UNIVERSITY OF THE WESTERN CAPE
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# Fathers' subjective lived experiences of their partner's medically high-risk pregnancy in the Western Cape, South Africa

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## DECLARATION

I declare that *Fathers' subjective lived experiences of their partner's medically high-risk pregnancy in the Western Cape, South Africa* is my own work, and that it has not been submitted before for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

31 August 2021

Ms Pascal Richardson | Date

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## ABSTRACT

The presence of a supportive and attentive father has been shown to hold a myriad of positive health outcomes for a pregnancy, and benefits the wellbeing of the mother, child, and the father himself. Pregnancy is a key period for fathers to become invested in their children's lives. However, obstetric research continues to be largely feminised, therefore neglects the experiences of men.

Considering that existing research shows that the antenatal period is a turbulent time for men, the aim of this research was to explore fathers' subjective lived experiences of their partner's medically high-risk pregnancy. This research was qualitative and exploratory in nature. Semi-structured interviews were conducted with eight fathers whose partner had experienced at least one medically high-risk pregnancy. Ethics principles were prioritised throughout the research process. Ethics clearance to conduct this study was received from the University of the Western Cape's Biomedical Research Committee. Data collection and analysis was grounded in an interpretive phenomenological research framework. This offers a versatile research approach to understanding individuals' subjective lived experiences of specific phenomena.

From this research, it is clear that a MHRP can be a stressful and traumatic life event for fathers. Despite this, fatherhood remained ultimately fulfilling. Fathers' experiences were significantly impacted by several factors, including (a) interactions with healthcare professionals, (b) access to quality information, and (c) social support. This research highlights the importance of addressing fathers' needs during a (medically high-risk) pregnancy, as a potential means of promoting sustained positive paternal involvement.

**Keywords:** birth, fatherhood, fathers, interpretative phenomenology, medically high-risk pregnancy, men, South Africa, subjective lived experiences

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# GLOSSARY

**Antenatal:** "before birth" (Biwas, 2016, p. 336), this is known as the prenatal period.

**Caesarean section [C-section]:** "the delivery of the baby through an incision in the abdominal and uterine walls" (Biwas, 2016, p. 334).

**Full-term pregnancy:** a pregnancy lasting between 39 weeks, 0 days and 40 weeks, 6 days (Biwas, 2016).

**Instrumental support:** tangible forms of support hat individuals provide to one another, such as assistance with housework, childcare, and finances (Cohen & Syme, 1985)

**Kangaroo care:** "a technique, adopted especially with premature babies, where baby and parent have prolonged skin-to-skin contact. This is thought to provide warmth, stimulation, and to encourage the baby to breast-feed" (Biwas, 2016, p. 335).

**Labour:** "labour is a series of continuous, progressive contractions of the uterus that help the cervix dilate (open) and efface (thin). This allows the foetus to move through the birth canal" (Johns Hopkins Medicine, n.d.).

**Maternal near-miss: "**A woman who nearly died but survived a complication that occurred during pregnancy or childbirth, or within 42 days of termination of pregnancy" (Soma-Pillay et al., 2015).



**Medically high-risk pregnancy [MHRP]:** a pregnancy which has an increased risk of maternal and/or foetal mortality (Harrison et al., 2003).

**Miscarriage:** "the spontaneous loss of a foetus before 20 weeks of pregnancy" (Biwas, 2016, p. 336).

**Neonatal intensive care unit [NICU]:** hospital unit specialising in the care of sick and premature babies. Neonates are most often taken to the NICU if they are born premature or have respiratory distress syndrome, congenital abnormalities, intrapartum asphyxia, infection, or antepartum haemorrhage (Lloyd & de Witt, 2013; Noergaard et al., 2018).

**Paternal involvement:** a father's involvement in his child's life (Lamb, 2010).

**Perinatal:** "the period from the 24th week of gestation to one week following delivery" (Biwas, 2016, p. 336).

**Postnatal:** "the first six weeks after birth" (Biwas, 2016).

**Premature:** "a baby born before the 37th week of pregnancy" (Biwas, 2016, p. 336).

**Singleton:** the development of a single baby in the uterus (Biwas, 2016).

**Social support:** informational, emotional or resource support given by one person to another (Cohen & Syme, 1985).

**Stillbirth:** "the delivery of a deceased baby after the 24th week of pregnancy" (Biwas, 2016, p. 337).

**Triplets:** the simultaneous development of three babies in the uterus (Biwas, 2016).

**Twins:** "the simultaneous development of two babies in the uterus. If two eggs are fertilized independently by two sperm, dizygotic or fraternal twins result; more rarely, one fertilized egg divides to produce monozygotic or identical twins" (Biwas, 2016, p. 337).



## ACRONYMS AND ABBREVIATIONS

**COVID-19** – Severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2)

**C-section** – Caesarean section

**HCP** – Healthcare professional

**IPA –** Interpretative phenomenological analysis

**MHRP** – Medically high-risk pregnancy

**MMR –** Maternal mortality

**NICU** – Neonatal intensive care unit

**SDGs** – Sustainable Development Goals

**UWC** – University of the Western Cape

# CHAPTER ONE: INTRODUCTION

## 1.1 Background

Over the past decades, the number of fathers who actively participate in their partner's pregnancy and childbirth has been growing steadily across the globe (Ekström et al., 2013; Premberg et al., 2008; Xue et al., 2018). The presence of a positive, responsive father plays an important role in promoting the health and wellbeing of expecting women and their children, and has therefore been identified as an effective avenue for intervention to improve maternal and neonatal health outcomes (Cataudella et al., 2016; Garfield & Isacco, 2006; Noergaard et al., 2018; Morrell et al., 2003; Rollè et al., 2019; Shorey & Ang, 2019). Early experiences of a partner's pregnancy can be very formative in promoting future paternal involvement in their children's lives. This is particularly important in the South African context which has historically been represented as having a high prevalence of fatherlessness (Freeks, 2017; Richter et al., 2010). Therefore, it becomes necessary to explore fathers' experiences of their partner's pregnancy. More specifically, it is important to explore fathers' experiences of medically high-risk pregnancy (MHRP), as research demonstrates that this can be a particularly turbulent period for expectant fathers (Fenwick et al., 2012; McCain & Deatrick, 1994; Shorey & Ang, 2019).



The overarching goal of this research was to explore fathers' experiences of their partner's MHRP in South Africa. A MHRP is characterised by specific attributes that increase the mortality risk of the mother and/or the child(ren) (McCain & Deatrick, 1994). Due to the life-threatening nature of such a pregnancy, pre-existing anxiety related to the pregnancy often becomes heightened, resulting in uniquely stressful circumstances (Shorey & Ang, 2019). Fathers have a distinct point of view during their partner's pregnancy, as they are not physiologically involved in the gestational period, but are often regarded as a parent in

the making and expected to assume several supportive responsibilities during this time (Enderstein & Boonzaier, 2015). Fathers often play an influential role in the home and can therefore encourage their partner to adopt healthy habits and to seek out ante- and postnatal care (Matseke et al., 2017). To support paternal involvement, we must understand what fathers' experiences are. By doing this, we can determine how to improve their experiences of the pregnancy, in order to promote father-child bonding, as well as sustained paternal involvement in the child's life.

This chapter is structured as follows; in the first section, I contextualise fatherhood and masculinity within South Africa, as well as identify how many men in the country are fathers. Thereafter, MHRP is defined, and attempts are made to quantify it. The latter part of this chapter addresses the rationale, aims and specific objectives of this thesis, as well as provides an outline of the rest of the project.

**1.1.1 Counting fathers in South Africa.** To fully understand fathers' experiences of their partner's MHRP, their narratives must be contextualised. One distinct aspect of fatherhood studies in South Africa is the lack of coherent large-scale household surveys specifically aimed at identifying fathers – biological, legal, or social – in the country. As there are no paternity histories available, inferences about the number of fathers can be made based on information gained through other sources (Morrell et al., 2003).[1] Synthesising various statistics, Morrell and colleagues (2003) estimated that between 45–50% of South African men aged between 15–54 years are fathers. More recently, analyses indicate that in South Africa, approximately 53% of men aged between 18–59 years have fathered a child (van den Berg & Makusha, 2018). This would equate to more than nine-million men.

[1] In this paper, 'father' will be used to describe participants who are biological fathers only. However, there are various conceptualisations of what it means to be a father. "Father" ranges from biological to social and cultural understandings. A social father is presumed to be a male figure who fulfils a paternal role in an individual's life (Clowes et al., 2013; Meyer, 2017; Morrell et al., 2003; van den Berg & Makusha, 2018).

However, this statistical data must be approached with caution as it does not necessarily reflect the number of fathers accurately.

**1.1.2 Counting medically high-risk pregnancies in South Africa.** A MHRP is conceptualised as a pregnancy which has an increased risk of maternal and/or foetal mortality (Harrison et al., 2003; McCain & Deatrick, 1994; Yokote, 2007). There are various criteria that may lead to a pregnancy being classified as medically high-risk.[2] The prevalence of MHRPs in South Africa is difficult to determine as there are no governmental statistics available on the nature of a given pregnancy. Instead, to estimate the prevalence of MHRPs in South Africa, data from several sources can be analysed:

- The maternal mortality ratio [MMR] has been steadily decreasing over the decades; however, it continues to be high. Estimates for the MMR for South Africa ranges between 139.3 (Bomela, 2020) and 536 (South Africa Demographic and Health Survey [SADHS], 2016) maternal deaths per 100 000 live births.
- Research conducted in Cape Town has shown that 5.83 out of 1 000 live births were classified as having a maternal near-miss. This means that for every 100 000 live births, 583 women experience life-threatening complications, and survive (Iwuh et al., 2018).[3]
- According to a recently published meta-analysis, as many as one in four known pregnancies end in a miscarriage, with researchers suggesting that the true incidence

[2] One or more of the following criteria must be met: the mother is under the age of 18, or above the age of 35; there is presence of pre-existing medical conditions; there is a history of complications during previous birth(s); there has been a development of pregnancy-induced medical conditions (including HELPP Syndrome and Gestational Diabetes Mellitus); multiple pregnancies (e.g. twins, triplets), and unexpected birth-related complications (such as breech position, perineal tears, perinatal asphyxia, excessive bleeding and emergency Caesarean sections) (Harrison et al., 2003; Yokote, 2007). It is important to note that these criteria are not exhaustive nor mutually exclusive; several criteria may be met simultaneously.

