so that individual readers may be able to infer results in other settings of the same nature.

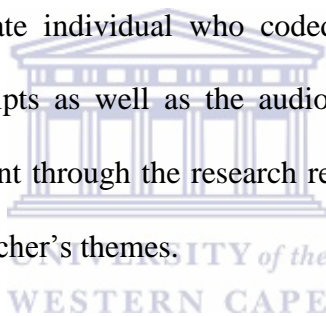
### **3.10.3 Dependability**

Dependability describes whether the facts involved in the study can be used by other researchers or peers to repeat the study, even without the intention of attaining the same results ((Elo et al., 2014)). In this research, the researcher requested a peer to be a companion at the research site on the first day of data collection. The peer was asked to pay attention to any faults or exclusions and report these to the researcher. Every fault detected was corrected promptly, and hence the data collection process continued. The co-supervisor of this research listened to the audio-recorded data and confirmed that the required information was there to answer the research objectives. The supervisors of this research were at all times notified of each step of the research. Thus this research followed the systematic format of a qualitative research process which allows room for future researchers to follow and yield unique results. Again an audit trail was maintained in this research. Each step of this research process was described in full by the researcher and the research report was reviewed by a second person (Brink, Van der Walt & Van Rensburg, 2006). The independent reviewer became familiar with this qualitative research process,

the methodology that was used, the results that were found by the researcher and the deductions that were made (Carcary, 2009). Similar ideas were brought forth after independent reviewing, which confirmed the trustworthiness of this research.

#### **3.10.4 Confirmability**

Confirmability is the independence or impartiality of the data (Mugisha, Van Rensburg & Potgieter, 2010). In this research, confirmability was ensured by following the overall qualitative research process and the use of field notes during data collection. Again the analysed data were reviewed by an independent coder to assess consistency and to ensure credibility. The researcher met an experienced individual in qualitative research and requested coding assistance. The proposal of this research as well as data collected for this research were given to a separate individual who coded the data in the absence of the researcher. The verbatim transcripts as well as the audio-taped records were given to the independent coder. The coder went through the research results and came up with their own themes, which matched the researcher's themes.



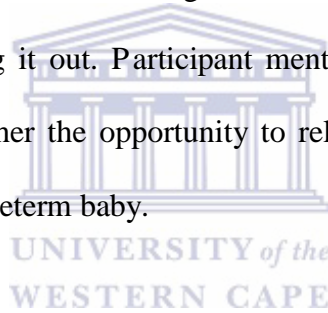
### **3.11 Ethics statement**

According to Pera and Van Tonder (2014) ethical principles are infinite and can all be congregated into the principles of beneficence and non-maleficence, autonomy, respect and justice. It is reported that these principles continue to be the most widely used in health research, including nursing research, irrespective of other forms of ethics theories such as traditional ethical principles, virtue and Ubuntu (Amstrong, 2007, cited in Pera and Van Tonder, 2014). This research was approved by the Senate Ethics Committee of UWC, the hospital Chief Executive Officer and institutional unit manager, as well as the participants who were interviewed (De Vos et al., 2005). The ethical principles that guided this study included beneficence, autonomy, respect and justice.

#### **3.11.1 Principle of beneficence**

This ethical principle describes the importance of ensuring the wellbeing of participants by protecting them from discomfort and harm (Brink, Van der Walt, & Van Rensburg, 2006).

This researcher provided a protective, private, calm setting for the interview. This was achieved by conducting the interviews at a private room. It was beneficial for prompt referral and for further counselling of mothers who became particularly distressed while discussing how they coped and their expected support needs. Participants were safe from accidental or deliberate harm as a result of fighting between patients or between patients and staff. This was possible as they were benefitting from the complex hospital security system put in place. One participant (participant 11) became emotionally distressed and was referred to the sister in charge of the unit for further management. The participant cried and mentioned that she felt relieved after crying it out. Participant mentioned that she appreciated taking part in the interview as it gave her the opportunity to release the tears and anger she had built up since she delivered her preterm baby.

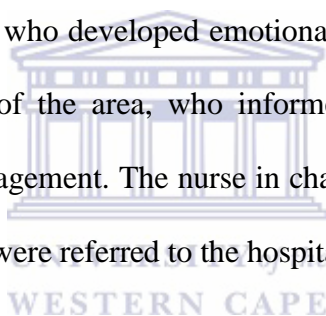


### **3.11.2 Principle of autonomy**

In this study participants were not forced to participate but were given the opportunity to decide to do so. The participants were informed about the scope of this research, including the potential benefits and risk of their participation. The information sheet was handed to participants before interviews took place. Again the content of the consent form was explained to the participants. The researcher provided the consent form and the participants were requested to sign the forms before participating. Participants chose to participate or not and were not penalised if they refused to participate, even after signing. One participant accepted participating in the study but when the researcher went to interview her, she refused to participate. Her reason was that she had accepted the situation and did not feel like taking part, and her husband was not comfortable with her taking part in the research.

During the time of signing the informed consent, each participant was given a unique number which replaced their names in order to maintain their anonymity. The researcher took the participants' contact details in case information was needed afterwards. The contact details were kept in the researcher's room, where no other individual could have access. Participants were given the chance to indicate if their interview could be audio-recorded or not. Participants were interviewed in their preferred language, and English, Afrikaans or Xhosa were selected because these are the languages most spoken in Cape Town. The consent form had a section for language option and participants were able to tick one of the three languages.

In this study if any participant experienced emotional discomfort or distress, the situation was managed as follows: Any mother who developed emotional distress during the interview was referred to the nurse in charge of the area, who informed the doctor responsible for the mother-baby unit for further management. The nurse in charge assured the researcher that the emotionally affected participants were referred to the hospital assigned social workers.



### **3.11.3 Principle of respect**

The principle of respect states that individuals have the right to self-determination which must be respected. It states that individuals with diminished autonomy should be protected (Polit & Beck, 2006). Therefore in this research participants were informed in advance and in writing about the aim and objectives of this research, the voluntariness of their participation as well as the freedom to withdraw at any stage of the research process without any consequences. This was made clear in their language of preference so that no misunderstanding was registered. This study involved adults aged 18 years and older, hence all that accepted to participate could give consent of their own free will. The interviewed participants were aged between 19 and 43 years.

### **3.11.4 Principle of justice**

This principle involves fairness in participant selection and treatment. Participants in this research were selected using purposive sampling. The researcher approached every mother that was present in the neonatal unit as was identified by the HCP as a potential participant. Therefore each participant was given a fair chance to take part in this research, except if they did not meet the inclusion criteria. Thus recruited mothers who met the inclusion criteria of this research were approached and given an introduction to the study. The principle of justice alludes to privacy and respect, which was maintained through anonymity and confidentiality measures. Hence the researcher informed participants that the interviews were to be audio-recorded, and permission for this was obtained from every participant. Interviews were conducted in a private room at the research site. All recordings and transcripts remained stored and locked up in a cupboard in the researcher's room and the recordings will be kept and destroyed five years after completion of this research (Brink, Van der Walt, & Van Rensburg, 2006). No identifiable information was attached to the data that were collected, and numbers were used instead. Participants were informed about the dissemination of the results of this research through publishing in a peer-reviewed journal and presentation at conferences. Submission of these results to the nursing managers of the neonatal care unit will ensure dissemination of this unique information.

### **3.12 Summary of chapter three**

Chapter three was based on the methodology that was followed in this research. This research followed a qualitative research approach and an exploratory and descriptive design. This research intended to explore and describe the coping strategies applied by mothers whose preterm babies were admitted to a neonatal unit. It intended to explore and describe the support needs of the mothers of preterm babies. Semi-structured interviews were conducted with 11 mothers of preterm babies. Participants were recruited using purposive sampling strategy, which enabled the researcher to recruit participants who had the

knowledge to share in order to meet the research objectives. Data were analyzed manually, and themes and categories were identified according to the research objectives established. Trustworthiness was maintained according to Guba's proposal of credibility, transferability, dependability and conformability. Permission to conduct this research was obtained from the Research Ethics Committee of UWC, the institution where the research was conducted, and from the participants. The ethical principles of beneficence, autonomy, respect for human dignity and justice were applied throughout this research. Participants were treated with dignity and respect at all times during data collection.



## Chapter four

### 4 Results of the study

#### 4.1 Introduction

This chapter presents the overall themes derived on the two objectives set out in this research. A description of the participants of this study, themes that emerged from the study and descriptions of these themes is presented in this chapter. The objectives of this study were twofold: first, was to explore and describe coping strategies applied by mothers of preterm babies admitted to the neonatal care unit; and second to explore and describe the support needs of mothers of the preterm babies admitted to the neonatal unit. The objectives of the study were used as a reference during the analysis of the data from the interviews. Three themes emerged on coping strategies: praying, attachment to baby and acceptance of the situation. On support needs, the themes that emerged included: support requests, support received from social circle and lack of and insufficient support. Feelings that these participants experienced included sadness, shock, mixed feelings, fear and deceit.

#### 4.2 Description of the participants

All participants of this study had delivered before 37 completed weeks of gestation, and all of the participants were aged between 19 and 43 years. All the participants were admitted in a neonatal care unit for at least three days. According to the unit manager of the unit where data were collected, the unit managed babies with body weights of between 650g and 1800g, whose duration of stay in hospital ranged between a few days to three months. Babies in this unit were discharged with a body weight of 1800g. Table 2 below presents some characteristics of all of the participants of this study. Out of 11 participants only two were married, and the rest were unmarried. Four of the participants were employed and seven were unemployed. The average gestational age for the participants in this research was 28 completed weeks. Most of the babies born were very preterm, which means most babies were born at between 26 and 34 completed weeks

of gestation. Ten of the participants in this study were Christians and one was a Muslim. Seven of the participants were first-time mothers. Three of the participants had been pregnant more than once and had more than one live baby. Two participants each reported having had a baby who died.

**Table 2: Demographic characteristics of participants**

<b>Participant No.</b>	<b>Age (yrs)</b>	<b>Married</b>	<b>Race</b>	<b>Gravida</b>	<b>Para</b>	<b>Educa.</b>	<b>Gest. Age (wks)</b>	<b>Employ.</b>	<b>Religion</b>
P1	43	No	Coloured	3	3	Gr. 5	32	Yes	Christian
P2	19	No	Coloured	1	1	Gr. 10	28	No	Christian
P3	23	No	African	1	1	Gr. 10	26	No	Christian
P4	23	No	African	1	1	Gr.12	26	Yes	Christian
P5	29	No	Coloured	3	3	Std 8	34	No	Christian
P6	21	Yes	Coloured	2	1	Gr.12	26	No	Christian
P7	33	No	Coloured	4	3	Std 7	29	No	Christian
P8	22	No	Coloured	1	1	Gr.9	28	Yes	Christian
P9	24	Yes	Coloured	1	1	Gr. 10	26	Yes	Muslim



P10	20	No	African	1	1	Gr.9	28	No	Christian
P11	20	No	Coloured	1	1	Std 8	27	No	Christian

### 4.3 Data presentation

A total of six themes emerged from analysis of the research data that covered the two research objectives: three themes emerged on coping strategies, which covered the first objective, and three themes emerged on support needs, which covered the second objective of the study. With regard to the first objective, the three (3) themes that emerged included praying, attachment to the baby and acceptance of the situation. With regards to the second objective the three (3) themes that emerged included: support requests, support from one's social circle and lack of support. Besides the themes, subthemes that relate to the various themes are further explained in this section. Participants mentioned that the support they received enabled them to develop positive coping strategies. We begin to present the themes on coping strategies, as seen below.

### 4.4 Themes and subthemes on coping strategies

Table 3 below presents the themes and subthemes that emerged and that answered the first research objective that was based on the coping strategies used by participants of this study post-delivery.

**Table 3: Themes and subthemes on coping strategies**

Theme	Subthemes
1. Praying	1.1. Praying for God's strength and grace

Theme	Subthemes
	and for baby's survival  1.2. Thanksgiving to God for babies' health and preferred gender
2. Attachment to baby	2.1. Bonding with baby  2.2. Seeing the baby
3. Acceptance of the situation	3.1. Perseverance in the situation  3.2. Mother's awareness of her responsibility



#### 4.4.1 Theme one: Praying

Praying was one of the themes that emerged which most participants mentioned as a coping strategy. Most of the participants mentioned that practising their spiritual beliefs involved praying. As one participant put it:

*“I pray a lot every time I go visit him, I pray and when I leave, I pray because ... In the evening I pray.” (P4).*

According to Arzani et al. (2015) prayer is a request or expression of thanks made to God. In this research ‘prayer’ may refer to a way of talking with God. Prayer can occur anywhere and anytime. Individuals approach God through prayer and ask for help, thank God, ask for forgiveness, and ask to forgive each other for the wrong they have caused. In this study participants prayed to thank God and ask for help regarding their baby's condition in hospital, and various aspects mentioned below. Two subthemes were identified under praying, which

included praying for God's strength and grace as well as praying for their babies' survival, and thanksgiving to God for the health of the baby as well as preferred gender. The subthemes are explained below.

#### **4.4.1.1 Subtheme: Praying for God's strength and grace and baby's survival**

When an individual consults with the supernatural being, it is usually for a purpose. Participants expressed prayer for strength, grace, and their baby's survival. In this study participants reported praying to God and asking for strength, hence trusting in their faith and God for energy to be able to do the right thing or do what one is responsible to do. Praying for God's strength refers to asking God for the power to withstand the pressure caused by a specific event, which in this case is preterm delivery and the subsequent admission of the neonate to the hospital. Participants in this research prayed for God's strength to enable them to face the challenges of preterm delivery, which they were not ready to handle. These participants believed that God could do wonders for them in different aspects to the benefit of their babies. One participant stated that she prayed for God to provide her with all the energy to be able to handle the stressful situation of preterm delivery on a daily basis:

*“Basically I pray to God for strength so that I can get through the day.” (P6)*

While some participants prayed to God for specific aspects regarding their babies, others prayed for God's general control over their situation. Another participant stated that she felt like abandoning her preterm baby at the scene when she delivered, but later on thought to depend on God to help her with the way she felt about her baby. The deep thought about God helped the participant to change her feeling towards her preterm baby and to stay and cope with the situation:

*“In the meantime I think I'll leave my child alone or something like that but I said no!*

*That the Lord is going to help me. And I'll be strong...” (P7)*

In addition to asking God for strength and handing over the stressful situation to God, participants further prayed for God's grace. Praying for God's grace implies that one wants undeserved favour from God. It involves praying for everything positive to come one's way. Participants prayed for the grace of God to be conferred upon them and help them in their time of need. One participant felt compelled to be in hospital to meet the needs of her baby. This participant felt that she was putting her other children at a disadvantage, and relied on God to intervene for her preterm baby to become ready for discharge:

*"I just feel sad because why, I want to go home. I miss my other children also... I can't go because of this child mos [because] I must give breastfeeding. But I just hope the Lord come and help me through this."* (P5)

One participant was excited to go home with her baby; however, because the baby was not at the stage to be discharged, the participant trusted God and remained positive that God will make it possible that her baby reaches the status of being able to be discharged. This participant had faith in the doings of God, expressed as below:

*"I want to be at home. And I say I know God is going to do that miracle in my life."*  
(P1)

Prayer was reported as an on-going activity, as noted by one participant who mentioned that she prayed a lot and continuously to overcome the difficulty she experienced after giving birth to a preterm baby, such as handling the baby and changing positions of the baby. The prayers were not solely directed at attending to their personal needs, but as well as for the wellbeing of their newborn babies. The participant mentioned that she always prayed for God's divine intervention. The participant paused –which could indicate that she felt that prayer could be the only solution to what she expected:

*“I pray a lot. Every time I go visit him, I pray and when I leave, I pray because ... In the evening I pray.” (P4)*

Some of the prayer requests were reported to be focused. Participants made specific requests to God, such as for survival of their own preterm neonate. This was illustrated by one participant who was taken aback by the rate and ways in which babies died in the neonatal unit. Another participant prayed against the death of her baby. Yet another mentioned that a lot of babies died, not only from a specific cause but that death happened even to normally delivered babies (normal vertex delivery), including babies born through caesarean section. For this participant, this meant that no human effort could mitigate the issue of death other than God. Thus the participant ceaselessly prayed to God so that her baby could remain alive:

*“Because when lay in Hospital X, I did see many children who dying. It’s dead, normal birth, Caesar cuts, the babies die, so I think yoh! It can happen to me, so I did, I did, pray, pray, pray...” (P8)*

Not only did participants of this study pray to receive from God, they also prayed to express thankfulness to God, as mentioned in the next subtheme.

#### **4.4.1.2 Subtheme: Thanksgiving for babies’ health and preferred gender**

As noted, prayers were not only directed at asking, the participants also appreciated what they had received and gave thanksgiving prayers. The thanksgiving theme is related to expressing gratitude to God for God’s favour acquired. Thanksgiving prayers were associated with gratefulness, with participants being happy to have their babies born alive and appreciating what was at hand, irrespective of the circumstances. Participants expressed being grateful for the lives of their babies as well as for being able to experience motherhood:

*“Ok. Everything about her. The way she looks at me. That is stuff it keeps me going. That is why I am not regretting the way she was born small ...” (P11)*

In another participant seeing her baby and observing new behaviour in the live baby gave her sufficient reason to attach more to her baby, making her feel good and cope well:

*“Because I see my baby’s alive, he’s crying, he’s open[ed] his eyes, I have my baby now, he’s crying and he’s ... opened his eyes. I hold my baby in my hands.”* (P10)

One participant stated that she expressed thankfulness to God for giving her a healthy baby. According to this participant her baby was thriving very well, despite the fact that the baby was admitted to the neonatal care unit, preventing them from going home. This mother mentioned that she was happy and went further to convey best wishes to other participants that God’s blessing is ultimate for their babies:

*“I can thank God for giving me such a little baby and she is growing well and everything is going good for her, even for other mummies, I wish them all the luck and if they know what the baby needs is the blessings from God, and I appreciate my blessing that I have from God.”* (P11)

Not only were the participants grateful and thankful to God for their babies being alive, they also expressed thanks to God for the baby’s gender. This was illustrated by some of the participants who expressed gratitude for a preferred gender for a male or female child as a result of their pregnancy. One of the participants expressed her thankfulness to God for giving her another child. Based on her choice of gender, the participant was happier that God gave her a girl child, whom she felt was a gift to the boys she had already delivered in the family:

*“I feel better that the Lord give me another child who is a girl so the boys have a sister [laughing].”* (P7)

The participants mentioned that embracing life helped them cope with the stress of having a preterm baby; having a baby was worth appreciating, even though the baby was born preterm. Most of the participants reported that being close to their babies also enabled them to cope better, which gave rise to a second theme of this research, outlined below.

#### **4.4.2 Theme two: Attachment to baby**

Being attached to the baby means loving to spend as much time with the baby as possible and at all times. Participants mentioned that being close to their baby helped them to cope better with preterm delivery. They said that they wanted to be with their babies at all instances while they were at hospital:

*“Spending time with him, spending time with my baby, then I’m not alone and... yes it’s basically all, [laughing] because that’s all I can do in this place.” (P2)*

Another participant mentioned that being with her baby was the most important thing for her to do in order to cope. This participant also mentioned that to be with her baby all the times and get ready for discharge and her going home was her ultimate goal:

*“I just want my baby with me and want him to grow up and let us go home and that my ... I will feel very glad [laughed], really, really” (P5)*

Participants also mentioned that they could not wait to go home with their babies so that they could have unlimited time with them. They mentioned that they could better take care of their babies and exercise their initial caring plans for them while at home rather than in the hospital, as illustrated by the quote from participants 1 and 2:

*“I’m excited to go home and look after him myself because I know how I am gonna raise my baby. I know what his needs are and this thing must be there for him. If I am putting him on milk, his stuff must be packed, or if he is eating porridge until he’s 6*

*months or whatever, it must be there, I don't want to struggle because he is small. And I want everything to be perfect for him.*" (P1)

*"Yoh! I would feel excited [to be home with baby] [smiling] because now I know my baby is at home, and I am at home and I can do what I had always wanted to do with my baby and I know he is out of the hospital. Because when he is in the hospital I am always worried, is he sick, is he healthy or so? That's why I just want him to be home. And at home they can feel there is love, and they are welcome at home. Here they don't feel that, that is why sometimes they are difficult. That's why I just want to go home where he can be at ease, because I know he will be at ease when he is at home."*  
(P2)

Two subthemes emerged from the main theme: bonding with baby and seeing the baby.

#### **4.4.2.1 Sub theme: Bonding with baby**

This could be described as the intense attachment that a mother develops with the baby, such that the mother becomes very loving to her baby. The attachment is usually called mother-infant attachment or bonding. It can happen while the mother is still pregnant and/or after delivery. This mother-baby bond may have a positive impact on the wellbeing of the baby as well as the wellbeing of the mother. Participants mentioned that they felt better when they came into contact with their babies and engaged in some playful activities with them. Frequent contact of participants with babies helped them to interact and bond by kissing, playing, cuddling, touching, and seeing their babies. One participant described how she bonds better with her baby by holding her baby in her arms:

*"Only for touching, if I go to him, I take him out of the incubator, put him to my breast, hold him to my arms, play with him, cuddle him, kiss him, and that attraction is getting me closer to him."* (P1)



#### **4.4.2.2 Subtheme: Seeing the baby**

Seeing a newborn baby means setting eyes on a baby that is born. When a woman gives birth to her baby, seeing the baby always brings joy and happiness to her. One mother mentioned that seeing her baby coupled with positive information from the HCPs, specifically the doctor regarding specific aspects about her baby, allowed her to cope better with the challenges of preterm delivery:

*“When I see the baby and when the doctor tells me no, it’s going good with baby, the weight is coming up, and then I feel good.” (P5)*

Another participant mentioned that her whole pregnancy journey was not good; however, the loving urge for her baby definitely made her cope better, regardless of the situation and type of birth. She said that seeing the characteristics displayed by her baby allowed her to cope day by day:

*“It wasn’t easy, yeah, but what keeps me going is the love I have for her. Ok everything about her. The way she looks at me. That is stuff it keeps me going. That is why I am not regretting the way she was born small ...” (P11)*

A participant mentioned that her baby’s life gave her enough reason to be strong after preterm delivery. She imagined herself if it happened that her baby died, like others did. This participant introspected and spoke within herself, by asking questions to herself. She came to a compromise to accept the situation since her baby was alive. She expressed that just having a live baby grew her attraction towards her baby, and helped her cope with preterm delivery:

*“Because I thought like what if she passed away, what will I feel? She’s still breathing, she’s still alive, so why am I feeling that way? So that encouraged me.” (P9)*

Love for the baby means having a resilient liking for the baby. Participants verbally and emotionally expressed so much love and attraction for their baby and mentioned that the love helped them to cope with the situation of having a preterm baby. In one participant this was confirmed by a huge smile and her body language:

*“I love, uuh I love my child. (Helping me to cope.) [Smiling... swiftly looking out through the window and having eye contact with researcher]. I love my child [loudly said].” (P1)*

#### **4.4.3 Theme three: Acceptance of the situation**

An individual accepts a situation in order to persevere, and in this study participants remained positive about their babies in the neonatal unit. Participants accepted the situation, and with intense love for their preterm babies they persevered and coped through the situation. Participants in this study also mentioned their awareness of their responsibility as mothers to the preterm babies. Participants mentioned that acceptance of the situation helped them to cope because it reduced their stress levels as explained by participant 1:

*“Uuh! I can’t explain how I was feeling! But, the time I was pregnant I was happy because I want to see him. I, I, to myself I was feeling, Ok fine, he’s gonna be like the other two. I’m gonna deliver him and take him home, look after him, take care of him. But now, this happen[ed], he’s a premature baby, I’m the mother, I have to be next to him, I have to be there for him, I have to take care of him. That’s why I’m still in hospital.” (P1)*

Two subthemes emerged: perseverance in the situation and participants knowing their responsibility.

#### **4.4.3.1 Subtheme: Perseverance in the situation**

Due to the love participants have for their babies they are obliged to accept the situation in which they find themselves, such as preterm delivery and admission. Participants acknowledged that the journey was not easy, but loving their babies and accepting the situation granted them perseverance and helped them to cope better. One participant mentioned that certain aspects demonstrated by her baby made her love her baby so much so that she was able to cope with preterm delivery:

*“It wasn’t easy, yeah, but what keeps me going is the love I have for her. Ok, The everything about her. The way she looks at me. That is stuff that keep me going”*(P11)

Another mother mentioned that accepting the situation was the best way to go about preterm delivery. She said that all she could do was to bear the pain so as to avoid stress which could destroy her ability to cope. This mother focused on suppressing things (such as listening to negative people) that could prevent her from coping with the situation of preterm delivery:

*“It’s hard but there’s nothing I can do. I must stay strong for what I’m going through, because if I stress it’s also not gonna be well.”* (P4)

#### **4.4.3.2 Subtheme: participants knowing their responsibility**

Sometimes knowing your responsibility allows you to function actively without withdrawal. If a mother understands her stance as a mother to a child she will cope with certain things. One participant explained the deceit of her thoughts during pregnancy, as she reflected on her previous pregnancies and anticipated a normal birth and prompt discharge, which unfortunately did not happen. This participant mentioned that it was best for her to accept the situation as she knew it was her responsibility to be there. Knowing her responsibility allowed participant 1 to cope better and remain beside her preterm baby:

*“The time I was pregnant I was happy because I want to see him. I, I, to myself I was feeling, Ok fine, he’s gonna be like the other two. I’m gonna deliver him and take him home, look after him, take care of him. But now, this happen[ed], he’s a premature baby, I’m the mother, I have to be next to him, I have to be there for him, I have to take care of him. That’s why I’m still in hospital.” (P1)*

Participants in this study acknowledged that their coping abilities depended on the support they received during the time their babies were admitted to the neonatal care unit. Some of the preferred support needs of participants who participated in this study are described next.