[3] Maternal near-miss: "A woman who nearly died but survived a complication that occurred during pregnancy or childbirth, or within 42 days of termination of pregnancy" (Soma-Pillay et al., 2015).

is significantly higher, as the majority of spontaneous abortions occur within the first twelve weeks when many women are still unaware of the pregnancy (Rice, 2018).[4]

- Data indicates that the percentage of birth via C-section in South Africa increased from 16% in 1998 to 24% in 2016 (SADHS, 2016).
- A South African study reported that nearly 6% of live births lead to an admittance in the neonatal intensive care unit [NICU] (Lloyd & de Witt, 2013).

From the above statistics, it is challenging to accurately establish the number of MHRPs in South Africa, as there is a distinct lack of large-scale surveys which analyse MHRPs in their entirety. Instead, researchers are reliant on a combination of statistics, some overlapping, others mutually exclusive, which allude to the possible prevalence of MHRPs in the country. Given that institutional data shows there are more than one million recorded live births per year in South Africa (StatsSA, 2019), it is fair to assume that MHRP affects tens of thousands of pregnancies every year.



South African statistics are mostly in line with those of other developing nations, systematically trailing behind the Global North in almost all measures of maternal, foetal, and neonatal health and wellbeing. This indicates that despite improvements in antenatal care, pregnancy and childbirth continue to result in preventable life-threatening situations for both mother and child (Moodley et al., 2018).

[4] Miscarriage: "the spontaneous loss of a foetus before 20 weeks of pregnancy" (Biwas, 2016, p. 336).

## 1.2 Rationale

This research serves three functions, detailed below.

Firstly, this research contributes to the small but growing body of South African research focusing specifically on fathers' experiences with pregnancy. There is a marked paucity of literature which delves into fathers' experiences with pregnancy, particularly MHRPs. Although there are several studies that explore the experiences of a MHRP from the mother's perspective, as well as research on fathers' perspectives of a low-risk pregnancy, few studies have explored the intersection of fathers' experiences and a MHRP. Work on fathers and fatherhood, particularly in the South African context, has been characterised by its focus on negative aspects including fatherlessness/absent fatherhood (Botha & Meyer, 2019; Makofane, 2015; Ratele et al., 2012) and teenage fathers (Makhanya, 2018; Madiba & Nsiki, 2017). Simultaneously, South African research on pregnancy and childbirth has a strong focus on teenage pregnancy (Bhana et al., 2010; Jewkes et al., 2001; Mkhwanazi, 2010), HIV/AIDS (Moodley et al., 2009; Rollins et al., 2007) and foetal-alcohol syndrome (May et al., 2008; Viljoen et al., 2005). Thus, the present research addresses a gap in the existing literature.



Secondly, this research aimed to highlight lived experiences of fathers' interactions with their partner's pregnancy, as well as other interactions within the healthcare and obstetric domains. Research on their experiences may guide future interventions to assist fathers during this potentially turbulent time by providing them with social and instrumental support. Therefore, improved antenatal and neonatal interventions directed at the father have the potential to curb deficiencies in reaching the country's Millennium Development Goals 4 and 5 regarding child and maternal health and well-being (Damian et al., 2019; Republic of South Africa, 2015), as well as the maternal and neonatal mortality goals in relation to South Africa's commitment to the Sustainable Development Goals [SDGs] set out by the United

Nations (Republic of South Africa, 2019).[5] Promoting active paternal involvement in infancy and childhood requires a strong operationalisation of factors that are hindering or facilitating paternal involvement. To effectively target fathers, researchers, practitioners, and policymakers must have a clear understanding of fathers' experiences of their transition to fatherhood, and how their own socio-cultural contexts play a role in shaping those experiences, as well as the challenges that men face in these spaces. This knowledge could enable the development of practices that are supportive and contextually appropriate.

Finally, due to the paucity of research in this field, these findings will be used to create an articulated agenda for future research.


### 1.3 Aim and objectives

The overarching aim of this study was to explore the subjective lived experiences of men whose partner had a MHRP in the Western Cape. Specific research objectives include,

1. To explore emotional experiences of fathers whose partner experienced a MHRP.
2. To explore fathers' interactions with the healthcare system and HCPs.
3. To identify fathers' perceptions of receiving and providing social support.
4. To explore experiences of early fatherhood.

[5] For example, focussing on SDG target 3.1, which is to reduce global MMR to less than 70 per 100 000 live births by 2030 (World Health Organisation et al., 2019). This can be achieved by involving fathers as decision makers in supporting their partner's ability to seek out and receive antenatal and postpartum care. This can be valuable in promoting continued medical checks, addressing a concerning fact that up to 16% of South African mothers do not attend any additional check-ups following the birth of their baby, therefore increasing the chance of a preventable death (StatsSA, 2020).

## 1.4 Conclusion

This introductory chapter argues that fathers play a crucial role in their partner's and child(ren)'s lives. It is therefore important to include their voices in pregnancy-related research, and to create targeted interventions which aim to promote paternal involvement during the antenatal and postnatal periods. Thus, this research sought to explicate fathers' experiences of MHRP in the Western Cape, South Africa.

The following section will outline the structure and logic of this paper.

## 1.5 Outline of thesis

**Chapter One: Introduction**. This chapter provided an introduction and contextualisation of the present research which demonstrates the significance thereof. In this section, the research rationale, aim and specific research objectives were outlined.



**Chapter Two: Literature review.** In this chapter, relevant literature meant to further contextualise this research is reviewed. Literature is presented following a chronological progression of a pregnancy, as to highlight how experiences inform one-another. This chapter concludes by introducing and debating the chosen theoretical framework, highlighting its applicability within this research setting.

**Chapter Three: Method.** In this chapter, the methods which were employed in this study are elaborated upon. This includes discussions on the research design, sampling strategy, participants, procedures, data collection, data analysis, trustworthiness, reflexivity, and ethical considerations.

**Chapter Four: Findings.** In this chapter, findings from the interpretive phenomenological analysis of the data are presented. This chapter provides an in-depth

description of each participant's account of their experiences, arranged chronologically, starting the moment they found out about the pregnancy, and ending in infancy. This chapter alludes to various links between experiences which make up a father's overall perception of a phenomenon.

**Chapter Five: Discussion.** In this chapter, the findings are discussed with reference to the aim and objectives of the study, and the discussion is specifically orientated towards identifying common themes that thread throughout fathers' narratives. In this chapter, findings from the present study are also compared to existing literature, bringing into discussion how various factors contribute to the formation of a coherent account of their experiences.

**Chapter Six: Conclusion.** In the final chapter, the findings and discussions are summarised, and reflections on the research methods as well as the theoretical framework are presented. In addition, this chapter includes a discussion on the limitations of the study. Finally, this chapter concludes by; (i) providing practical recommendations for HCPs and healthcare facilities to improve fathers' experiences of MHRPs, and (ii) recommendations for future research.

# CHAPTER TWO: LITERATURE REVIEW

The importance of paternal involvement in pregnancy has received international recognition; however, there is a dearth of literature exploring this topic in South Africa, particularly from the fathers' perspectives.

As presented later in this chapter, this study is grounded in an interpretive phenomenological approach, thus the contextuality and nuanced moments in individuals' lives are recognised and can have a significant impact on their experience of an event. Therefore, the literature review has been structured to reflect the chronology of a pregnancy, demonstrating the delicate play between several actors and events in constructing a father's overall experience of specific moments in the pregnancy.



## 2.1 The antenatal experience

Although there is a paucity of local research on the constructions of fatherhood during the antenatal stages of their child's development, international studies have demonstrated that men's self-identification with fatherhood roles often begins to develop during pregnancy (Cataudella et al., 2016; Dheensa et al., 2013; Genesoni & Tallandini, 2009). As a result, fathers become emotionally attached to their unborn child(ren), and therefore share a sense of responsibility and commitment with the mother.

Available research on fathers and pregnancy, primarily from international sources, indicate that fathers construct pregnancy as a unique experience, characterised by mixed emotions, overwhelming moments, and a deep sense of happiness (Draper, 2002; Fenwick et al., 2012; Makusha et al., 2018). These emotions manifest in various ways throughout the pregnancy – closely intertwined with the lived realities of each father. This chapter argues

that there are clear experiential consistencies across fathers' recollections of their partner's pregnancy, each cropping up in different moments in the pregnancy. This chapter is organised to allow a chronological tale of fathers' interactions with their partner's pregnancy, following their stories from the moment they found out about the pregnancy, until early infancy.

### 2.1.1 Finding out about the pregnancy

Confirming the pregnancy typically represents the beginning of the couple's pregnancy journey. Existing research elucidates that finding out about the pregnancy is characterised by experiencing two sets of distinct emotions: shock and disbelief, as well as joy and excitement (Draper, 2002; Fenwick et al., 2012; Forsyth et al., 2011; Genesoni & Tallandini, 2009; Kowlessar et al., 2015; Swart, 2020). Participants in a quantitative study conducted by Forsyth and colleagues (2011) indicated that they experienced mixed emotions when finding out about their partner's pregnancy, with the vast majority feeling happy and excited, whilst simultaneously expressing concern and worry. Similar findings were presented in metasynthesis of literature on first-time fathers' experiences of pregnancy (Kowlessar et al., 2015). Across all the studies they examined, the authors found that although fathers reported some feelings of anxiety when first finding out about their partner's pregnancy, many of these anxieties were accompanied by some form of positive reaction, such as excitement, acceptance, and fulfilment, creating for many fathers an overwhelming set of mixed emotions (Kowlessar et al., 2015). These findings are supported elsewhere (Draper, 2002; Genesoni & Tallandini, 2009; Fenwick et al., 2012; Poh et al., 2014).