#### **4.5 Themes and subthemes on support needs**

The second objective of this study was to explore and describe the support needs of mothers with preterm babies admitted to the neonatal care unit. According to Participants’ responses, they would cope well with support from their relatives, HCPs as well as other participants experiencing the same situation within and outside the neonatal care unit. The participants also verbalised that the support they received from their social circle, HCPs was very helpful for them to cope well and this is mentioned below. While some participants acknowledged support provided by relatives and HCPs, some expressed lack of support. The themes that emerged included support request, support received from the social circle and lack and insufficient support (Table 4). Most of the support mentioned as lacking and insufficient was on the side of the HCPs who are considered to be most proximal to the participants and their babies.

**Table 4: Themes and subthemes on support needs**

<b>Theme</b>	<b>Subthemes</b>
1. Support request	1.1. Freedom to go in and out of hospital 1.2. Group session 1.3. Counselling and comfort
2. Support received from one's social circle	2.1. Support received from HCPs, 2.2. Support received from relatives 2.3. Group support
3. Lack of and insufficient support	3.1. Health Care professional's attitude 3.2. Insufficient Education from HCPs

**1.1.1 Theme one: support request**

The participants of this study mentioned support needs that they would have loved to have while admitted in the neonatal care unit with their preterm babies. These included: Freedom to go in and out of hospital, Group session and Counselling and comfort.

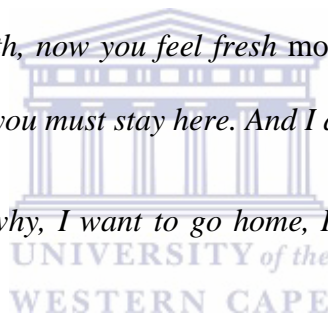
**4.5.1.1 Freedom to go in and out of hospital**

Participants in this study preferred to be allowed to visit their homes while their babies were in the neonatal care unit. The participants mentioned that freedom to go home would allow them experience their normal life styles. In this study some participants had other children who were left behind and they were not sure of how those children were coping in their

absence. Other participants complained that the neonatal unit environment was unpleasant due to HCPs attitudes, boredom and poor resting facilities. Participants questioned why they could not go to their home on a temporal basis while the preterm babies were in the neonatal care unit. These participants requested some liberty in their lives after preterm delivery. They expressed that they were confined to the hospital, and this caused pressure in their daily living. Participants felt frustrated because they stayed just a few kilometres from the hospital, and could transport to themselves back and forth without requesting help from hospital management:

*“Why we can’t go home? Like I need clean clothes mos, nhe? Now I must stay here with those dirty clothes. It’s not even R20 to go home and come back. Only take clean stuff, get a nice wash, bath, now you feel fresh mos and come back ... but you don’t get to leave this hospital, you must stay here. And I am not happy with that.” (P1)*

*“I just feel sad because why, I want to go home, I miss my other children also ...” (P5)*



#### **4.5.1.2 Group session**

Most of the participants of this study wished and suggested that there could be meeting groups, where they could perform certain activities such as praying, have relieving discussions, support each other emotionally, and share experiences. This could continue to uplift their spiritual and emotional spirits and attend to other needs, hence meeting the basic health requirements of an individual.

Meeting other participants with the purpose of interacting could be a good way to enable participants to share their burden. Meeting other participants in group discussion could help the participants to cope better, as they could get exposed to learning from one another’s experiences and comfort one another. One participant requested that the facility organize

such meetings, and mentioned that these meetings could help them cope with preterm delivery. It was mentioned that mothers of preterm babies admitted to a neonatal unit could use such meetings as a platform for debriefing, which could help them feel better.

*“... like at hospital X, not here (hospital Y), it was, all the mothers come together, then they say they experience how they are with their babies. Now here there is nothing, you are just in your room every day. I think they must do something like that – bring the mothers together, say something about the experience, hold church, pray. I think they must do stuff like that.” (P2)*

#### **4.5.1.3 Counselling and comfort**

Some participants felt that they needed counselling and comfort while admitted to the hospital. Counselling is a meeting between two people where one of them is a professional in listening to others' problems and giving directions on how to go about solving them:

*“Maybe some counselling here. I can't give counseling, but at least if you speak to someone you feel better. And especially as someone who don't know. It's better.” (P9)*

It was also mentioned by participants that a comfortable sleep area would help them cope well after delivery and hospitalization of their preterm baby. A comfortable sleep area was one of the noted aspects that participants complained about. Participants mentioned that the sleep area offered was not comfortable hence creating tiredness in them as well as hinder them from rendering proper care to their preterm babies. The participant expressed that:

*“Ok the place we sleep is not right and I can't keep my child like other mothers can keep their child and give breast feeding and also steady' (P5).*

## **4.5.2 Theme two: Support received from one's social circle**

Social support is help that comes from any person or individual that the participants are related to. It can be the healthcare team, a friend, members of the nuclear or extended families, spiritual family, love life, or any Good Samaritan. Almost every participant mentioned the support they received and were excited, happy and appreciative. The participants mentioned that support from family, a spouse and HCP would be helpful during the period of preterm delivery and admission. Support from HCPs within and outside of the neonatal unit was received and acknowledged by participants as important to them after preterm delivery and admission, as indicated below.

### **4.5.2.1 Subtheme: Support received from HCPs**

Receiving health information and support may relieve suffering in individuals who are anxiously waiting for recovery and discharge of their preterm babies. Participants in this research expressed lack of skills with regard to the care of their babies. They acknowledged that health education and support (information about their baby, assisting in holding their babies) was given to them by HCPs, which made them feel better and improved their coping abilities, as indicated in the quote from participant 6:

*“They [HCP] taught me how to do, how to dry, how to touch my baby because he was very small. I didn't know how to pick him up, I did not know how to touch him ... [laughed], but the staff in the hospital were great. I will say they were very encouraging when I asked them to help me, yeah.” (P6)*

This was supported by another participant (P6), who mentioned that HCPs carried out her (participant) responsibilities in her (participant) absence by making her baby comfortable. This allowed her to experience a calm and soothing atmosphere, hence enabling her to cope better:



*“They [HCPs] care ... and every time I go to the toilet they keep my child and I come after that is not crying ... they keep her, stuff like that.” (P8)*

Sometimes in the hospital health education may be given to the mothers of preterm babies on how to take care of their babies. Some participants mentioned that they encountered difficulties with their preterm babies while in hospital but were fortunate to receive help from the nurses who worked in the neonatal care unit. The participants mentioned that nurses showed participants how to hold and feed their babies. The nurses looked after the babies and gave special attention when participants went out of the neonatal unit. The participants further mentioned that in addition to the help the nurses rendered to them, they were given tasks to perform, thus contributing to the care of their preterm babies. These participants mentioned that the tasks that were given to them were daunting, and acknowledged that they lacked enough knowledge to perform such tasks. They added that the nature of their baby's condition had contributed to their inability to perform the tasks as allocated by the nurses. Therefore participants require sufficient education with regards to the care of their preterm babies. This was supported by some participants who voiced that they needed more support and education with regard to the care of their baby:

*“It's very difficult, but with the help of the nurses it gets better. But they give us specific duties like to change nappies and feed the baby. But my one is still [too] small to suck, so now we feed him through a tube. They insert a tube near the stomach and then I feed him through there. The only difficult thing is when I have to change him, because after feeding him I have to change the position ... he's very small so I don't know how to handle him.” (P4)*

*‘They [HCPs] talk with me and they make my baby nice. That is how they were working yesterday. My baby was vomiting so I gave the baby more milk, then she must take softly the baby and wrap the baby and the baby is sleeping nice.’ (P10)*

Participants mentioned that the HCPs acted as their mothers. These participants said that HCPs were very patient with them, because as mothers of preterm babies they relied on the HCPs for assistance throughout each entire day. Some participants acknowledged that the HCPs demonstrated a sense of respect and warmth towards them, as illustrated by the quote from participant 11:

*“They [HCP] make relax everything. That’s the support that is also the nice thing. They are also like mothers here, you mos don’t need a mother around here, so they are as mothers here around you .... you run to them, sister this, or that, sister this. And they are not complaining ‘Oh mommy, you are annoying, uh mummy, you this’. They’re able to help, they are friendly ... That’s all.” (P11)*

This was supported by another participant (P9) who noted that HCPs could look after their preterm babies in their absence, such as when they went to take a bath or perform other duties, unlike in other neonatal care units. One mother acknowledged the good care she received in this neonatal unit in hospital Y where this research was conducted, comparing it to another neonatal unit in hospital X where she had previous experience:

*“Like for instance you want to go wash or do something; if the baby cries you can’t go wash at hospital X. You must sit till that child sleeps or keeps quiet, because they are not gonna make her keep quiet. Here in this hospital, you can go wash yourself, do everything finish and the sister will help you keep her quiet or sleep.” (P9)*

Some participants mentioned that the HCP assisted them in caring for their babies when they made mistakes in the course of taking care of their baby. They also mentioned that the nurses spoke to them while taking care of the baby, which could be a form of educating the participants. The one mother stated:

*“They talk with me and they make my baby nice. That is how they were working yesterday. My baby was vomiting so I gave the baby more milk, then she must take softly the baby and wrap the baby and the baby is sleeping nice.” (P10)*

Participants not only appreciated support from the HCPs who were at the unit all the time, but also from other HCPs outside the unit.

Talking to someone outside the unit was also acknowledged by participants to be of significant help in their coping process. This could be talking to a counselor, family member, friend or spiritual guardian. Participants believed that it is normal to talk about something concerning them to someone. Participants expressed that talking to someone was very helpful in allowing them to cope. A participant appreciated talking to the researcher and acknowledged that meeting the researcher was very therapeutic in her situation:

*“You know sometimes you have to talk about things, then you feel much better. I was two months at Hospital X and for the whole two months I was low, so I didn’t talk to anyone. When my mom came we used to talk about stuff but I didn’t tell her how I feel. And so for me you spoke to me, now I feel like a bird again. [Made a joke showing a bird through the window ‘you see the bird that flies’.] So I feel like that now.” (P11)*

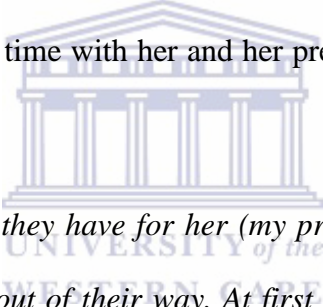
Speaking to someone was confirmed by another participant as helpful, who added that it is better to talk to someone who might be able to keep it confidential, and this could be achieved by talking to someone they don’t really know:

*“I can’t give counselling, but at least if you speak to someone you feel better. And especially someone who don’t know. It’s better.” (P9)*

Apart from support received from HCP teams, relatives contributed to supporting participants. This is seen in the subtheme below.