Research conducted in South Africa echoes these experiences. Makhanya (2018) interviewed nine young, unmarried fathers residing in KwaZulu-Natal. In their study,

fourteen out of fifteen pregnancies were unplanned. For some men, finding out about their partner's unexpected pregnancy was joyous, with several indicating that they always wanted to father children. However, for most, the moment was characterised by initial shock and disbelief. These negative reactions soon subsided, most taking responsibility for the unborn child.

Finding out about a partner's pregnancy is evidenced to be a moment characterised by mixed emotions – anxiety, shock, and disbelief, and joy, excitement, and fulfilment. Existing research indicates that confirming the pregnancy marks an important moment for men, with most taking responsibility, and establishing a bond with the unborn child. This is often achieved through attending ultrasounds and check-ups during the pregnancy, discussed in the following section.



### 2.1.2 Attending antenatal check-ups

Traditionally, maternal health issues, including pregnancy and childbirth, have primarily been regarded as a feminine matter. In recent years, fathers' attendance of their partner's antenatal check-ups has increased, with many fathers wanting to join the appointments (Dheensa et al., 2013; Fenwick et al., 2012). Research demonstrates that father-child attachment often sets in when the father attends antenatal check-ups, highlighting the need to further understand how the antenatal care environment can promote, or inhibit, paternal antenatal involvement (Dheensa et al., 2013; Poh et al., 2014).

A systematic review of studies on protective and risk factors associated with parent-foetus and parent-infant relationships found that the attachment and bonding with the child starts during the pregnancy, not only for the mother, but also for the father (Cataudella et al., 2016). During gestation, this attachment is unique as it is characterised by a unidirectional

cognition of, and emotional reaction to, the developing foetus. Father-foetus bonding, embodied by "subjective feelings of love for the unborn child", serves as an early response to parenthood (Cataudella et al., 2016, p. 190). Literature confirms that although fathers are not physiologically involved in the pregnancy, they continued to form strong attachments to their unborn child.

A metasynthesis of literature on men's experiences of antenatal visits, conducted by Dheensa and colleagues (2013), revealed that across studies, fathers wanted to be involved in screening, not only to support their partner, but because they regarded fatherhood responsibilities to set in prior to the birth of the child. This meant that many wanted to use the opportunity of attending antenatal appointments to find out how the pregnancy was progressing, but also to bond with their unborn child(ren). Despite a desire to attend check-ups, many fathers were unable to do so due to work commitments. In such instances, fathers were solely reliant on their partner relaying information, meaning that they did not necessarily have access to all of what was said by the HCP during the appointment. Other fathers reported that although they attended the antenatal appointments, they did not feel that they were adequately involved in the process, and therefore had feelings of being redundant. This was not only brought on by their physiological alienation from the pregnancy, but also by the mother and HCP's attention being paid to the procedure, leaving fathers feeling side-lined (Dheensa et al., 2013). Other research confirms that despite fathers' desires to be actively involved in antenatal sessions, they are often left feeling excluded from the whole process (Bäckström & Wahn, 2011; Cosson & Graham, 2012; Fenwick et al., 2012; McCain & Deatrick, 1994; Messner, 2010; Steen et al., 2012; Xue et al., 2018).

Although studies indicating feelings of exclusion experienced among fathers during the pregnancy are based on international cohorts, several inferences can be made regarding

the interactions fathers have with HCPs in the South African setting. Participants in Matseke et al. (2017) shared these sentiments of exclusion. This research was conducted with six focus groups consisting of a total of 53 men aged 26–50 years, who attended primary healthcare clinics in rural Mpumalanga. Although most fathers in the group accompanied their partner to the clinic, not all attended the actual antenatal care appointment. Those who did attributed their desire to attend to their interest in receiving information about the pregnancy directly from the HCP. In their study, many men felt that their attendance came at odds with their cultural norms, which position men firmly outside the pregnancy domain, therefore arousing fears that the community might regard them as being "bewitched" (Matseke et al., 2017, p. 224). For others, attending the antenatal appointments was practically infeasible due to the long queues at the clinic. Fathers also described the clinics as being 'unwelcoming' to fathers, highlighting that this was reinforced by the visual indication that most visitors were female. As a result, some fathers expressed that they felt out of place. Interestingly, one participant noted his desire to attend the appointment, but that he was barred from joining his partner by the healthcare facility (Matseke et al., 2017). This demonstrates an inconsistency in policy enforcement, as he was allowed to join some antenatal check-ups but not others. Other South Africa literature on men's attendance of antenatal appointments highlight that men find it increasingly important to support their partner by accompanying them to the antenatal check-ups. This attendance was not only characterised as serving to inform the men, but also as an overt sign of support to their partner (Makhanya, 2018; Swart, 2020).

From the available literature, it can be inferred that accompanying a partner to her antenatal appointments is evidence of the father's concern about the overall health and well-being of the mother and unborn baby. Research indicates that the primary source of exclusion from the pregnancy is often the healthcare staff and healthcare setting. Poor interactions with

HCPs often meant that fathers do not feel adequately informed of the pregnancy, heightening fathers' anxieties.

Antenatal checks are a potential opportunity for fathers to get involved and gain knowledge about the pregnancy and birth, encourage father-foetus bonding, and encourage fathers to become, and remain, actively involved in their child(ren)'s lives.

### 2.1.3 Support systems

A theme frequently arising in psychosocial obstetric research is support systems, classified as any informational, emotional or resource support given by one person to another (Cohen & Syme, 1985). Access to, and representation of support is a key theme in obstetric research (Xue et al., 2018); largely, it relates to informational and social support systems, discussed below.



**2.1.3.1 Receiving informational support.** Appropriate, clear information has been shown to have a significant impact on fathers' experiences of their partner's pregnancy (Boyce et al., 2007; Forsyth et al., 2011; Xue et al., 2018). As highlighted above, research indicates that fathers often feel excluded in the healthcare setting, particularly when attending the antenatal check-ups with their partner (Cosson & Graham, 2012; Fenwick et al., 2012). Research demonstrates that fathers who report poor interactions with HCPs felt more excluded, more stressed, and less supported, in comparison to their counterparts who reported satisfying interactions with HCPs (Boyce et al., 2007; Forsyth et al., 2011; Xue et al., 2018). This indicates that access to information has a significant impact on fathers' emotional well-being and ability to cope with the situation. As a result, fathers report seeking out additional information from external sources, including formal antenatal classes, friends and family, and the internet (Forsyth et al., 2011; Johansson, 2012).

In their meta-synthesis, Dheensa and colleagues (2013) found that men heavily rely on technical and statistical information, and many did their own research following consultations with HCPs. Gathering additional information served to cope with the situation, allowing fathers to feel empowered and have a sense of control. In another study, fathers highlight that they attended antenatal classes with their partner to gain a better and more practical understanding of the pregnancy and childbirth process (Cosson & Graham, 2012). However, like the fathers in Premberg and colleagues' (2008) research, many felt excluded from the antenatal classes. Similarly, research by Cosson and Graham (2012) confirmed findings from previous studies which indicate that fathers perceive parenting support programmes to be mostly designed for the mother. This maternal-focus was further embodied by the nurses who facilitate the session, with fathers indicating that they felt that the nurses regarded them as attending the sessions "under sufferance" (Cosson & Graham, 2012, p. 127).



**2.1.3.2 Receiving social support.** During a pregnancy, receiving social support can be a great asset to the expectant couple. Social support is understood as "the presence of others, or the resources provided by them, prior to, during, and following a stressful event" (Ganster & Victor, 1988, p. 17). A search of the literature has yielded mixed results on fathers' access to social support systems. Most fathers report that even if they themselves had access to support, this was still outweighed by the quality and quantity of support that their partner received (Forsyth et al., 2011; Lindberg & Engström, 2013). In other studies, fathers reported receiving satisfactory support, identifying friends and family as invaluable assets in their pregnancy experience (Enderstein & Boonzaaier, 2015; Inglis et al., 2016; Poh et al., 2014). For example, in research conducted in South Africa by Enderstein and Boonzaaier (2015), fathers reported that they received social support from family and friends and felt that mothers and other female relatives played a key role in showing support. Likewise, Poh and

colleagues (2014) found that men receive tangible and intangible support from family and friends. Receiving social support is shown to be important in mitigating stress among expectant fathers.

**2.1.3.3 Providing support.** The expectant father is widely regarded as the expecting woman's principal support system during the pregnancy, with the responsibilities often shared with other family members. The level and type of support that men can provide their expecting partner varies depending on the specific circumstances of the pregnancy, but also by the stage of the pregnancy. Studies highlight fathers' concerns and frustrations when their pregnant partner suffers from pregnancy-related, or other illnesses (Ekström et al., 2013; McCain & Deatrick, 1994). Feelings of a lack of control over the situation were also heightened for men whose partner had previously had a MHRP (Ekström et al., 2013).

Several fathers managed their sense of helplessness by opting to become actively involved in other ways. For example, across studies, fathers report that they provided instrumental support to their partner by doing household chores, assisting her physically, providing her with food that she craved, pampering her with massages and foot rubs, making attempts to gain a better understanding of her experiences, and motivating her throughout the pregnancy (Ekström et al., 2013; Fenwick et al., 2012; Makhanya, 2018; Poh et al., 2014; Swart, 2020). In a South African study, all fathers maintained that pregnant women should be supported by their partner; however, perceptions of the nature of that support varied (Matseke et al., 2017). Men considered providing instrumental and emotional support to their expecting partner to be important duties that the father had to fulfil. These supportive roles manifested as providing financial support for the mother, assisting in domestic chores, and accompanying their partner to her antenatal healthcare appointments (Matseke et al., 2017). Additionally, another South African study revealed that several unemployed fathers

supported their partner in the best way they could, by being accessible, involved, and loving (Makhanya, 2018).

Another way that men provide support to their partner is by getting involved in the preparations for the baby. A meta-synthesis of literature on men's transition into fatherhood highlighted that men often engage in activities to prepare for the arrival of their new family member (Genesoni & Tallandini, 2009). This preparation was not only mental, but also involved physically preparing the environment for the baby: decorating the nursery, buying baby necessities, making arrangements for more satisfactory living conditions, and more generally, financially preparing for the costs of raising a child (Fenwick et al., 2012; Genesoni & Tallandini, 2009; Makhanya, 2018; Swart, 2020).

Despite differences in initial reactions to the pregnancy, the news of the upcoming fatherhood represented a profound change in the men's lives, requiring changes in schedules, plans and a reconfiguration of their relationship with the mother (Ekström et al., 2013; Genesoni & Tallandini, 2009; Poh et al., 2014). Fathers noted their experiences of preparing for the arrival of the baby, practically but also emotionally. This demonstrated that fathers begin to engage with elements associated with the baby prior to the infant's birth, therefore committing time and energy into preparing for, and engaging with, the pregnancy and baby.



### 2.1.4 Experiencing pregnancy loss

There are two 'natural' types of pregnancy losses: miscarriages and stillbirths, both of which affect thousands of South Africans annually (Madhi et al., 2019; Swart, 2020).[6] Despite the prevalence of pregnancy losses, the psychosocial impact thereof is often

[6] Stillbirth: "the delivery of a deceased baby after the 24th week of pregnancy" (Biwas, 2016, p. 337).

unrecognised, particularly for the expectant father. Available research in this area demonstrates a bias to understanding women's experience of pregnancy loss, again highlighting the feminisation of pregnancy and obstetrics in general.

Research indicates that pregnancy loss can be a very traumatic experience for not only the expecting mother, but also the father (O'Leary & Thorwick, 2006; Swart, 2020; Williams et al., 2019). A systematic review conducted by Williams and colleagues (2019) demonstrated that a pregnancy loss represented an emotional and cognitively complex time for men; however, many felt that socio-cultural expectations constrained them from adequately articulating their feelings. Similar conclusions were researched by O'Leary and Thorwick (2006), who indicated that grieving men were less likely to express their emotions and were also less likely to receive meaningful socio-emotional support from family and friends. This made fathers feel excluded, and that they had no avenue through which to verbalise their grief (O'Leary & Thorwick, 2006).



Research conducted in South Africa by Swart (2020) identified the intense grief that South African men experience following their partner's stillbirth. For these fathers, the months leading up to the birth were filled with expectations, which were shattered when they were thrust into a situation from which they could not retreat. In their study, participants expressed that they did not feel that they could openly express their grief, resulting in the adoption of negative coping strategies, including avoidance strategies (Swart, 2020). For many, the indefinite postponement of managing the grief has resulted in long-term emotional difficulties. This highlights the importance of providing HCPs with information and skills to assist in managing expectant parents' grief in the event of a pregnancy loss.

## 2.2 Labour and birth experiences

Research on men's experiences of their partner's pregnancy has gained increased attention in recent years, with studies demonstrating that the presence of a positive, active father is beneficial for the mother and child, as discussed previously (Cataudella et al., 2016; Garfield & Isacco, 2006; Noergaard et al., 2018; Rollè et al., 2019; Shorey & Ang, 2019). For many fathers, the birth of their child(ren) signifies a long-awaited moment: their first opportunity to truly see and hold their baby. This moment represents an abrupt and dramatic transition into fatherhood, and many fathers have a strong desire to be present for their child's birth (Ekström et al., 2013; Genesoni & Tallandini, 2009). The role that a father plays during the birth is influenced by various factors, including socio-cultural norms, characteristics of the couple's relationship, the nature of the birth, as well as the environment within which the birth occurs. This section will highlight fathers' experience of their partner's labour and birth: characterised by mixed emotions (stress and fulfilment), influenced by their interactions with the HCPs, and moulded by how fathers navigate the NICU.



### 2.2.1 Mixed emotions

A search of available literature indicated that fathers' experience of their partner's labour and birth was characterised by mixed emotions; stress and fulfilment (Genesoni & Tallandini, 2009; Harvey & Pattison, 2012; Hugill et al., 2013; Shorey & Ang, 2019). For most, their anxieties about the potential of a life-threatening situation were combined with the excitement of a new family member.

In a qualitative study, Yokote (2007) identified that emergency birthing complications resulting in an unplanned C-section caused extreme fear and uncertainty for expectant Japanese fathers. Fathers indicated that despite consenting to the C-section, they were riddled with anxiety about the safety of their partner and/or child. Research by

Johannson (2012) demonstrates that a correlation exists between having an emergency C-section and having a less positive birth experience. This demonstrates that emergency medical interventions can result in increasing stress for fathers. Fenwick and colleagues (2012) found that fathers who had previously experienced birth complications with their partner had increased fear and frustration in their subsequent pregnancies. The impending labour and birth served as a catalyst for the re-emergence of stress related to their experiences of the previous traumatic pregnancy. Fathers described their desire for a complication-free birth, highlighting the importance they placed on their partner's and child's health and well-being. Similarly, research by Hugill et al. (2013) found that fathers experienced mixed emotions regarding birth of their child(ren). The joy of becoming a father was frequently coupled with fear and anxiety regarding the child and mother's well-being following a pre-term birth (Hugill et al., 2013).

In other studies, fathers' fears regarding the welfare of their partner and child were verbalised as a feeling of helplessness (Etheridge & Slade, 2017; Lindberg & Engström, 2013). Fathers' stresses and fears were compounded by the chaotic organisation of the emergency operating room, which fathers in Etheridge and Slade's (2017) study described as a 'rollercoaster of emotions' due to how quickly the labour and birth was progressing. This created a mixed set of emotions comprising of fear, stress, and relief.

Elmir and Schmied's (2016) meta-ethnography conducted on fathers' experiences of complicated births, found several commonalities in the ways in which fathers verbalise what they went through. One of the most prevalent themes was that of an 'unfolding crisis'. This synthesis referred to the complex emotions that accompanied birth complications. Fathers narrated their "panic" and "shock" in relation to the stressful labour process (Elmir & Schmied, 2016, p. 68). This panic was intensified when fathers received limited information about procedures, or when they struggled to understand what was happening with their

partner. For many, these fears began to dissipate after the C-section was complete and the baby was born.

For many couples, fears regarding the successful delivery of the baby change to fears for the baby's life if their child has to receive emergency medical interventions. In research conducted by Harvey and Pattison (2012), the authors highlighted that fathers were often witnesses to the neonate's resuscitation, as it typically occurs in the same room as the birth. Fathers in their study recalled that they were, "worried, distressed, petrified, panic-stricken or scared" (2012, p. F441). Fathers' recollections of their child's birth and resuscitation was vivid and imbued with descriptions of negative emotions. Research by Etheridge and Slade (2017) support previous findings which indicate that the birth can be a potentially traumatic experience for many men. This trauma was found to be motivated by poor interactions with HCPs, largely characterised by a lack of information, and being unrecognised as part of the parenting team, findings which are supported by Inglis and colleagues (2016). A further investigation into father–HCP interactions is presented in the following section.



### 2.2.2 Father-HCP interactions

Literature pertaining to fathers' experiences of labour and childbirth strongly suggests that positive interactions with HCPs contribute to a satisfactory birth experience, and vice versa (Chapman, 1991; Johansson, 2012). Despite these benefits, a number of authors have recognised patterns of miscommunication between fathers and HCPs, particularly in the event of emergency birth complications (Etheridge & Slade, 2017; Lindberg & Engström, 2013; Messner, 2010; Widarsson et al., 2015). Research by Elmir and Schmied (2016) highlights fathers' experiences of "craving information" as a result of miscommunication with HCPs (2016, p. 70). The authors found that when fathers received information from helpful and

communicative HCPs, this support was welcomed, and contributed to a reduction in their anxiety throughout the process (Elmir & Schmied, 2016). Lack of communication not only leaves fathers feeling excluded and frustrated, but also impedes their involvement in the decision-making process (Elmir & Schmied, 2016; Lindberg & Engström, 2013).

Feelings of exclusion were mitigated by having a supportive and communicative labour guide present, including nurses, a midwife, and/or other HCP (Chapman, 1991). When fathers were provided with adequate support and information, they were increasingly satisfied with their involvement in the birthing process. Overall, fathers expressed their desire for responsive and supportive HCPs, which would increase their feelings of involvement and appreciation (Lindberg & Engström, 2013). The presence of supportive staff was also found to be particularly important in the NICU environment, where parents and staff often have prolonged interactions, discussed below.



### 2.2.3 Fathers' experiences of the NICU

A growing body of literature suggests that having a neonate in the NICU can be an extremely stressful period for both parents (Hugill et al., 2013; Lindberg & Engström, 2013; Noergaard et al., 2018; Prouhet et al., 2018; Provenzi & Santoro, 2015). Research has found that parents of infants in the NICU have a high incidence of symptoms of post-traumatic stress syndrome (Lefkowitz et al., 2010; Schecter et al., 2020). Emotional distress has been shown to affect parental ability to establish a parent–child relationship, therefore acting as a barrier to bonding. It is important to consider fathers' experiences of the NICU as previous South African research reported that close to 6% of live births lead to a NICU uptake (Lloyd & de Witt, 2013).

Two factors play a key role in shaping fathers' experiences of the NICU: (1) the health of their child and (2) their experience of the NICU environment and staff (Modé et al., 2014; Prouhet et al., 2018; Provenzi & Santoro, 2015).