#### **4.5.2.2 Subtheme: Support received from relatives**

Family support is the assistance one gets from family members such as mother, father, sisters, brothers, children, uncle, auntie, grandmother and grandfather, as well as the partners described as husband or boyfriend. Family support is seen to be important in enabling coping in participants. One participant acknowledged the persistent love demonstrated by her parents through constant visiting at the hospital. She said that her parents went against all odds to meet the visiting hours and spend time with her and her preterm baby, which she appreciated a great deal:



*“[My parents] ... the love they have for her (my preterm baby) is inexplicable, it’s a joy inexplicable. They go out of their way. At first we didn’t have a car, so they (my parents) did walk to hospital X and we live in X area. They my parents did walk, many times. And yesterday they did come and show me they did buy a bakkie, so I told them daddy, you don’t have to walk to come here, we are going to hospital Y. So he said he don’t mind, he don’t care, even if we go to where, he will find a way to come to us. I really appreciate their support and love.” (P11)*

Another participant mentioned that her mother and sister were of great support to her when she needed them. This participant preferred to be away from hospital, but could be back at the hospital as soon as she was needed. She mentioned that this could only be possible with the help of her family who provided her with the transport facility as well as moral support. She acknowledged receiving education (in terms of what to expect after preterm delivery and how

to manage the different encounters such as weight drop of the baby) and moral support from her mother, mentioning that she had a very reliable means of communicating with her mother whenever she was down emotionally or did not understand anything about the welfare of her preterm baby:

*“Support from my family, eemmm, like twice she got ill, this yellowness for her was getting worse. They phoned me 3 o’clock. I used to go visit, I used to go to her twice every day, every morning and at night, and ... then they phoned me in the morning that the yellowness is getting worse, I have to get to hospital, they need my blood. My sister, I woke her up and then she drove me, so in many ways they being there for me ... my mother she always supports me when I am feeling down, I just send her a message or something. Like the baby was losing weight and then I sent my mother that this and this, telling my mum, ‘Mama, I don’t know why she is losing weight and I don’t feel nice she is losing weight so.’ So my mother told me ‘Nooo, you don’t have to worry, you must know that, every day is a challenge for her. She is fighting still every day.’ That’s the message she sends me, and then she comes to visit me, she visits often.” (P9)*

One participant praised her family for frequent visits, which prevented loneliness and stress that could prevent positive coping. Participants acknowledged that frequent visits and moral support given by their families as well as the provision of basic needs helped them cope better:

*“Eeeh the support that I get from my family? They are very nice they came, 3 days in a week or every 3 days in the week.” (P4)*

Another mother stated the following:

*“I get my clothes and my food; they bring me stuff to eat. They bring me stuff for the baby, my clothes and stuff like that. I get all the support, everything, everything.” (P8)*

Another expressed the support she received from her family members as follows:

*“Yeah there is support [from family members] ... they are coming here and talking, they are talking. Like: you must be strong ... but everything's going to be fine. Mmm, in this moment if I need something or I ask them something, if they have the must help me, if he can help me. But if they can't, like if they don't have money to buy me something its fine... That is all.” (P7)*

Support from one's partner or husband can be comforting and could help positively in the coping process. Most participants appreciated that their partners or husbands visited them while in the hospital and this helped them cope better. One participant appreciated the brave and frequent visits of her boyfriend, which enabled her to cope well:

*“He's fine, with it because his aunt also gave birth to a premature child so it's not something new to him ... so he's calm and very supportive. He comes every day to see the baby and pray with me.” (P4)*

Another participant mentioned the roller-coaster feelings of her husband with regard to the birth and admission of her preterm baby. She spoke with a smile as she said:

*“I can say the support of my husband is great. He's actually very excited; he can't wait to have the baby home. But he is also very sad because he cannot be with the baby like I am with the baby. I am being closer with the baby. That's the connection he would also want to have, but he can't have because the father is only allowed at certain times in the ward.” (P6)*

Another mother acknowledged that the presence of the father of her baby coupled with the presence of her family members helped her to cope better:

*“They are very nice, they came 3 days in a week or every 3 days in the week. Plus the father he comes every night and every day afternoon. I feel glad and happy with the father. That’s all I need from him.” (P8)*

One participant greatly appreciated the presence of her boyfriend coupled with the life of her baby. This mother counted herself amongst the most fortunate people whose babies are able to be with their fathers:

*(Smiling)I have my boyfriend, my baby’s father with me, because some fathers don’t know where their baby is...” (P11)*

#### **4.5.2.3 Subtheme: Group support**

Sharing information amongst participants about their babies could help to reduce tension in an individual mother. Information can be shared through a group meeting in a formal or informal manner. For participants information could be shared between those who share the same burden or between participants and HCPs.

Only one participant confirmed that she interacted with people in the same situation, which allowed them to talk and vent their frustrations, making them feel better after preterm delivery and as their baby was admitted to the neonatal care unit:

*“I mix with people, with the people, with my roommates and so, because when you are alone and you don’t have someone to talk to, it is not nice, you feel depressed. Like in the first time I always cried because there was no one to talk to, but now it’s better because it’s not me alone in the room, there are more people and you can communicate with each other. Then you forget about that yesterday you did cry and so .... So that’s how I always ... feel better. I communicate with people.” (P2)*

Despite the support that participants received, some preferred support aspects were missed as reported by participants. The section below mentions support that was determined to be lacking and insufficient by participants of this study.

### **4.5.3 Theme three: Lack of and insufficient support**

Even though most participants appreciated the care they received from HCPs and relatives, and mentioned that they needed the support some expressed dissatisfaction with the treatment they received from the neonatal care unit as well as from their partners. Most participants mentioned an aspect of support that was missing from the support they received. Participants expressed concerns regarding HCP's attitudes as the most lacking aspect in terms of the support they needed.

#### **4.5.3.1 HCP's attitudes**

Some participants in this study complained about the attitudes of HCPs towards them as well as towards the care of their preterm babies. Some participants perceived that their babies were treated differently by HCPs. Participants mentioned that some babies were treated with respect and dignity others were ignored:

*“They must, they must, you see like, we are, I think, we are, 10 inside there. But other people are doing this, so how can I not do that? And everybody is like, they put that clothes, their better stuff. It's only mine. There is one same level like mine, but that one, every morning he's been – she's been washed, he has a new thing on. For these 2 days they did not even touch my baby to wash.” (P1)*

Another participant mentioned that some HCPs attitude was appalling and not appreciating, and HCPs were inattentive to their needs which made them sad. The participant expressed as follows:



*'And sometimes here you don't get the support that you would get at home. Sometimes the nurses are rude! sometimes they are nice, sometimes they are too busy to help you and that's not nice'.(P2)*

Unhappiness was expressed by some participants mentioned that bonding time with the babies was too little. They mentioned that they were told by the HCP to put the baby back in to the incubator without allowing them enough time to bond with their preterm babies. Some participants compared care delivery between two hospitals, and automatically disregarded the care delivery of the hospital Y where this research was conducted:

*"They say as soon as he finishes to drink, he must go back to the incubator, because of the light. But the time when he was there by hospital X, he was also on the light, if he finish to drink I put him in my skin to skin, and when he fall asleep, now I feel happy, now I put him back, close it and maybe go down, get some air or what. But they don't want to allow that. I'm not happy, I'm not happy the way, about for their rules, I'm not happy." (P1)*

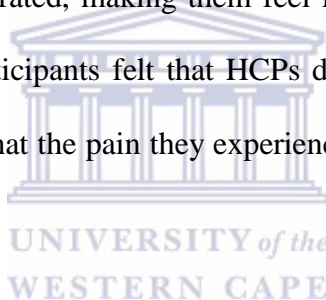
*'but I didn't get that chance to bond because they must put him under this oxygen so there wasn't time to bond and I didn't give him breast.... So it was not nice'(P2).*

Bonding could be effective, depending on the approach of the mother to her baby. One participant mentioned that the participants need an explanation on how to commence interaction with their preterm babies in the neonatal care unit. This mother, who admitted having received support in the form of education from HCPs, again mentioned that HCPs needed to be more physically involved in the care of a preterm baby with the help of HCPS. She expressed that touching the baby and many other aspects with regards to care of these

babies was not happening in the unit. This same mother further mentioned that it was important that a mother be orientated to the neonatal unit as soon as her baby is admitted to it:

*“I do think they can be a little more involved with how you touch the baby and whatever... because sometimes they don't ... [pause and shy looking down] give you the attention that you really need ... basically when a mother comes into the ward, and the baby is lying in the incubator and you don't know what to do, the staff can explain exactly what to do. When you ask them questions it will be nice to receive a lovely answer in a nice manner, to feel like at ease.” (P6)*

Some participants were unhappy because HCPs demonstrated a delay in service provision. This made participants very frustrated, making them feel like forcefully signing a discharge for their babies before time. Participants felt that HCPs did not understand what they were going through. They mentioned that the pain they experienced was ignored by HCPs, causing them more pain:



*“I feel the nurses must help you where they can. Because sometimes if you, there is something wrong or you need something, then you ask them, then they [are] always busy. They always said you must wait, then you wait long .... And that is not how it should be.” (P2)* Another participant again expressed her unhappiness, in the following way:

*“Like yesterday I was struggling to give milk, to get milk, so I asked the sister the following night for the pills. She made a note on the incubator. I was sitting until 3 o'clock yesterday afternoon waiting for that pills and from 11am-3pm he didn't even drink. And that doctor who forced me to give him the cup. I said to him 'Doctor, but I don't have milk, where must I get milk? This one gonna be losing weight here mos, because there is nothing to give to him'. 'No! That's not my problem!' I say, Ok fine.*

*If this is the case, give my baby, I can take him home, and I can raise him there on my own.” (P1)*

Participants also complained about disrespect and impatience from HCPs which were bad experiences for them. According to the participants, HCPs documented false information which made them feel as though they were negligent about their babies, which added to the participants’ already existing stress:

*“And that, respect! They don’t have respect! You see like, I have an operation mos, sterilisation, so it’s painful, and they don’t have mercy. And I told them you must be, you have mercy to me because I have an operation. I can’t run from here to there. If I come there, maybe I be half an hour late, you must have patience! But ah! I saw in the book, they write there in his file, the mother don’t, the mother are not interested! One of the sisters writes there the mothers are not interested in the baby.” (P1)*

#### **4.5.3.2 Insufficient Education from HCPs**

Even though participants of this study acknowledged the support from the HCPs, some of the participants mentioned that the teaching of participants with regards to certain aspects of care of the baby were lacking. One participant mentioned that teaching participants on how to be more engaged with playing with or touching of their babies was lacking. The participant mentioned that:

*‘I do think they can be a little more involved with how you touch the baby and whatever... because sometimes they don’t.... (Pause and Shy looking down) give you the attention that you really need’.(P6)*

Another participant mentioned that HCPs gave her tasks to perform which she was not confident in. This participant said that:

*'But they give us specific duties like to change nappies and feed the baby. But my one is still small to suck so now we feed him through a tube. The only difficult thing is when I have to change him because after feeding him I have to change the positions of which he's very small so I don't know how to handle him'(P4)*

#### **4.6 Summary of Chapter four**

For the first objective on coping strategies, three key themes were identified, which included praying, attachment to the baby, and acceptance of the situation. For the second objective on support needs, three main themes were identified, which included: support requests, support received from one's social circle and lack of and insufficient support. Results showed that participants have different ways in which they cope after preterm delivery. The results also showed that the participants preferred different support needs to enable them cope with preterm delivery.



## **Chapter five**

### **5 Discussion, recommendation and conclusion**

#### **5.1 Introduction**

This chapter presents the discussion of the results of this study in detail, by comparing them with the available relevant literature. The objectives of this study were two folds the first one was to explore and describe the coping strategies used by mothers whose preterm babies were admitted in a neonatal care unit in one hospital in Cape Town and the second one was to explore and describe the support needs of mothers whose preterm babies were admitted in a neonatal care unit in one hospital in Cape Town. Thus the findings of this study are discussed according to these objectives. An inductive approach was used to develop themes after which a deductive approach was used to explain the results comparing with an established Brief COPE model. Following the discussion, limitations of the study that were encountered during the research process are presented and how the researcher tried to overcome these. Furthermore, recommended actions are stated for aspects of concern that came out of the results of this study. Overall conclusion of the study is presented and lastly the summary of chapter five.

##### **5.1.1 Coping strategies of mothers ‘with preterm babies**

To achieve answers to research objective one a sample of participants who were interviewed in this research was made up of mothers who were in the hospital with their preterm babies and had not abandoned them. All the participants who were interviewed each had a way in which she dealt with the stress they were going through.

From the first objective on coping strategies it was found that participants use praying, attachment to their baby and acceptance of the situation as coping strategies. Participants

prayed, accepted the situation and enjoyed being attached to their babies, which made them cope better. The items of the Brief COPE model deal with ways in which individuals have been coping with the stress in their lives, such as the stress caused by preterm delivery. There are many ways to try to deal with problems. The items in the Brief COPE model require individuals to identify what they have been doing to cope with stress, such as that of preterm delivery. Obviously different people deal with issues in different ways, but this research was interested in what participants do to cope with the stress caused by preterm delivery. Through the items on the Brief COPE model, one identifies a particular way of coping. The researcher wanted to explore what individual participants do to cope (coping strategies) and what support they prefer after preterm delivery. The participants were expected to respond to qualitative open-ended questions on the basis of what they do to cope which were later compared to the items on the Brief COPE model. The researcher was more interested in knowing exactly what participants do, hence using qualitative interviews suited for the data collection. This avoided forcing participants to mention what they may not want to, by allowing them to tick on the scale. The various themes that emerged on coping strategies are discussed below, starting with the former.

Below are the coping strategies expressed by participants who delivered preterm babies and participated in this research. These include praying, attachment to their baby and acceptance of the situation as discussed below

#### ***5.1.1.1 Praying as a coping strategy***

Almost every mother in this study mentioned that they were praying to God and believed they received help and strength, which helped them to cope better with the stress caused by preterm delivery. Participants expressed thankfulness to God for giving them a baby, as well as requesting grace and strength through praying. This is consistent with the results of a study

reported by Arzani et al. (2015), who found that prayer was the most important strategy that mothers of preterm babies used to cope with having a preterm baby. Prayer is usually carried out for various reasons, such as to praise and worship God, give thanks to God for something one has achieved, apologise and try to find forgiveness from God for what one has done wrong, and at times to ask for assistance from God (Davison, 2012). People usually pray when they find themselves in difficult situations, some pray as a daily routine in the family, and some pray because others do. Prayer can occur anywhere and in any style, hence people pray in churches, homes, workplaces and while travelling, to name a few (Perriam, 2015). Praying as a means of expressing spirituality could also either be when people ask from God for themselves, or when they ask from God on behalf of others (Carvalho et al. (2014). In this study, praying was mostly carried out by participants for thanksgiving and to ask God to intercede and to provide good health to their preterm babies, as seen in Chapter 4. Apart from participants who use praying for reasons mentioned above, Sharp (2010) mentioned that praying as a God-seeking method is utilised by people for different reasons. For example, Babamohamadi, Negarandeh and Dehghan-Nayeri (2011) conducted a study and found that patients with spinal cord injury use seeking help from religious belief through praying to cope with the situation. Patients who experience chronic pain use praying to cope with their emotions, as described by Peres and Lucchetti (2010). Findings of a study by Bryant-Davis and Wong (2013) identified that the approaches used by spiritual people to deal with stress include endorsement of beliefs, enrolment in activities, and access to support from faith communities.