Research shows that the health, physical appearance of the baby, as well as the quantity (and the visual appearance) of medical equipment are factors which impact fathers' practical ability, as well as their perception of their ability to interact with the neonate (Feeley et al., 2013; Lundqvist et al., 2007; Noergaard et al., 2018; Stefana et al., 2018). Whilst spending time with their neonate in the NICU, some fathers felt insecure about being left alone with such a small and fragile baby. These insecurities are shown to be mediated by the severity of their child's condition, as well as the effectiveness and perceived support from the NICU staff (Feeley et al., 2013; Hollywood & Hollywood, 2011; Leonard & Mayers, 2008; Lindberg & Engstrom, 2013). In their research on South African parents' experiences of providing kangaroo care to their preterm neonate, Leonard and Mayers (2008) found that fathers experienced the NICU environment to be intimidating and unfamiliar.[7] In many instances, the child's medical equipment became a (physical) barrier which prevented them from holding and interacting with their new-born. Interestingly, the authors highlight how, despite their commitment to be involved, many fathers had difficulties providing kangaroo care to their neonates. Fathers expressed that their physiology (chest build and hairiness) made the kangaroo care uncomfortable. In retrospect, fathers in their study reported forming close relationships with the NICU staff, and ultimately regarded staff as informative and supportive (Leonard & Mayers, 2008).

[7] Kangaroo care, also known as 'kangaroo mother care', comprises continuous skin-to-skin contact between mother/father and infant (dressed only in a nappy and hat), exclusive or nearly exclusive breast-feeding (Leonard & Mayers, 2008).

Research points to fathers' experiences of the NICU as being closely informed by socially constructed and internalised conceptions of emotion regulation and expression in line with dominant discourses on masculinity (Hugill et al., 2013; Ireland et al., 2016; Provenzi & Santoro, 2015). For example, in a study, fathers verbalised their internal tension in controlling their emotional reactions to the situation, with one father expressing he felt unable to cry in front of the hospital staff (Hugill et al., 2013). Therefore, it may be challenging to adequately scope fathers' emotional reactions to their new-born's hospitalisation, due to socio-cultural determinants that position men as being less expressive.

Existing literature confirms that having an infant in the NICU is a stressful experience for both the mother and father of the baby (Hugill et al., 2013; Leonard & Mayers, 2008; Provenzi & Santoro, 2015). These stress levels can be mitigated through the presence of supportive and responsive NICU staff. Additionally, NICU staff play an important role in promoting parent-child interactions, often having to provide practical guidance to the couple to safely navigate the medical equipment. Feelings of inadequacy in relation to being able to take care of their neonates, coupled with a genuine fear for the welfare of their baby, as well as a desire to maintain social expectations of male emotionality, result in many fathers struggling to cope with the reality of having a hospitalised new-born. If unrecognised, this inability to manage emotional experiences may lead to serious mental health struggles (Lefkowitz et al., 2010; Schecter et al., 2020).



### 2.3 Paternal involvement

A child's homecoming typically symbolises the beginning of a man's physical integration into fatherhood, with the accompanying responsibilities manifesting in the completely dependent neonate. Historically, during the early neonatal stages, women have

been expressly responsible for taking care of the baby; however, social constructions which posit men as inferior parents to new-borns and infants are changing (Rollè et al., 2019; Shorey & Ang, 2019). Over the past decades, these changing paternal responsibilities have been theorised about, described in detail in Lamb and colleagues' (1985) seminal work, identifying paternal involvement through accessibility, engagement, and responsibility.

### 2.3.1 Paternal involvement: An overview

Research shows the presence and active engagement of a father to have a significant impact on the health and well-being of the mother and child (Noergaard et al., 2018). This positive, attentive paternal involvement during their partner's pregnancy is beneficial for the mother and child as it: reduces the length of labour, supports complication-free births, reduces the need for emergency Caesarean sections [C-section], promotes a higher birth weight, lowers the rate of placenta abruptions, decreases infant mortality and promotes the emotional well-being of the mother (Cataudella et al., 2016; Longworth et al., 2015; Xue et al., 2018).

Findings from the rapidly growing body of research on child development evidence the positive, long-term impact that an available and involved father can have on his children's lives. Positive paternal involvement has been linked to numerous positive health outcomes for infants including improved infant weight gain, improved breastfeeding, and improved neurodevelopment (Garfield & Isacco, 2006; Rollè et al., 2019; Shorey & Ang, 2019). Additionally, neonatal paternal involvement is associated with positive psychosocial outcomes for the father, such as an increase in self-efficacy, confidence, and lower levels of distress (Makusha et al., 2013).

Research demonstrates that many fathers place great importance on being a support structure for their partner and infants. This includes being attentive and empathetic, as well as adapting to new family roles and household responsibilities when the baby comes home (Chin et al., 2011; Genesoni & Tallandini, 2009; Shorey & Ang, 2019). In an analysis of the literature, Chin and colleagues (2011) found that fathers are often uncertain about how to care for the neonate, resulting in anxieties and a lack of self-confidence in their ability to parent. Likewise, another study highlighted how postnatal involvement was hampered by deficiencies in adequate information on taking care of a new-born (Johansson, 2012). Similar findings were highlighted in a meta-synthesis conducted by Shorey and Ang (2019), which highlighted that men's lack of neonatal parentcraft resulted in maternal gatekeeping, which reinforced fathers' feelings of inadequacy, and served as a barrier to paternal involvement. In their research, the authors demonstrated that fathers gain confidence in their ability to care for the baby as time progresses. However, the authors also highlight that many men continue to regard the mother as the primary caregiver (Shorey & Ang, 2019).



### 2.3.2 Paternal neonatal involvement in South Africa

Qualitative research on South African fathers' accounts of their involvement in childcare show that men report to be involved in a range of traditional and non-traditional activities. This includes intimate physical care (such as feeding and bathing), emotional engagement and play (Enderstein & Boonzaier, 2015; Hosegood & Madhavan, 2012). Through this, many fathers are challenging existing gender norms by being active and attentive caregivers.

Similar perceptions have been reported by Matseke and colleagues (2017), who found that men had mixed views regarding the appropriate level of male involvement in their

child's first few months. For some men, paternal involvement was very important, with activities ranging from domestic chores to taking care of the baby. However, some fathers highlighted that despite their interest in being actively involved, they were limited by their lack of knowledge (Matseke et al., 2017) – research findings which were also demonstrated by Shorey and Ang (2019). Other men in Matseke et al.'s (2017) research expressed that their cultural beliefs dictated that the father be uninvolved with the neonate, instead he must take active measures to avoid interaction for the first ten days. In the same vein, some men expressed that they were unwilling to take days off from work to assist their partner in caring for the neonate, explaining that caring for the baby was the responsibility of the mother, not the father (Matseke et al., 2017). This demonstrates the variability of men's perceptions of appropriate levels of paternal involvement in South Africa.



### 2.3.3 Paternity leave

Numerous studies indicate that an inability to provide support to partners and infants was exacerbated by insufficient paternity leave (Genesoni & Tallandini, 2009; Johansson, 2012; Matseke et al., 2017; Noergaard et al., 2018; Shorey & Ang, 2019; Steen et al., 2012). Limited paternity leave reinforces the exclusion of fathers from the ante- and post-natal periods. This is also evident when considering that maternal obstetric care is typically scheduled within regular work hours, thus acting as a barrier to involvement for fathers who are unable to attend ultrasounds and other check-ups (Steen et al., 2012). In South Africa, legislation only makes allowance for fathers to receive ten days of unpaid paternal leave (Republic of South Africa, 2018). In stark contrast, maternity leave generally spans up to four months for mothers. The legal minimum paternity leave may affect the home environment in the perinatal period of a MHRP, as the mother and/or child may be required to stay at the hospital or may need additional assistance when returning home. Familial responsibilities

may therefore come at odds with preapproved paternity leave, placing undue burden on the father.

## 2.4 Fatherhood and masculinity

The importance of paternity and fatherhood in the construction of masculinity in South Africa has been identified by several studies (Enderstein & Boonzaier, 2015; Hosegood & Madhavan, 2012; Makusha et al., 2013; Richter et al., 2010). Social expectations of fathering differ across time and space and are known as the 'epochs' of fathering. Presenting and defining an entire nation's constructions of masculinities and fatherhood as a singular construct would be negligent; however, the varying conceptions of South African masculinities are woven together by several shared threads. South African studies of the meanings and understandings of paternal involvement demonstrate that men harbour several perceptions of what a man's role in the household should be (Enderstein & Boonzaier, 2015; Matseke et al., 2017; Swart, 2020). Research indicates that the societal perceptions of traditional fathers and fatherhood are that of a provider and protector of the mother and child (Clowes et al., 2013; Cosson & Graham, 2012; Enderstein & Boonzaier, 2015; Meyer, 2017).

One of the most prevalent views is that fathers should bear financial and material responsibility towards their children and should feel shame if they are unable to do so (Hosegood & Madhavan, 2012). This socio-cultural value of the father as the provider does not only exist in the collective psyche of the people but has also been codified in South African law, with legislation aiming to promote paternal involvement increasing since the political and social reforms in the early-1990s (Richter et al., 2010). Changes in the

constitution promoted and protected the active involvement of the father, as well as stipulated their responsibilities towards their child (Richter et al., 2010).[8]

Parallel to legislative reforms, new conceptualisations of fatherhood and masculinity have been welcomed in the broader social ethos (Ratele et al., 2012). Fathers' involvement in the household has transformed to that of a nurturing, peaceful, affectionate and physically involved parent, becoming increasingly involved in childrearing and housework (Enderstein & Boonzaier, 2015; Makusha et al., 2013; Ratele et al., 2012). Although once feminised, taking an active interest in your children's lives is now increasingly regarded as a desirable attribute, serving as a strong indicator of a man's commitment to his family. These changes in stereotypically masculine versus feminine activities are influenced by various factors: globalisation, industrialisation, changes in the labour market, an increase in education and political and legislative reforms (Crespi & Ruspini, 2015).