Choumanova et al., (2006) conducted a study on the use of religion and spirituality as a coping strategy in women with breast cancer, and found that these women not only prayed to God to heal them, but also prayed for others to come to their rescue to provide support to them in their traumatic situation. This might have been because people with chronic or deadly

conditions become depleted of resources to keep them going, and thus turn to ask God to touch the hearts of givers to locate them and intervene. Again, in the current study almost every participant mentioned that they relied on the mercy of God for coping and normalisation of their situation. This was reflected in the religious background of the participants in this research: every participant noted that they were either Christian or Muslim, which explained why they depended on God to relieve them of the trauma they were going through. This is in accordance with the study by Wachholtz, Sambamthoori and Morgantown, (2013), which found that dependence on prayer by individuals who are facing a stressful event increased between the year 2002 and 2007. A study by Sharp (2010) found that praying helps to link one to God, at whom one can direct and exhaust anger, use to build and uphold self-esteem, make situations seem less threatening, as well as prevent paying attention to negative aspects that will induce stress. Harris, Schoneman and Carrera, (2005) mentioned that personal prayers which result in active coping strategies will reduce stress better than prayer that leads to avoidant coping strategies. This was supported by Bryant-Davis and Wong (2013), who mentioned that positive spiritual approaches tend to reduce stress, which is good for the participants.

In this study prayer helped participants to build their confidence in receiving God's help. Participants in this study expressed that praying helped them to have hope in receiving the assistance of God. According to the responses of participants in this study, praying instilled certainty in them. Praying helped to reassure them that their babies will be well and be discharged from the unit and sent home. Praying helped participants in this study to remain thankful and appreciative of the goodness of God. As a result participants' existing stressful feelings because of sadness, shock, mixed feelings, fear and deceit might have been reduced by prayer. This is in line with a study by Anderzen-Carlsson, Lamy and



Eriksson, (2014) who found that religious involvement has a strong influence on distress such as emotional or mental.

The theme of praying was supported by the concept of religion in the Brief COPE model. The Brief COPE model explains that participants continuously prayed and meditated as they found comfort in their religion and spiritual beliefs (Carver 1997). Prayer was put in practice by the participants as, they called on God's name at all times and expressed faith as they believed God could help them keep their babies alive. Participants of this study expressed faith that God could increase their strength to care for their babies, as well as overcome the stress caused by preterm delivery. It can be mentioned that participants of this study demonstrated personal prayers for thanksgiving and for God to relieve them of stress. They prayed for God to intercede in healing their babies (Carvalho et al., 2014).

#### **5.1.1.2 Attachment to baby**

Attachment through the ability of the participants to spend time close to their preterm babies was another theme that emerged from the interviews as a coping strategy used by mothers who delivered preterm babies and took part in this research. In this research participants found attachment to their babies through mother-baby bonding as well as through seeing their babies frequently. This research revealed that closeness with the newborn has enormous benefits for the mothers' coping strategies. This is because when mothers are closer to their babies, they don't have as much to worry about, which releases stressful feelings. Flacking et al. (2012) mention that attachment to their baby increases and secures mother-infant bonding, and augments mothers' confidence and competence in the care of their preterm babies, which reduces chances of stress and anxiety and prevents depression in participants. These participants experience joy and happiness, which helps to reduce fear in them as well as

prevent rejection of their preterm babies; this eventually leads to better growth and development in the infant (Anderzen-Carlsson, Lamy & Eriksson, 2014).

In contrast, Gribble (2016) mentioned that mothers of preterm babies find it difficult to attach to their preterm babies due to the fact that they are unsure of the babies' chance of survival. This means that the mothers might get traumatised if anything should happen to the preterm babies they have great attachment to, leading to the effects of grieving. However, participants in this study experienced attachment to their babies by touching, kissing, playing with, and cuddling their babies. This behaviour towards the baby, as seen in most participants in this study, could be a coping strategy used today by mothers who deliver preterm babies. This is in line with a study by Cleveland and Horner (2012), who set out to better understand the experiences of Mexican American mothers in the NICU. They found that mothers of preterm babies coped by leaving part of themselves with their babies, as well as staying with and watching over their babies in hospital. Flacking and colleagues (2012) mentioned that attachment to the baby can be emotional – a mother does not have to be physically present at the baby's side, because mother-baby attachment commences when a mother falls pregnant. They added that the mother-baby attachment or mother infant-bond grows throughout the gestational period. However, they mentioned that physical mother-baby attachment is vital to keep the relationship between the mother and baby after delivery strong and lasting.

In this study, mothers' ability to view and remain close with their babies helped them to cope through the preterm stressful situation. However, another study reported that mothers of preterm babies explained that they coped better when they stayed away from the NICU and the hospital environment where the baby was admitted (Smith et al., 2012). In this study one participant preferred to stay away from her baby who was admitted to the neonatal care unit. Although she preferred to stay away from hospital, leaving her baby in the hands of the nurses, this mother still visited her baby every day. This participant was one of

the participants who requested counselling and additional support from HCPs to help her cope better after having a preterm baby. Probably she could not withstand the situation and needed counselling support to encourage her closeness with her baby. It could as well be as a result of the fact that the participants were very lonely at the hospital and lacked intimate conversation sessions. Hence due to unavailable counselling support and sessions to distract her, this mother preferred to stay away from her baby, without knowing the effects on both of them. The intermittent separation might have prevented constant bonding, and bonding is vital for the growth and development of the baby and for the psychological health of the mother. This closeness reduces maternal stress and anxiety and prevents depression.

It is important to note that in the setting where this study was conducted, participants expressed their desire for counselling services. Thus counselling services could be implemented in the hospital setting and offered to all mothers, so that every mother who delivered a preterm baby would have the opportunity to be counselled. This would encourage mothers to stay by the side of their babies and practice physical attachment. Frequent visits and staying with the baby further help to strengthen the bonding, and effective bonding could have a favourable impact on the development of the baby.

### ***5.1.1.3 Acceptance of the situation***

Acceptance of the situation was another coping strategy that emerged from the data that were collected using a semi-structured interview guide in this research. Acceptance of the situation refers to knowing or giving up power to try and solve a problem. In this way one knows that nothing can be done by one's own power (Conry, 2008). The participants in this research expressed that understanding their responsibility as mothers and persevering with the conditions imposed by preterm delivery enabled them to accept the situation, which helped them to feel better, thereby enhancing positive coping. These participants persevered and

stayed in the hospital with their preterm babies and not abandoning them there with the HCPs.

This is in accordance with the results of a study by Arzani et al. (2015), who explored mothers' strategies regarding the birth of a premature baby. They found that patience and strength were coping strategies used by mothers who delivered preterm babies. Arzani and colleagues (2015) also mentioned that patience and strength revived in mothers who took part in their study only after mothers realised the instincts of their motherhood role. It can be mentioned that accepting a problem is the beginning of solving the problem. For example, in the grieving process the stage of acceptance ends the process, and the individual becomes relieved of the burden caused by a particular stressful situation (Conry, 2008). During this time the individual tends to acquire strength, which allows withstanding of the stress brought about by a particular situation. Accepting the situation allows the mother to be more wakeful, attentive and interested in the care of her preterm baby, or else the mother could remain in the cycle of stress and subsequent depression (Conry, 2008). However Conry (2008) mentions that accepting the situation is not the end of stress, because reminders of the situation (such as the date of birth of the baby) might still provoke stressful feelings, which might continue for life. Therefore, individuals need to understand how to manage these stressful emotions when they experience them.

Acceptance of the situation was matched to the concept of acceptance in the Brief COPE model. This means that participants tend to accept the realism of the situation, and accept living with the stressful situation, which enables coping. In this study participants demonstrated acceptance through perseverance and awareness of their responsibility. These participants remained in hospital for the duration, from delivery till the time of data collection and beyond, without going out of the hospital, as their movement was regulated by the hospital policy.

### **5.1.2 Support needs of mothers with preterm babies**

The second objective of this study was to explore and describe the support needs of mothers of preterm babies admitted to a neonatal care unit. Three main themes identified were: support requests, support received from one's social circle as well as lack of support. Participants mentioned support that they would need after preterm delivery and admission. The participants also acknowledged that they received some needed support from their social cycle. The participants also expressed a lack and insufficiency of some needed support. The support needs of participants of this study included: emotional needs, physical needs, learning needs as seen in the discussion below.

#### **5.1.2.1 Support requests**

The first theme on support needs was support requests from participants. Participants felt that some support needs were not met in the period of preterm delivery and admission. The participants verbalised that they would prefer to have freedom to go in and out of hospital and do things that they needed to do to keep their domestic expectations up to date and feel at home. Some of the participants mentioned that, they would prefer to bath in their homes rather than in hospital. Other participants also wanted to go out of the unit because they wanted to check on their other children who were left behind, interact with other people outside the hospital, as well as engage in other environments.. Other participants expressed boredom due to idleness and unfriendliness of the neonatal care unit environment due to HCPs attitudes Wigert, Berg, and Hellström, (2010) conducted a study and examined the factors that prevented mothers' presence in the neonatal care unit where their babies were admitted. They found that reasons such as going to take care of their homes and other children left behind, mother suffering from a health condition an unfriendly neonatal care unit

environment were the causes of absence of mothers from the neonatal care unit. This confirms some of the reasons why participants in this study mentions about freedom as a need to cope better with preterm delivery and admission Research shows that mothers of preterm babies prefer an environment that resembles their home, rather than being confined in a hospital environment (Russell et al., 2014). It is mentioned in research by Flacking (2012) that a parent can be physically absent but still emotionally attached to the baby. This was understood when participants who took part in this study mentioned that they would love to be released from time to time to get in touch with those remaining at their home, and would come back to the neonatal unit to take care of their preterm babies. These mothers expressed that they felt confined to one place, which made them feel disheartened. It was noticed that participants were set in a specific routine, such as feeding the baby, resting and eating, and back to feeding the baby. These mothers were not allowed to participate in activities outside of the baby and themselves, which made them bored and stressed. Participants only met each other during meals, which was not a time designed for formal interaction. In a study by Flacking, (2012) results showed that mothers could still be emotionally attached to their babies without physically being present. However, it is imperative to encourage physical closeness with the baby since it helps in maintaining emotional and haemodynamic stability in the baby. In this wise, hospitals are advised to provide homelike boarding environments for mothers who have preterm babies admitted in a neonatal care unit.

Other participants mentioned that they would feel at home with the provision of prayer sessions in a group and group discussions with fellow participants who share the same traumatic experience. This is consistent with the findings of a study by Bahrami et al. (2011), which found that praying in a group was more effective in improving the quality of life of cancer patients than praying alone – they found a statistically significance difference between

personal and shared praying. However, Bahrami and colleagues (2011) indicated that personal prayer also influences quality of life in a positive manner. Participants in this study felt that meeting with others in any form could prevent boredom, crying alone and depression. These mothers felt that being together could help in distracting them, so that issues about the preterm baby could be forgotten thus reducing stress in them. In a quasi-experimental study by Abdeyazdan, (2014) parents whose preterm babies were admitted in a neonatal care unit received support in the experimental group unlike the control group in form of psychological training as well as meeting and sharing their feelings with other parents who are affected by preterm delivery. Results showed that stress was significantly reduced in parents of the experimental group. Therefore, group meeting and information sharing amongst individuals affected by preterm delivery is of great importance in stress reduction and facilitation of coping. In a study by Guillaume et al. (2013) it is mentioned that communication with parents of preterm babies is a very vital aspect for relief of stress and boredom in these parents. Some participants of the current study also reported that communication with others, especially HCPs, kept them going as it provided them with information about their preterm babies. However, other mothers complained that they needed more communication exchange between themselves and the HCPs regarding their babies.

Counselling and comfort were another support needs mentioned by participants in this study. The participants mentioned that one on one or group meetings would help them do well after preterm delivery. Participants of this study mentioned the need for Physical needs (a good bed to sleep in); courtesy and counselling services (psychological and emotional needs) from HCPs which could help them cope very well after having a preterm baby. Lubbe (2005) conducted a study on an Early Intervention Programme for Parents of Neonates in which parents expressed the support they needed to be able to deal with their preterm delivery situation. The support needs expressed by these parents included information needs,

communication needs, emotional needs, learning needs, discharge needs and individual needs. In the current study one participant became emotional during the interview and later appreciated having spoken to the researcher, and as she mentioned that she felt better as she had vented her feelings. The participant thus needed emotional support, which is in line with Lubbe's study. The emotionally affected participant was referred to the sister in charge of the neonatal care unit, who dealt with the situation further according to the unit protocol regarding stressed mothers.

Mothers of preterm babies admitted to a neonatal care unit seem to depend a lot from HCPs for support after delivery. This could probably be because they spend most of their time with the HCPs during the period of delivery and admission of their preterm babies. This is in line with a study, by Linberg and Ohrling (2007), which revealed that mothers of preterm babies preferred support from HCPs as well as from family members to enable them to cope better with the preterm event. Another study revealed that staff professionalism and staff empathy were amongst the preferred needs of mothers after preterm delivery (Sawyer et al., 2013).

#### **5.1.2.2 Support received from one's social circle**

Apart from what the majority of participants mentioned about support needs during preterm delivery and admission, the participants mentioned received support needs from their social cycle. With regards to support received from one's social circle, participants received support from their relatives, HCPs and group support. Participants verbalised that the support they received from their relatives included the frequent visits by relatives. They mentioned that the relatives gave them comforting and reassuring words such as 'do not worry, everything will be fine, be strong'. The relatives also provide basic needs to the participants such as clean clothes, food and money. Apart from the support received from relatives in the social circle, participants also acknowledged support received from HCPs. With regards to the support



from HCP, participants mentioned that HCPs assisted them with the care of their babies such as helping them to feed their babies. The participants also mentioned that HCPs also gave particular attention to their preterm babies in their absence such that they were able to carry out certain activities such as hygiene needs, elimination needs, nutrition needs without rushing. HCPs also supported participants by listening to their frustrations which created calmness in anxious participants. This current study results revealed that the majority of the participants were able to cope with the preterm stress by receiving support from various members of their social circle, such as their relatives (mothers, fathers, siblings, husbands or boyfriends, and church family), HCPs as well as group support.

Research confirmed that parents of preterm babies need special support to ensure better coping and hence survival of their babies (WHO, 2012). Support to parents of preterm babies has long been established as an important support structure, and this was also documented in an earlier study by Hughes et al. (1994), who noted that parents of preterm infants use support from relatives and HCPs as strategies to cope with the stress associated with preterm birth and hospitalisation. Another more recent study by Schappin et al. (2013) mentioned that with enough social support for mothers of preterm babies, coping well can be established, thereby avoiding poor handling of the situation by the affected individuals. From the interviews that were conducted it was understood that all mothers who participated in this research received some form of support and were not left alone with their babies in the hospital. Most of the participants in this study appreciated the support they received from relatives, HCPs, as well as group support. It is worth mentioning that the support received allowed participants of this study to cope with the situation of preterm delivery. Some participants expressed complete satisfaction with the support they received from both family and hospital staff, stating how family members brought them food, clothes and love encouraged them with words, visited them daily reassured them. Therefore these participants

were satisfied with the provision of their basic human needs by their families. In a study by Cleveland (2008), parenting in a NICU was studied and one of the themes that emerged was that mothers viewed basic needs as important to help them cope better after delivery and admission of their preterm babies. These mothers were also gratified with receiving truthful information with regards to the progress of their babies. This is confirmed by the study conducted by Lubbe (2005), in which participants expressed the need for updated information about their neonates. Participants in Lubbe's (2005) study expressed that help had been coming from other people such as HCPs and relatives, and that they had been trying to get advice from other people on what to do about the stressful condition.

In this study, the participants appreciated sharing information in a group as a form of emotional support. Participants mentioned that meeting other mothers with whom they shared the same burden of preterm delivery enabled them to cope better. They acknowledged that merely listening to the other mothers talking about their experience and about their preterm babies helped their feelings to be less tense. Some of the participants expressed that talking or listening to someone outside the neonatal unit was of great help for them to cope well after preterm delivery. However, such emotional support was mentioned as insufficient by other participants in this study. In a study by Russell et al. (2014) it was found that mothers of preterm babies coped better by communicating and receiving explanations regarding their babies' condition. They also mentioned that interpersonal relationship creation with staff as well as sensitive and emotional support, reassurance and encouragement were of additional influence on the ability of mothers of preterm babies to do well in the neonatal care unit during their baby's admission. These findings are in line with previous studies that reported that mothers' ability to gain information from HCPs and understand the condition of their babies helped them to cope with the situation of preterm delivery (Smith et al., 2012; Ward, 2001).

Most of the mothers in this study explained that when they received information about their babies from the doctors and nurses, it generally made them feel better, which creates conditions for effective coping. However, other mothers expressed a need for more information regarding their babies' health condition, as well as their duration of stay in the hospital. Thus, routine and regular health education could help inform mothers who are in the hospital with their preterm babies, and this will facilitate positive coping. This could prevent boredom in mothers and make them feel like staying with their babies while they are admitted to the neonatal care unit, unlike others who decide to stay away from their preterm babies. This could also help participants to feel safe in taking part in the care of their babies. The importance of communication is also seen in a study by Russell et al., (2014) in which mothers of preterm babies regarded the aspect of communication such as receiving of information regarding their babies wellbeing as the most important need that made them cope with the stress caused by preterm delivery. With regard to communication, participants turn to doing other things to take their minds off the stressful situation and help them think less about the stressful situation. As mentioned earlier, participants in this study informally connected to talk to other mothers to take their minds off or think less about preterm delivery by engaging in other discussions.

The theme of support received matched with use of emotional support in the Brief COPE model, which explains that participants have been receiving emotional support from others as well as receiving comfort and understanding from someone (Carver, 1997). Participants in this study received support from family members, HCPs, and fellow mothers of preterm babies in form of material, information and care of their babies, which played a great role in reducing the emotional trauma caused by preterm delivery event, hence helping them to feel better (Abdeyazdan, 2014). Even though the majority of the mothers appreciated the support

they received, some expressed that some support needs were not met as well as expressed a lack of support, as seen below.

### **5.1.2.3 Lack of support**

Support in the neonatal unit could be in the form of provision of information needs (such as education and communication), emotional needs, learning needs, discharge needs and individual needs (Bracht et al., 2013). In this current study, participants expressed a lack of and insufficient support on certain aspects which included HCPs attitudes (with regards to respect and patience) towards them and education on the care of their preterm babies.

Some of the participants mentioned that they expressed concerns about inconsistency with regards to the care given to their babies. Lack of respect from HCPs who worked in the neonatal unit was also reported by some of the participants of this study. Again participants in this study reported that HCPs demonstrated impatience with them. Impatience demonstrated by HCPs was understood when the participants mentioned that they were forced by HCPs to deliver care to their babies irrespective of unavailable resources. This causes such negative experience in participants of this study (Lindberg and Ohrling, 2008). Participants reported that they were treated differently as they mentioned that they were not given the chance to leave their baby without attention nor take a siesta sufficiently, unlike other participants who had the opportunity to do what they pleased. Some participants also reported that their babies were treated differently from other babies who were admitted in the same neonatal care unit. Other participants also mentioned that they needed more help in the process of touching and caring for their babies, hence demanding learning needs, as according to Lubbe (2005). Again in this study while some mothers mentioned that the support they received from HCPs was helpful, they also expressed that it was insufficient. Research confirmed that, without sufficient support to mothers who deliver preterm babies, these mothers may develop anxiety

and stress, which could result to not being able to hold, touch or care for their preterm babies after delivery (Kendall-Tackett, 2009). This is clear in a study by Bracht et al., (2013) whereby an education and support programme was used on mothers of preterm babies admitted and later assessed. It was found that after receiving support, mothers practically became more active in the care of their babies. They became positive towards their babies' recovery and were ready to take their babies home and take good care of them.

Therefore it is important to ensure that mothers of preterm babies remain connected with their babies in the hospital, which will facilitate their connection even when the baby is discharged (Anderzen-Carlsson et al., 2014). This connection or mother-baby bond would be possible with a collaborative support from relatives, health care professionals as well as group support as reflecting in the responses of the participants in this study.

The concepts of Lack of support were not identified to match those in the Brief COPE model. However, lack of support could result in participants demonstrating aspects of the Brief COPE model as a result of negative coping. Without support the participant could remain in denial and disbelief that they have delivered a preterm baby (Carver, 1997). Participants can also remain in frustration and unable to cope (Lindberg and Ohrling, 2008). They could turn to substance use, where they might seek relief through the use of drugs and alcohol consumption. Behavioural disengagement may also result, where the participant gives up on the situation and fails to thrive (Carver, 1997). Self-blame is another aspect on the Brief COPE model that may affect mothers of preterm babies when there is no support; here the participant keeps blaming and criticising herself (Carver, 1997). This can result in failure to achieve positive coping and good health. Support in any form is seen to be beneficial to mothers of preterm babies in order to eliminate negative coping strategies.

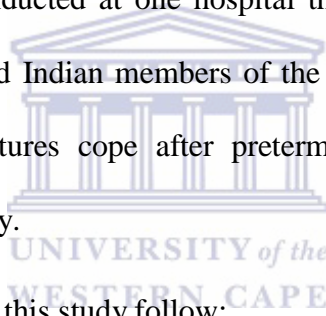
However, some of the coping strategies obtained from the sample in this research as well as the support needs expressed by the participants could not be related to the strategies of the Brief COPE model. Therefore one could mention that certain factors, such as time, place and personal preferences could determine the coping strategies used and support needs of different individuals (Seligman & Csikszentmihalyi, 2014). It was noted that attachment to their baby helped participants to cope with the preterm situation, which was not linkable to the items on the Brief COPE model. Also, with regard to support needs, lack of support as well as support requests mentioned by participants in this research could not be directly linked to the items in the Brief COPE model. These aspects could not have been identified without utilisation of a qualitative research approach of this type (Burns & Grove, 2005). Thus the Brief COPE model can be expanded by adding the themes that were obtained from this qualitative research. Also, some concepts such as active coping, planning, venting, behavioural disengagement, self-blame, humour, denial and substance use were not utilised as coping strategies by participants in this research. Participants who used drugs were not included in this study, which may be the reason for the absence of the coping strategy of substance use in this sample. This shows that participants who deliver preterm babies utilise other coping strategies; it could be deduced that different coping strategies in use might be provoked by certain situations.

It was very important that the participants in this study mentioned their support needs, so that the hospital will be able to use these expectations when new guidelines and protocols are developed. The current study followed the normal research process used when conducting a study; however, some inescapable limitations were noted and are mentioned below.

## **5.2 Limitations of the study**

This research was qualitative in nature and thus the results cannot be generalized to the entire population. Even though this research aimed only at gaining understanding of the phenomenon under study rather than aiming for generalization, an explicit description of the research site has been provided for readers of this research to be able to generalize on their own. However, some of the mothers who were interviewed were referred from a tertiary hospital, hence granting an opportunity to access mothers whose babies had been nursed in a NICU. Another limitation of the study was that information was not obtained from mothers who would have abandoned their pre-term babies

In addition, this research was conducted at one hospital that predominantly serves coloured and African rather than whites and Indian members of the population, hence missing out on learning how some races or cultures cope after preterm delivery, which could have an influence on the results of this study.



Recommendations that arise from this study follow;

## **5.3 Recommendations**

Results showed that participants have different ways in which they cope after preterm delivery. Thus HCPs need to strengthen the system to increase the effectiveness of coping and endeavor to encourage positive coping strategies in the mothers who develop preterm babies.

The results of this study also showed that the participants preferred different support needs to enable them cope with preterm delivery. Hence HCPs assigned with the responsibility to care for mothers and their preterm babies in the neonatal care unit should be knowledgeable about

these different support needs in order to ensure comfort. This will make care delivery to mothers of preterm babies approachable, with good understanding between mothers of preterm babies and HCPs. This will help to make the preterm event less stressful, and mothers will be more attached to their babies in the mother-infant bond.

The researcher suggests that neonatal unit managers constantly assess their subordinates on their attitudes towards mothers of preterm babies, perhaps by allowing the mothers of preterm babies to complete exit forms on discharge. The researcher will make an appointment to visit the neonatal unit where this research was conducted, and what was revealed by the participants' voices will be explained to the unit manager and the HCPs. This may enable HCPs to adjust in the way they manage mothers of preterm babies admitted to the neonatal care unit. Adjustment in the attitude of HCPs may provide a comfortable atmosphere to mothers of preterm babies and may boost the ability of mothers to care for their preterm babies in the most relaxing way, thereby encouraging normal baby development and growth.

It was also generally noted that coping of mothers who participated was related to the support they received from the HCPs, their relatives and partners. Therefore support to mothers of preterm babies can be continuously encouraged in order to maintain the zeal in the mothers to look after their preterm babies. This is because it will keep the mother-infant bond intact, which remains beneficial to the development and wellbeing of the babies – and especially preterm babies.