A growing body of work on fatherhood in South Africa highlights how men actively try to renegotiate their identity and the expected roles of fatherhood; not only to provide financially, but to be a source of emotional and social support for their family (Enderstein & Boonzaaier, 2015; Ratele et al., 2012). Research highlighted previously has also demonstrated changes in gendered responsibilities, with several studies evidencing fathers' active involvement in their new-born's life (Enderstein & Boonzaier, 2015; Hosegood &

[8] For example, the Children's Act (No. 38 of 2005) which was implemented in line with the United Nations Convention on the Rights of the Child in 1989. This Act aims to promote the safety and wellbeing of the child, placing their interest above those of any other party involved. To achieve this, children born to married, or long-term partners are automatically placed under the legal guardianship of both biological parents. However, men who are precluded from these criteria of automatic legal paternity, such as unmarried, or short-term partners, are conferred responsibilities towards the child, such as financial provision, but no allocation for paternal rights are made. Therefore, although the father has a legal obligation to provide for his child, he does not have provisions for his rights of contact, care, and guardianship with the child in the Act. Consequently, whilst attempting to promote the interests of the child, the Act also serves as a barrier to many fathers, as they are legally required to contribute financially, but the mother is not necessarily legally required to grant him visitation. This becomes increasingly problematic as South Africa has a decrease in marriage rates (StatsSA, 2016), thus excluding much of the country's fathers from their parental rights by default.

Madhavan, 2012; Leonard & Mayers, 2008; Makusha et al., 2013; Matseke et al., 2017, Swart, 2020). This confirms that many South African fathers have a commitment to their children and are willing to ignore social norms which position them as inferior parents, particularly to new-borns and infants.

### 2.4.1 Fatherhood as transformative

For most men, becoming a father represents a transformation, requiring them to not only affirm their parentcraft, but also provoking a redefinition of their identity. Across studies, authors report that men's transition to fatherhood is accompanied by significant self-growth, often characterised as: having a newfound sense of responsibility, being more empathetic, being more sensitive to the needs of others, becoming more mature, and developing new coping strategies (Chin et al., 2011; Inglis et al., 2016; Premberg et al., 2008; Shorey & Ang, 2019; Steen et al., 2012).



For most men, the transition into fatherhood was constructed as a profound experience, with a meta-synthesis of the data showing that there is a reported overt behavioural change from being self-orientated to becoming family orientated (Shorey & Ang, 2019). This manifested as changing their lifestyle to accommodate their family, reprioritising daily activities, and recognising that their needs were to be regarded as secondary to that of their family (Etheridge & Slade, 2017; Shorey & Ang, 2019; Steen et al., 2012).

This section presented an overview of national and international literature on fathers' experiences of various aspects of their partner's pregnancy, presented in specific gestational phases, as well as masculinity and fatherhood. A review of the available literature on related topics indicated that fathers' experiences of their partner's pregnancy are characterised by mixed emotions: stress and fulfilment. Their experiences are shown to be

influenced by several factors, including interactions with HCPs, access to information and social support. Many men have a desire to be involved in the pregnancy (and childrearing) and are shown to form attachments to their children long before they are born. Men's experiences of these situations are heavily underpinned by the socio-cultural moment within which they are situated – giving them an opportunity to identify with a traditional fatherhood, or carve out a space where attentive, loving, playful paternal involvement constitutes a key part of what it means to be a 'good man'.

### 2.5. Philosophical orientation

The aim of the current research was to explore how fathers experience a MHRP, within the South African context. The goal is to understand how fathers make sense of this experience, and how meaning is created through subjective realities. Consequently, this research was situated in a qualitative paradigm, specifically, I was guided by a phenomenological framework.



Phenomenology can be conceptualised as a type of research inquiry which seeks to uncover unique human experiences associated with a particular phenomenon (Conklin, 2007; Creswell & Creswell, 2018; Tuffour, 2017). This form of research is firmly established in interpretivism and social constructivism, as it seeks to understand how people make sense of the world within which they live (Brocki & Wearden, 2006; Creswell & Creswell, 2018; Tuffour, 2017).

In phenomenology, the detailed examination of human experience requires the unearthing of an 'essence' of a lived experience. The 'essence' of an experience relates to the multifaceted and nuanced thoughts, perceptions and opinions that make a particular experience characteristically different from any other (Alase, 2017; Creswell & Creswell,

2018). The interpretation of a phenomenon is not only unique to those who have experienced it, it also represents the subjective and contextual differences between these individuals. In accordance with interpretivism and social constructivism, phenomenological orientations emphasise the multifaceted nature of reality, with each experience warranting investigation. Phenomenological research is idiographic, and is inherently grounded in a unique retrospective account of an event, provided by an individual who has experienced a particular phenomenon (Alase, 2017; Conklin, 2007; Tuffour, 2017). This highlights the inductive nature of phenomenology.

To make sense of the experiences of fathers whose partner had a MHRP, I used an interpretive phenomenological approach. This type of phenomenology is ideographic, hermeneutic and contextual, as it highlights how people interpret their own lives, and how meaning is attributed to specific life events (Alase, 2017; Conklin, 2007; Eatough & Smith, 2009; Tuffour, 2017). Interpretive phenomenology, or Heideggerian phenomenology, is distinct from the descriptive phenomenology of Husserl, as it maintains that the researcher cannot be separated from who they are as humans, and can therefore not attempt to bracket their worldviews (Alase, 2017; Porter & Robinson, 2011). Instead, I endeavoured to be continuously cognisant of, and contemplate on, my subjectivities as an individual.

Interpretive phenomenology maintains that our interpretations fundamentally mould our experiences of phenomena; from mundane daily tasks, to once-in-a-lifetime experiences (Brocki & Wearden, 2006). Therefore, interpretive phenomenology is increasingly used in healthcare related social research, since experiences of individuals' interactions with health, well-being, illness, and healthcare systems are unique (Biggerstaff & Thompson, 2008; Messner, 2010). This points to the constructed nature of health and well-being, and how a specific event, such as a MHRP, may be constructed differently among those who experience it. Furthermore, the use of interpretative phenology focuses our attention away from the

MHRP, and towards the experience thereof, therefore acknowledging the importance of experience and interpretation with regards to health (Eatough & Smith, 2009). Numerous factors are responsible for the construction of these unique experiences; including the accessibility of the healthcare environment, access to emergency services, level of risk, the parental relationship, and the presence of support structures (Biggerstaff & Thompson, 2008). These factors affect the way in which an individual makes sense of their experiences based on the socio-cultural construction of a healthy pregnancy, as well as personal feelings towards the realisation that their partner's pregnancy is high-risk.

Systematic research for evidence-based practice is essential, particularly for complex bio-psycho-social phenomena, such as a MHRP. This is illustrated by the frequent use of interpretive phenomenology in the health psychology field, with the latter making up the majority of published works using interpretive phenomenology as a framework and/or a research strategy (Brocki & Wearden, 2006). Gaining an in-depth understanding of the way different individuals interact with, and conceptualise, healthcare, provides a valuable insight into potential areas of improvement within the system.



(A discussion and exploration of the limitations of using IPA is presented in the final chapter of this thesis, see "6.3.1 Limitations").

## 2.6 Conclusion

This chapter has explored and presented literature on various aspects of fathers' experiences of, and involvement in their partner's pregnancy. Taking into consideration the complexity of factors that shape men's experiences of their partner's pregnancies, this project was aligned to an interpretive phenomenological framework, the appropriateness of which was discussed in-depth.

The next chapter will include the methods and procedures of this research project.

# CHAPTER THREE: METHODS

The methods used in this study were guided by the aims and objectives of this research. In brief, as the aim of this study was to explore the subjective lived experiences of men whose partner had a medically high-risk pregnancy, a qualitative research design was employed. Specifically, the research was guided by an interpretive phenomenological framework.

In this chapter, I discuss the research methods that were employed in conducting this study. I outline the research design, participants and sampling, research procedures, data collection, data analysis, trustworthiness, ethical considerations, and a reflexivity section.



## 3.1 Research design

The purpose of the research was to explore subjective lived experiences of a specific phenomenon. The exploratory nature of this research was facilitated using an exploratory qualitative research strategy. Exploratory research allows researchers to explore a phenomenon in a flexible and inductive manner (Biggerstaff & Thompson, 2008; Creswell & Creswell, 2018). This research strategy is suitable when there is relatively little known about the topic under investigation (Creswell & Creswell, 2018), as was true for the present research. A qualitative approach was appropriate as it recognises the subjective nature and contextuality of human experience (Conklin, 2007). Specifically, in accordance with the theoretical framework, this study used an interpretive phenomenological inquiry into the experience of MHRP from the perspective of the father.

## 3.2 Sampling and participants

**3.2.1 Inclusion criteria.** To be eligible for participation in the present study, the individual must have had a partner with whom they experienced a MHRP which resulted in at least one live birth, and the birth must have taken place in the Western Cape, South Africa. Furthermore, the participant had to meet all the following inclusion criteria: be an adult male older than 18 years; be able to give informed consent; and be able to communicate effectively in English or Afrikaans. In line with the foundations of phenomenology, the intention was to recruit a non-homogenous sample, therefore eliciting responses from a diverse group of participants (Pietkiewicz et al., 2014). Consequently, participants were not excluded from participation based on socio-demographic variables, as the purpose of this research was to explore fathers' subjective experiences, which is postulated to be unique, complex, and diverse.

**3.2.2 Sampling strategy.** In congruence with the research objectives, a purposive sampling strategy was considered the most suitable sampling method. This entails that only participants who met the inclusion criteria were included. This type of non-probability sampling is not dictated by statistical randomness; rather, participants are selected based on specific characteristics or experiences (Creswell & Creswell, 2018). This research sought to recruit at least eight fathers whose partner experienced a MHRP. This sample size was considered appropriate to suit the scope of this research (Morse, 2000; Pietkiewicz et al., 2014). Each interview yielded in-depth, complex information, thus the information power elicited was sufficient for the aims of the research. Information power refers to the relevance, depth and quality of information gained from qualitative data collection methods (Malterud et al., 2016).

**3.2.3 Description of participants.** Demographic information is summarised and presented in Table 3.1. In accordance with ethical guidelines, pseudonyms are used throughout to safeguard the anonymity of each participant.

**Table 3.1**

*Participant demographics*

| Participant, age | Pregnancy history with partner (year) |
|---|---|
| Jacob, 25† | Singleton, full-term, C-section, macrosomia[A], healthy (2015) |
| Schalk, 30* | Singleton, miscarriage (±2018)<br>Singleton, miscarriage (±2018)<br>Singleton, stillbirth (2019)<br>Singleton, full-term, vaginal, healthy (2020) |
| Ricky, 36† | Singleton, PCOS[B], miscarriage (±2019)<br>Singleton, PCOS, full-term, C-section, healthy (2020) |
| Adam, 65* | Singleton, miscarriage (±1988)<br>Singleton, full-term, vaginal, healthy (1989)<br>Singleton, miscarriage (±1991)<br>Singleton, full-term, vaginal, healthy (1992)<br>Singleton, full-term, vaginal, amnion band syndrome[C], NICU (1995) |
| Zaid, 39† | Singleton, endometriosis[D], preeclampsia[E], full-term, C-section, healthy (2008)<br>Singleton, endometriosis, preeclampsia, full-term, emergency C-section, healthy (2011) |
| Brian, 30† | Fraternal twins, full-term, C-section, healthy, one admitted to the NICU (2019) |
| Dawid, 44* | Fraternal twins, preeclampsia, 4 weeks premature, emergency C-section, NICU (2011) |
| Patton, 48† | Triplets, appendicitis[F], 14 weeks premature, emergency C-section, NICU (2011)<br>Fraternal twins, full-term, C-section, healthy (2013) |

*Note.*

* Interview conducted in Afrikaans.

† Interview conducted in English.

[A] Macrosomia describes a baby who is born larger than average, typically weighing 4000g or more at birth (Stotland et al., 2004).

[B] Polycystic ovary syndrome (PCOS) is a hormonal condition causing ovaries to enlarge and grow small cysts (Ehrman, 2005).

[C] Amnion band syndrome is a rare congenital condition occurs when strands of the amniotic sac separate and float freely in the amniotic fluid. These strands then become entangled in the digits and other extremities of the foetus, constricting blood supply and often resulting in growth disruption, deformities, and malformation of the organs. Infants suffering from amniotic band syndrome have varied prognoses, each depending on the nature and extent of the damage caused (Sing & Gorla, 2020).

[D] Endometriosis is a gynaecological condition whereby endometrial tissue (which should be inside the uterus) appears outside the uterus in the body cavity (Johns Hopkins Medicine, n.d.).

[E] Preeclampsia is a potentially fatal pregnancy complication characterised by high blood pressure, and damage to the liver and kidneys (Johns Hopkins Medicine, n.d.).

[F] Appendicitis is when an appendix becomes sore, swollen, and/or diseased (Johns Hopkins Medicine, n.d.).

As indicated in Table 3.1, the sample consisted of eight men who were interviewed individually over a secure online platform. All participants were fathers whose partner experienced a MHRP resulting in at least one live birth. The youngest father was in his mid-twenties at the time of the interview, and the oldest was in his sixties.

Between the eight participants, they had experienced a total of eighteen known pregnancies with their partner resulting in: seventeen live births (eight singleton births, three sets of twins and one set of triplets), five miscarriages and one stillbirth. Most babies were delivered via C-section, accounting for thirteen of the seventeen live births. Eight of the new-borns were admitted to the NICU, with one perinatal loss.

Please refer to Appendix A for a narrative summary of each participant's experience.



## 3.3 Data collection tools

**3.3.1 Semi-structured interview**. Qualitative research endeavours to explore complex, unique and value-laden narrative information (Creswell et al., 2007). Accordingly, interviews are the primary data collection tool for qualitative research as interviews are flexible and inductive, facilitating data collection when there is little known about the topic at hand (Englander, 2012). Therefore, to achieve my research objectives, in-depth, semi-structured interviews were conducted.

Semi-structured interviews allow a research topic to be freely explored by the participant, in conversation with myself, the researcher (Creswell et al., 2007; Creswell & Creswell, 2018; Englander, 2012). However, it also enabled me to direct the conversation to include discussions regarding themes and events pertinent to the study. Each interview was therefore guided by an interview schedule (Appendix B). This stated the primary topic of discussion, "Please tell me about your experiences of your partner's MHRP." The interview

schedule also included prompting items which could be asked to elicit more information, if necessary. The prompt questions asked about fathers' reactions to various events in the pregnancy, the fathers' interaction with the health-care system, perceptions of social support, experiences relating to the birthing process, as well as their experiences of fatherhood since the MHRP. Interviews were limited to English and Afrikaans as I am fluent in both. I chose to conduct all the interviews myself, as the process of phenomenological research emphasises the co-constructed nature of a narrative (Englander, 2012). Therefore, to maintain the trustworthiness of the research, the interviews were conducted consistently by one researcher, myself.

To elicit necessary information about a participant, and their experience of a specific phenomenon, it is essential that attention is not only given to the content of their narratives, but also to paralinguistic and non-verbal communications. These non-linguistic communications include audible changes in pitch, volume, emotion, and prosody, as well as physical communications, such as body language, posture, gestures, and facial expressions. Using appropriate conventions, these communications were noted down during the interview, and likewise included in the final interview transcripts (McLellan et al., 2003).



**3.3.2 Demographic survey**. Supplementary information regarding the demographic composition of the sample was collected through a brief structured questionnaire (Appendix C). Items included the participant's age, marital status, highest level of qualification, home language, and occupation. In addition, specific questions were included regarding previous pregnancies, other children, and a brief description of the nature of the MHRP that their partner experienced.

### 3.4 Procedures

This research project was registered at the University of the Western Cape. Ethics clearance to conduct the study was obtained from the Higher Degrees Senate, as well as the Biomedical Research Committee (BMREC) of the institution (BM20/1/16) (Appendix D).

Advertisements for the research were posted on various social media platforms, including Facebook, Instagram, Twitter, and WhatsApp, with the aim of recruiting fathers through referrals (Appendix E).

Once a father indicated that they would be interested in speaking to me, I established phone contact to explain the research more in-depth, verify eligibility, confirm interest, and set up the interview. Information sheets (Appendix F and Appendix G) and written consent forms (Appendix H and Appendix I) were emailed to all participants (in their language of choice) at least two days prior to their interview, and participants were asked to submit the signed consent forms before participating in the interview.



Due to national COVID-19 lockdown regulations (Republic of South Africa, 2020), all interviews were conducted over a secure online platform, such as Skype, MS Teams or WhatsApp, or over the telephone. Interviews were only conducted if the participants were in a private and secure environment, such as at home or at another safe space.

At the start of each interview, I engaged in polite conversation with the participant, building rapport and setting them at ease. I then highlighted key aspects about the research, including the research scope, what their participation would entail, their rights as participants, confidentiality procedures, and options for future counselling. Participants were encouraged to ask questions and asked to confirm in which language they would prefer to be interviewed. (Participants who chose to be interviewed in Afrikaans were informed of the possibility that an external translator may be used to validate the translation, to which all agreed). Finally, I

again asked fathers for explicit verbal consent to audio-record the interview, at which point I started the recording.

In line with the theoretical orientation, I used a central statement to open the discussion, "Please tell me about your experiences of your partner's MHRP." This was purposefully non-directional to allow fathers to start their story where they perceived it to begin – for most their narrations began at the point that they found out about the pregnancy. From there onwards, I relied on the participants' narrations to guide the conversations, while being cognisant of keeping the conversation on topic as far as possible. During the interview process, some fathers required more prompting than others, reflecting the difficulty with which they narrated their experience. In these instances, I relied on prompt questions to elicit more information. Once the interview reached its close, I conducted a brief demographic survey, to establish basic information on each participant, including age, marital status, and home language. Thereafter, I debriefed the participant, and answered any other remaining questions. Participants were reminded that their information letters contained contact information for reputable establishments that provide free counselling services.



In total, I interviewed eight participants, and conducted a follow-up interview with two of them. The two follow-up interviews were conducted as one interview was interrupted by the arrival of the participant's children from school, and the other participant had a work-related incident to attend to. In both instances, the interview was ended, and a follow-up was scheduled as soon as the participant was available – in both cases the follow-up interview took place within three days of the initial interview.

The interviews varied in duration, with the shortest one being half-an-hour, and the longest being close to two hours. All but two interviews were conducted over a secure online platform with two-way video streaming. This facilitated conversations by allowing myself and the participant to see each other – therefore granting me an opportunity to observe their

non-linguistic communications, such as facial expressions and gestures. The other two fathers were interviewed over the telephone, as on both occasions, we had difficulties establishing a reliable online connection.

The first step in the data analysis was to transcribe all interviews. The transcriptions were compiled verbatim, including non-verbal and para-linguistic communications (MacLean et al., 2004; McLellan et al., 2003). In total, five interviews (3 participants, 2 follow-ups) were conducted in Afrikaans, and therefore also required translation. I translated all interviews and submitted the translated scripts to a qualified Afrikaans-English translator to validate their accuracy.[9] Interviews were transcribed as soon as possible after the termination of the interview so that analysis could be undertaken prior to further data collection. This allowed me to reflect on each interview and identify areas of interest, which proved a helpful guide in enhancing the depth of subsequent interviews. This process also enabled follow-up interviews to be conducted when necessary.



### 3.5 Data analysis

The aim of the study was to elicit and analyse rich narratives of fathers' subjective lived experiences of their partner's MHRP. In accordance with this, an interpretive phenomenological analysis (IPA) technique was used to analyse and interpret findings. This analysis technique is congruent with the implementation of a Heideggerian phenomenological framework. In line with this approach, I conducted data collection and analysis simultaneously which allowed the research process to continuously evolve to better encapsulate the participants' experiences (Creswell & Creswell, 2018).

[9] The external translator signed a standard non-disclosure agreement and did not receive any information regarding the identity of the participants.

The following section provides a systematic outline of each step in the data analysis process. This promotes the trustworthiness of the analysis and interpretation. There is no single method for conducting an IPA successfully. Therefore, I used a synthesis of strategies developed by experts in the field to guide the analysis (Alas, 2017; McCormack & Joseph, 2018; Pietkiewicz et al., 2014).