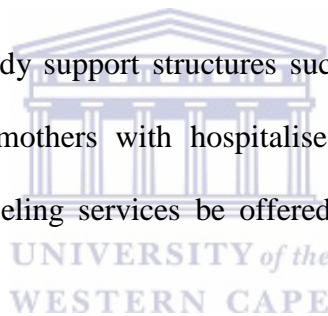
It was very interesting to find that mothers who participated in this research could verbalise how they felt and how they coped, as well as their preferred needs. However, mothers did not understand the policies under which the HCPs carried out their duties. Therefore this research suggests that HCPs should ensure relevant information and openness when educating mothers on what to expect from the neonatal care unit during admission of their preterm baby. This



will enable mothers to understand the rationale behind the policies under which the HCPs operate.

This was a qualitative study with a very small sample size of 11 participants. The research was conducted at one research site as the intention was not to generalise the results but to have a deeper understanding about the coping strategies and support needs of mothers with preterm babies at the neonatal care unit at this site. However, the researcher recommends that a larger-scale study be conducted on partners' support and on mothers who have no social support structure, for possible generalisation and policy impact, and also that the existence of new themes noted in the study be explored in the general population, in order to inform the adjustments to the COPE model.

Based on the findings of the study support structures such as counseling support from the hospital is very important for mothers with hospitalised preterm babies. Therefore this research recommends that counseling services be offered to mothers who deliver preterm babies.



Based on the results of this research, where mothers requested church activities like prayer sessions, counseling services, liberty to go to where they desire, a good sleep area. It could be mentioned that mothers who delivered preterm babies in this setting battle to acquire a restful life. Thus it could be recommended that more research be done on how hospitals help mothers of preterm babies to keep up with their spiritual status and acquire rest and calmness after delivery.

#### **5.4 Conclusion of the study**

This research was conducted aiming to yield answers to two research objectives which were based on the coping strategies and support needs of mothers of preterm babies. The manner in which women who deliver preterm babies manage their stress after delivery coupled with

what they need to mitigate their stress levels were the core interest of the researcher of this study. Premature delivery is a stressful event and demands a lot of energy from the affected individuals. Despite the small sample of this study, results indicate that there exist various strategies and support requirements to effectively manage the stressful event of preterm delivery. This study yield important information that could be considered when managing mothers who are affected by preterm delivery for better care. Ploicy makers could also use results of this study to draft guidelines or protocols governing care provided in a neonatal care unit. More research is required in this field for possible generalisation.

## **5.5 Summary of chapter five**

Aiming to understand the coping strategies of mothers of preterm babies as well as their support needs, this study used a qualitative research approach and an exploratory and descriptive design to elicit information from the participants. The findings of this study showed that mothers have various ways in which they cope after preterm delivery, and the HCPs need to strengthen the system to increase the effectiveness of such coping strategies. The results of this study also showed that participants require support in order to cope better, and that mothers have different support needs centered on their babies' wellbeing to enable them cope with preterm delivery. Hence health care professionals tasked with the responsibility of caring for mothers and their preterm babies should demonstrate a warm attitude towards these mothers. This will encourage the mothers and relieve the emotional pressure that mothers of preterm babies do experience. This will make care delivery to mothers of preterm babies more user-friendly and effective, with more understanding between the mothers and health care professionals. In this way, mothers will be more attached to their babies in the mother infant-bond, and this will enhance good care of the baby by the mother which might prevent illness and death of the baby. This chapter is the last chapter of this study and also presented the limitations and recommendations for further

study.



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### APPENDIX A - INFORMATION SHEET (ENGLISH)

**Title:** Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Intensive Care Unit in Cape Town.

You are being invited to take part in a research project conducted by student, **Delphine Sih Awah, of the University of the Western Cape**, student number: **2446108**. Please take some time to read the information below which will explain the details of this research project. Please ask any question about any part of this project that you do not fully understand. It is very important that you clearly understand what this research is about and how you could be involved. This research was approved by the Senate Research Committee of the University of the Western Cape and will be conducted according to the guidelines and principles of the international declaration of Helsinki, South African guidelines for good clinical practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

#### **What is this research about?**

This research is about: **“Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Care Unit in one hospital in Cape Town”**. You are invited to take part because you delivered a preterm baby and your baby is admitted in the neonatal intensive care unit in this hospital and thus you have been identified as a possible participant for this

research. It is important to conduct this study because; health care providers need to understand how mothers whose preterm babies are admitted in the neonatal intensive care unit cope with the situation. The researcher's best hope is that the result of this research will guide the development of appropriate care and support mechanisms for mothers of preterm babies. This will facilitate mothers' ability to cope with the stressful preterm event as well as cope with the neonatal intensive care unit environment. Your participation may bring new information that may be useful for effective management of mothers and their preterm babies in hospitals in Cape Town, South Africa. The study will be conducted in the neonatal intensive care unit in the hospital. If you decide to participate you will be interviewed by me or an interpreter in a private room during a suitable time.

#### **What will I be asked to do if I agree to participate?**

You will be asked to conduct a semi-structured interview with the researcher or the interpreter. During the interview, it will only be you, the researcher and the interpreter in the room. The interview will last about 30-40 minutes. The researcher or interpreter will ask you questions that allow you to express your feelings in your own way. The interview will only be audio-recorded after your permission. You will indicate by a tick in one of the boxes in the consent form below. The interview will include: questions on what you do in order to cope with the situation of preterm delivery and the support needs.

#### **Would my participation in this study be kept confidential?**

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, your name will not be included in the data. During the interview you will be given a number that will only be known by you, the researcher and the interpreter. The researcher will be able to link your interview to your number and no one else will have an understanding of it. To ensure your confidentiality, no information will be disclosed to anyone else without your consent. The researcher's computer has a password that is only accessible by

the researcher. If we write a report or an article about this research project, your identity will be protected. This research project involves making audio-recording of you to ensure quality documentation. The researcher and the interpreter will transcribe the recordings. All recordings and transcripts will be stored and locked up in a cupboard in the researcher's room and the recordings will be destroyed after a period of three years and after completion this research.

### **What are the benefits of this research?**

There is no direct benefit associated with taking part in this research. Your participation is voluntary and without payment to you. However, you may benefit from the opportunity to reflect on your coping experience. You will be able to recognise and interpret your ability to cope. Also you will have the opportunity to discuss the challenges you are facing as from the time your baby was born till date. You may also have the opportunity to discuss your future expectations regarding care of your baby. The results may help the researcher learn more about mothers' coping strategies after preterm delivery. It is hoped that the information gained may assist the provision of support to other mothers in your situation in the future.

### **What are the risks of this research?**

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this research. You may get tired or emotional during the interview. To prevent you from feeling tired, the interviews will be limited to 30-40 minutes. But if you require additional time to tell your story or if you want to take a break, please feel free to tell the researcher or the interpreter. If you become distressed in the course of the interview, you will be referred to the sister and doctor in charge of the ward and they will determine what further management is most appropriate. This may include referral to the social worker or psychologist attending to patients at this hospital.

### **Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is **completely voluntary**. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

### **What if I have questions?**

This research is being conducted by Delphine Sih Awah from the School of Nursing (SON) at the University of the Western Cape. If you have any questions about the research study itself, please contact Delphine Sih Awah at 8 Lopar Court, Parow Street, Parow, 7500, on 0219304048 or on [2446108@myuwc.ac.za](mailto:2446108@myuwc.ac.za). Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact

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This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: .....).





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## **APPENDIX B - INFORMATION SHEET (XHOSA)**

Isihloko: Ukuphanda nzulu ngendlela abazomeleza ngazo omama abanabantwana abazelwe ngaphambi kwexesha baze bagcinwa kwi Intensivu Unit yentsana eKapa.

Umenyiwe ukuba uzokuthatha inxaxheba koludliwano ndlebe luphandwa ngu, Delphine Sih Awah, osuka kwiDyunivesithi yephondo lwentshona koloni, inombolo yomfundi: 2446108. Nceda uthathe ixesha ufunde lemiba ilandelayo icacisa ngoluphando. Nceda ubuze xa kukho into onagiqondiyo. Kubalulekile ukuba ube unolwazi olupheleleyo malunga naludliwano ndlebe nokuba uzakuthatha yiphi inxaxheba. Oluphando luvunyelwe yi Komothi yophando yeDyunivesithi yephondo lwentshona Kolonikwaye luzakulandela imigaqo nemiqathango ye international declaration of Helsinki, imiqathango yomZantsi Afrika yokusebenza ngokukhuselekileyo kwezonyango kwakunye ne Medical Research Council (MRC) enika imiqathango ekhuselekileyo nemigaqo yokuphanda.

### **Lungantoni oluphando?**

Oluphando lumalunga nokuphanda nzulu ngendlela abazomeleza ngazo omama abanabantwana abazelwe ngaphambi kwexesha baze bagcinwa kwiIntensivu Unit yentsana eKapa. Umenyiwe ukuba uzokuthatha inxaxheba kuba uzele usana ngaphambi kwexesha elifanelekileyo ukuba luzalwe ngalo kwaye usana lwakho lugcinwe kwi intensive care unit yentsana esibhedlele ngoko ke uchongiwe njengomntu olufaneleyo oluphando. Kubalulekile ukwenza oluphando



kuba; Abo banikeza unyango bafuna ukwazi ukuba bazomeleza njani omama abazele intsana ngaphambi kwexesha zaze zagcinwa kwi intensive unit. Umnqweno womphandi ngowokuba iziphumo zoluphando zinike ithuba lokuba kwenziwe imigaqo ekhuselekileyo yokunceda abazali abazele intsana ngaphambi kwexesha zaze zagcinwa kwi intensive unit. Oluphando luzakunceda omama bakwazi ukumelana nobunzima bokufumana abantwana phambi kwexesha nokumelana nendlela ekufuneka babaphathe ngazo. Ukuthatha kwakho inxaxheba kuzakunceda ukuzisa ulwazi olutsha oluyakunceda kulomba wokumelana nobunzima komama nabantwana babo abavele phambi kwexesha eKapa, eMzantsi Afrika. Oluphando luzakwenzelwa kwi intensive care unit zentsana esibhedlele. Ukuba uzakuthatha inxaxheba udliwano ndlebe luzakwenziwa ndim okanye umntu oyitoliki ozakube ehamba kunye nam.



### **Ndizakucelwa ukuba ndenze ntoni xa ndithe ndavuma ukuthatha inxaxheba?**

Uzakucelwa ukuthatha inxaxheba kudliwano ndlebe olunemiqathango emifutshane ngumphandi okanye itoliki yakhe. Ngexesha lodliwando ndlebe izakuba ngumphandi, nawe, netoliki kwigumbi lodliwano ndlebe. Udliwano ndlebe luzakuthatha imizuzu engamashumi ama 30-40. Umphandi okanye itoliki bazakubuza imibuzo ekuvumelayo ukuba uthethe ngokukhululekileyo. Udliwanondlebe luzakucholacholwa ngonomathotholo wokucholachola indaba ngesivumelwano sakho. Uzakubonisa ngokukhetha kwibhokisi ezikwisivumelwano sokuthatha inxaxheba. Udliwando ndlebe luzakuba nezi zinto zilandelayo: imibuzo malunga nokuba wenza kanjani ukuzomeleza malunga nesimo sokuzala umntwana phambi kwexesha nenxaso oyifumanayo.

### **Ingaba ukuthabatha kwam inxaxheba koludliwano ndlebe kuyakugcinwa kuyimfihlo?**

Umphandi uyathembisa ukugcina imfihlo malunga nawe nokuthatha kwakho inxaxheba. Ukubonakalisa imfihlo, amagama akho akazukubhalwa phantsi. Ngexesha lodliwanondlebe

uzakunikwa inombolo eyaziwa nguwe nomphandi netoliki kuphela. Umphandi uzakudibanisa udliwano ndlebe phakathi kwakho naye ngenombolo yakho kuphela akekho omnye umntu ozakwaziswa. Ukuqinisekisa imfihlo akukho nanye into oyithethileyo eyakuxelwa omnye umntu ngaphandle kwemvume yakho. Ikomputha yomphandi ikhuselekile ivulwa ngenombolo eyaziwa nguye kuphela. Xa sibhala ingxelo ngoludliwano ndlebe uzakuhlala ugcinwe uyimfihlo. Ukucolachola kusetyenziswa unomathotholo kuzakunceda ukubonisa umsebenzi oyikhwalthi. Umphandi netoliki zizakubhala phantsi ngokwamazwi aqokelelwe kunomathotholo. Zonke ke ezi zibhalo zizakugcinwa zitshixelwe kwikhabhathi yomphandi kwigumbi lakhe zitshatyalaliswe emva kweminyaka emithathu elandela ukuqokunjelwa kwale projekthi.

### **Yintoni inzuzo yoluphando?**

Akukho nzuzo ozakuyifumana. Ukuthatha inxaxheba kuphuma entliziyweni yakho ngaphandle kokulindela intlawulo. Kodwa, ungafumana inzuzo yokuba uphalaze wabelane nathi malunga nokuba uzixolisa njani ngemeko omelene nayo. Uzakukwazi ukukhukmbula nokucacisa indlela ozixolisa ngayo. Uzakufumana nethuba lokwabelana nathi ngenzima obuthe wamelana nazo ngexesha umntwana wakho ezalwa ukuzakuma namhlanje. Ungakwazi nokucacisa inxaso oyilindileyo malunga nokukhulisa usana lwakho. Iziphumo zizakumnceda umphandi akwazi ukuncedisa ngenxaso enokunceda omama ekuzomelezeni kwixesha elizayo.

### **Ngowuphi umngciphekiso woluphando?**

Ukuthatha inxaxheba nokuthetha ngabantu kungabeka emngciphekisweni. Asisayi kukubeka kuwo lomngciphekiso. Ukuba uziva ukhathazekile okanye uhlukumezekile ngexesha loludliwanondlebe, ungabe kanti udiniwe ngenxa yexesha. Ukukhusela ekudinweni, udliwano ndlebe luzakuthatha kuphela amazuzu eyi 30-40. Kodwa ukuba ucela ixesha elongezelelweyo ukuba ucacise okanye ukuba uziva unqwenela ukuba uphiwe ixeshana lokuphumla unelungelo

loko ungakhululeka ukundicela okanye ucele itoliki yam. Ukuba uziva uchukumisekile emphefumleni sizakuthumela kumongikazi omkhulu okanye kugqirha apha ewadini lesibhedlele bona bazakubona ukuba bakuncede njani na ukuxolisa umphefumlo wakho. Oku kungaquka nokuba uthunyelwe kunoNtlalontle okanye ugqirha wengqondo osebenzisana nesibhedlele.

Kunyanzelekile na ukuba ndibe koluphando okanye ndingayeka phakathi na xa ndinqwenela ukuyeka?

Ukuthatha inxaxheba kwakho koluphando kuxhomekeke kuwe. Ungakhetha ukuba ungathathi nxaxheba. Ukuba ukhethe ukuthatha inxaxheba ungayeka nanini na xa uziva ufuna ukuyeka. Awuzukohlwaywa okanye ungafumani kuhoywa xa kufanele uhoyekile.

### **Kuzakwenzeka njani xa ndinemibuzo?**

Oluphando lwenziwa nguDelphine Sih Awah osuka kwisikolo sobongikazi (SON) kwiDyunivesithi yePhondo leNtshona Koloni. Ukuba unemibuzo malunga noluphando nelungelo lakho njengomntu othathe inxaxheba nxulumana noDelphine Sih Awah ku 8 Lopar Court, Parow Street, Parow, 7500, kule nombolo yomnxeba 0219304048 okanye umbhalele kule 2446108@myuwc.ac.za. Nokuba ufuna ukuxela ubunzima ohlangene nabo ngexesha loluphando nceda uqhagamshelane nomphathi wam kule dilesi ilandelayo

Prof K Jooste

Head of Department

University of the Western Cape

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Bellville 7535

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Prof José Frantz

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

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[chs-deansoffice@uwc.ac.za](mailto:chs-deansoffice@uwc.ac.za)

Oluphando luvunyelwe ukuba lwenziwe yiKhansile yeSinethi yeDyunivesithi yePhondo lweNtshona Koloni. (Nombolo yesiqinisekiso: .....).



## Appendix C: Consent Form (English)

UNIVERSITY OF THE WESTERN CAPE



Private Bag X 17, Bellville 7535, South Africa

*Tel:* +27 21-9304048 *Cell:* +27 (0)839612902

E-mail: 2446108@myuwc.ac.za

### APPENDIX E - CONSENT FORM

Language:

English

Afrikaans

Xhosa

Audio-record interview

Do not audio-record interview

**Title: Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Care Unit in one hospital in Cape Town.** The research project has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that

I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name.....

Participant's signature.....

Date.....



## Appendix D: Consent Form (Xhosa)



IDYUNIVESITHI YEPHONDO LWENTSHONA KOLONI

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9304048 Cell: +27 (0) 839612902

Email: 2446108@myuwc.ac.za

UXWEBHU LESIVUMELWANO SOKUTHATHA INXAXHEBA

Ulwimi:

- Isingesi
- Isibhulu
- IsiXhosa
- Ukuvumela udliwano-ndlebe lucholacholwe ngonomathothola wokucholachola indaba
- Ukwala ukuba udliwano-ndlebe lucholacholwe ngonomathothola wokucholachola indaba

Isihloko: Ukuphanda nzulu ngendlela abazomeleza ngazo omama abanabantwana abazelwe ngaphambi kwexesha baze bagcinwa kwi Intensivu Unit yentsana eKapa.

Oluphando lucacisiwe kum ngolwimi endiluvayo. Imibuzo yam ngoluphando iphenduliwe. Ndiyazi ukuba ukuthatha kwam inxaxheba kuzakuba nemiphumo enjani kwaye ndikhululekile ukuba ndithabathe lenxaxheba akukho nto endinyanzelayo. Ndiyayazi ukuba ukuthatha inxaxheba kwam kuyakugcinwa kuyimfihlo. Ndiyayazi ukuba ndingarhoxa ngaphandle kokunika isizathu nangaphandle koloyiko kwaye ukurhoxa kwam akusayi kubanemiphumo emibi okanye ukuphulukana noncedo.

Inombolo yomthathi nxaxheba.....

Ukutyikitya komthathi nxaxheba.....

Umhla.....

## Appendix E: Interview Guide (English)

UNIVERSITY OF THE WESTERN CAPE



Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9304048 Cell: +27 (0)839612902

E-mail: [2446108@myuwc.ac.za](mailto:2446108@myuwc.ac.za)

INFORMATION

Participant No: .....

Participant age :.....(Must be 18 years or older)

Date of interview.....



Good day Madame,

My name is Delphine Sih Awah. I am a student at the University of the Western Cape. I am doing Masters in nursing. Thank you for giving me the opportunity to interview you. I am going to start by asking you some questions about yourself then we will continue with the main interview. Please feel free to give the most accurate answers as possible. Every information you give will remain confidential.

2. How old are you?
3. Where do you stay?
4. What is your highest educational level?
5. What is your marital status?
6. How many children do you have?



7. How many times have you been pregnant?
8. How many people do you live with?
9. How old is the baby now?
10. How many weeks pregnant were you before delivery?
11. What is your denomination?
12. Do you work? If yes what kind of work?



UNIVERSITY OF THE WESTERN CAPE



Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9304048 Cell: +27 (0)839612902

E-mail: 2446108@myuwc.ac.za

Participant No: .....

Participant age :.....( Must be 18 years or older)

Date of interview.....

**Title:** Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Care Unit in one hospital in Cape Town

Researcher: Delphine Sih Awah (Student No: 2446108)

Contact details: Tel: 0219304048 email: [2446108@myuwc.ac.za](mailto:2446108@myuwc.ac.za)

The interview guide will be based on two questions and will be followed by probes

- 1. Please can you tell me what helps you to feel better with the situation of giving birth to a premature baby?*
- 2. Can you tell me what you need to help you cope better after giving birth to a premature baby who is admitted in a neonatal care unit?*

## Appendix F: Interview Guide (Xhosa)



IDYUNIVESITHI YEPHONDO LWENTSHONA KOLONI

Private Bag X 17, Bellville 7535, South Africa Tel:

+27 21-9304048 Cell: +27 (0) 839612902

Email: 2446108@myuwc.ac.za

Inombolo yomthathi nxaxheba: .....

Iminyaka yomthathi nxaxheba :.....( Kufanele ibeyiminyaka elishumi elinesibhozo(18)  
nangaphezulu)

Umhla wodliwano ndlebe.....



Molo mama,

Igama lam nguDelphine Awah. Ndingumfundi kwiDyunivesithi yePhondo lweNtshona Kolono. Ndifundela isidanga seMasters kwizifundo zoBongikazi. Ndiyabulela ngokubaundiphe elithuba lodliwano ndlebe. Ndizakuqalisa ngokubuza imibuzo malunga nawe emva koko sizakuqhubeka singene kumxholo wodliwano ndlebe. Ndicela ukhululeke ukundinika impendulo ezichanekileyo. Yonke into ondixelela yona izakugcinwa iyimfihlo.

1. Mingaphi iminyaka yakho?
2. Uhlala phi?
3. Uneliphi izinga lemfundo?
4. Ingaba utshatile okanye awutshatanga okanye ungumhlolokazi na?

5. Bangaphi abantwana onabo?
6. Mangaphi amaxesha owawukhe wakhulelwa ngawo?
7. Bangaphi abantu ohlala nabo?
8. Lunexesha elingakanani usana lwakho luzelwe?
9. Ubukhulelwe ixesha elingakanani okanye iveki ezingaphi?
10. Yeyiphi inkolo yakho?
11. Uyaphangela? Ukuba kunjalo usebenza umsebenzi onjani?





IDYUNIVESITHI YEPHONDO LWENTSHONA KOLONI

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9304048 Cell: +27 (0) 839612902

Email: 2446108@myuwc.ac.za

Inombolo yomthathi nxaxheba: .....

Iminyaka yomthathi nxaxheba :.....( Kufanele ibeyiminyaka elishumi elinesibhozo (18) nangaphezulu)

Umhla wodliwano ndlebe.....

**Isihloko:** Ukuphanda nzulu ngendlela abazomeleza ngazo omama abanabantwana abazelwe ngaphambi kwexesha baze bagcinwa Unit yentsana eKapa.

WESTERN CAPE

Umphandi: Delphine Sih Awah (Student No: 2446108)

Unxibelelwano: Tel: 0219304048 email: 2446108@myuwc.ac.za

Imiqathango yodliwano ndlebe iyakukhokelwa yimibuzo emibini eyakulandelwa kukubuzisa nzulu.

1. Wenza njani ukuzomeleza kulemeko ukuyo?

2. Ungandineda undixelele ngenxaso oyifumana kubasebenzi bale unit kuquka abongikazi, ogqirha, onontlalonle njalo-njalo?



UNIVERSITY OF THE WESTERN CAPE  
Privaatsak X 17, Bellville 7535, SOUTH AFRICA  
Tel: [+27 21-9304048](tel:+27219304048) Cell: [+27 \(0\) 839612902](tel:+270839612902)  
email: [2446108@myuwc.ac.za](mailto:2446108@myuwc.ac.za)

To Whom it may concern  
Western Cape  
Cape town

Request for permission to conduct research

Dear Sir/ Madame

I am Delphine Awah and I am doing Masters at the University of the Western Cape. My supervisor is Dr. Regis R Marie Modeste and the co-supervisor is Dr. Million Bimerew. The research I wish to conduct for my Master's thesis is about **'Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Intensive Care Unit in Cape Town'**. The purpose for this study is to explore and describe the coping strategies used by mothers whose preterm babies are admitted in a NICU in Cape Town. This study will also explore and describe the support needs of mothers of preterm babies as perceived by the mothers.

I hereby seek your permission to approach mothers who delivered preterm babies at your institution for data collection. Please find attached a copy of a synopsis and a full thesis proposal as well as copies of the consent form, the information sheet and the interview guide written in English, Xhosa and Afrikaans to be used in the process of the research. Attached is also a copy of the approval letter which I received from the University of the Western Cape (UWC) Senate Research committee. Upon completion of this study I take the responsibility to provide the Department of Health a copy of the full research report. If you require any information please do not hesitate to contact me on cell: 0839612902 or email: [2446108@myuwc.ac.za](mailto:2446108@myuwc.ac.za). Thank you for your time and consideration in this matter. I look forward to hearing from you.

Sincerely yours'

Delphine Sih Awah

Good Morning Ms Sih Awah

I would like to inform you if you have not received an answer from us, permission granted.

Kind Regards

Mallory Belelie  
PA to Dr L Naudé  
**Manager: Medical Services**  
**KARL BREMER HOSPITAL**  
**Private Bag XX1 Bellville (7530)**

Tel: [+27 21 918 1223](tel:+27219181223)

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E-mail: [mallory.belelie@westerncape.gov.za](mailto:mallory.belelie@westerncape.gov.za)

Website: [www.westerncape.gov.za](http://www.westerncape.gov.za)

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Western Cape  
Government

BETTER TOGETHER.



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WESTERN CAPE





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WESTERN CAPE

OFFICE OF THE DEAN  
DEPARTMENT OF RESEARCH DEVELOPMENT

08 September 2015

**To Whom It May Concern**

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:  
Mrs D Sih Awah (School of Nursing)

Research Project: Exploring coping strategies of mothers with preterm babies admitted in a Neonatal Intensive Care Unit in Cape Town.

Registration no: 15/6/7

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

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*