**3.5.1 Immersion in the text.** To gain a sense of the entire experience as described by the participant, I listened and re-listened to the audio-recordings of each interview. This was coupled with readings of the transcripts, and in some cases, the translations. This process made me intimately familiar with the phrases, emotions, perceptions, and nuanced interpretations of each narrative. To maintain a clear record of my personal thoughts as the interviews were being analysed, I took notes of my interactions with, and reactions to, the transcripts. Once I became intimately familiar with the tone, emotion, intensity, and other para-linguistic emphases in the interviews, I analysed the interview transcripts. To create a coherent understanding of each father's experiences, the data was analysed carefully. This was facilitated, first, through a process of coding.



**3.5.2 Coding units of general meaning**. The rigorous process of deconstructing the text started by identifying 'units of general meaning'. This is a word, phrase, or any general communicative pattern that signifies a unique, coherent meaning to the listener (Alase, 2017). Initial coding strategies made use of verbatim quotes from each participant. This was done to keep the authorship of the narrative central to the participant.

**3.5.3 Clarification and synthesis of codes.** Qualitative research strategies typically produce rich and dense information. Therefore, it becomes essential to 'winnow' the text (Creswell & Creswell, 2018). This is a process by which only information pertinent to the topic under investigation was retained, whilst non-significant information was relegated. This strategy further eliminated redundant codes. This was not a prescriptive process; however,

themes were prioritised and omitted based on their importance to the participants, relevance to the research, and overall contribution to meaningful data. Identified codes were then compared to other units, and potential connections based on shared meaning was identified.

**3.5.5 Labelling themes from clustered meanings.** One of the most important processes in conducting IPA is to uncover the 'essence' of the separate clusters of meanings. The themes that make up the essence of experiences are central to the narratives of each father. During this step, identified meanings were labelled and clustered according to underlying meaning themes, which in this case was represented by several key emotional experiences.

**3.5.6 Compiling an analytic summary of each interview.** Once important themes had been identified, I returned to each transcript and created a summary of the experience. These summaries incorporated direct quotes, interpretations of the narrative, as well as identification of present themes.



**3.5.7 Contextualising and comparing interview summaries.** Each interview summary was further compared to other summaries. This comparison of narratives highlighted shared experiences common to the phenomenon under investigation. This juxtaposition also allowed contrasts to be drawn between the different experiences of fathers. Building on the contextual modifying factors that shape behaviour also promotes transferability of the research findings (Anney, 2014).

**3.5.8 Compiling a coherent narrative of the experience of MHRP as told by fathers.** Following the in-depth analysis of the raw data, findings were synthesised into an evidence-based explication of the subjective-lived experiences of a father whose partner had a MHRP. These findings are presented in Chapter 4 and Chapter 5 of this paper.

### 3.6 Trustworthiness

All research must abide to theoretical and practical guidelines regarding reliability and validity of the research concept, carried through until the final dissemination of findings. In qualitative research, this reliability and validity of the study is operationalised as the criteria of trustworthiness. The proceeding section will introduce the constructs that promote research trustworthiness, as presented in the seminal work by Lincoln and Guba (1985). This criterion is divided into four key considerations: credibility, dependability, transferability, and confirmability.

**3.6.1 Credibility.** Credibility refers to the extent to which the data and the data analysis accurately reflect the lived realities of the participants (Anney, 2014). Essentially, it encompasses the confidence in the truthfulness of the findings, resulting from an honest narrative, as well as an accurate interpretation of that narrative. There are several strategies that can be employed to promote the credibility of the research. Firstly, the research design chosen to execute the objectives of this study was congruent with the research aim, as subjective lived experiences inherently require a qualitative research approach. Secondly, credibility was promoted by familiarising myself with up-to-date literature on the given topic. As there was a paucity of research regarding this topic, it was essential to elicit as much in-depth information as I could during the interviews. Therefore, time was spend building rapport with participants by engaging in polite conversation. To promote candid accounts, I strived to demonstrate unconditional positive regard for the fathers during their interviews. Thirdly, data collection and analysis occurred simultaneously, therefore facilitating a process whereby I could return to participants and conduct a follow-up interview if necessary. In this study, a follow up interview was conducted with two fathers. Finally, research findings were submitted to be reviewed by an academic peer who also conducted a quality control check of the transcriptions; thus, increasing their familiarity with the data, and enhancing their ability

to comment on the validity of the themes identified (they also signed a non-disclosure agreement). In summary, several strategies were used to promote the credibility of my research findings.

**3.6.2 Dependability.** For research to be regarded as trustworthy, it must also yield dependable results. This refers to the "stability of the findings over time" (Anney, 2014, p. 278). Therefore, this asks whether similar conclusions would be reached under independent, but similar circumstances. To promote dependability, I kept a clear record of the sampling, data collection and analysis processes. I also provided exhaustive descriptions of the context within which the fathers' experiences occurred. This provided the findings with a contextual foundation. This is in line with the phenomenological assumptions that no single 'truth' exists; rather, reality and experience comprise of the juxtaposition of different personal, socio-cultural, and phenomena-related factors. The use of a peer review process also improved the dependability of the information, as themes were analysed within context.



**3.6.3 Transferability.** Transferability relates to the findings being rich enough to provide valuable insights into the topic being researched. These insights ought to be relatable to others who experience the similar phenomenon, within a similar context. Although it is important to generate relatable data, the nature of qualitative research necessitates that findings should be understood in relation to the contextual realities of the original narrator (Anney, 2014). Therefore, although precise transferability cannot be achieved, the value of the research also lies in the thick and detailed description of the context and the phenomenon provided by the researcher. Thus, I sought to synthesise the participants' narratives, whilst still emphasising the contextuality and uniqueness of their experiences.

**3.6.4 Confirmability.** Lastly, confirmability refers to the degree to which findings can be confirmed by others conducting similar research. This is typically evaluated by cross-referencing findings to those of other researchers. This aspect is challenging, as there is a lack

of research on this topic in South Africa. Hence, instead of comparing findings to identical studies, results were compared with findings from other research on fathers' experiences of pregnancy, pregnancy loss, medically assisted births, the NICU and early parenthood.

### 3.7 Reflexivity

The section above has demonstrated how the key aspects of trustworthiness were promoted throughout the research process. These considerations are in line with those necessary for any qualitative research. To understand the lived experiences of fathers whose partner had a MHRP, I followed an interpretive phenomenological framework. In line with a Heideggerian interpretive phenomenological approach, I, as a researcher, must have self-awareness of my own subjectivities, both as a human and as a researcher, which may influence the research process (Conklin, 2007). To stay true to this philosophical foundation, I remain committed to engaging in a process of self-reflection, starting at the research conceptualisation, and continuing until the final work is disseminated. This requires a dedication to turning inward and facilitating reflexivity. In the context of IPA, reflexivity refers to the researcher's acknowledgement and acceptance of personal assumptions, values, attitudes and biases (Biggerstaff & Thompson, 2008).



What I must make abundantly clear is that I cannot speak directly for my participants. I can only interpret and convey their life stories; but I cannot claim to have been personally affected by a MHRP. I am not a father, and by extension, I am not a male. I am a young, White woman, with a tertiary education, no husband, no children, and no life-threatening medical history. At best, I can tell you that my mother had a medically high-risk pregnancy.

The pregnancy itself progressed 'normally'. Two weeks later than the expected due date, her water broke. She and my father rushed to the hospital. After being in labour for six hours, I had still not descended into the birth canal. The obstetrician evaluated the situation, and I was finally delivered via an emergency C-section. The same complications arose when my brother was delivered three years later. Although she may not have been in a life-threatening situation, all surgeries come with risk. My father witnessed, experienced, and internalised the risk. He stood helplessly by as doctors cut her open and brought his children into the world. During this research process I realised that I have asked my mother, on numerous occasions, what her experience was, how I was born, how the surgery felt, how the scar looks, and how she feels about it. In retrospect, I have never asked my father a single question on the matter. Why should I? He was not in labour, cut open, and stitched together; he was standing in the room, just watching. This research has shown me that these assumptions about the unaffected, silent witness – the father – are completely flawed.



After completing high-school, I enrolled at university, and later pursued a research interest in women's health and well-being. My honours thesis was on women's experiences of breast cancer. It was a quantitative study, numerating each experience into a neat code. At the same time, I was involved in qualitative data collection, with the same population, for a fellow student. My conversations with the women came at a contrast to my previous interactions with them. I better understood the nuanced details of their life with cancer, whereas before I could only state that this woman or that one scored χ on a depressive symptomology scale, has χ number of family members supporting her, has χ levels of stress or χ hope for the future. Just like their hospital patient codes, I had inadvertently reduced their identity to a mere number by quantifying who they were. Keeping this in mind, I wanted my master's research to be different; I would talk to my participants, listen to their stories.

The value of qualitative research extends far beyond the human obsession with universal truths, it shows us the multifaceted details of the human experience; one which is characterised by a fiercely unique, individual experience, at the crossroads with the larger, collective structure within which we live. Qualitative research's ability to create space for the unique in the universal, and the universal in the unique, is perhaps its most important attribute; for what is the point of understanding a human devoid of context? It is this importance of context which signifies the interpretivist and constructivist foundation of interpretative phenomenological analysis. Multiple realities exist.

This became abundantly clear in my conversations with the participants. Each had a unique story to tell, yet their stories were frequently unified by similar experiences which characterised specific moments in their lives. Some fathers spoke with ease, taking over the interview, verbalising their stream of thoughts, and giving me a front row seat to some of their most traumatic, hopeless, and special moments. At several points during the various interviews, I became emotionally affected by what was being said. A dull pain ached in my chest as fathers spoke about their traumas, their losses, their pains. I left each interview with a renewed interest in the topic; previously based on my curiosity on the matter, now driven by an emotional attachment and a sense of responsibility to share each father's story.

A year into my thesis journey COVID-19 struck. A world under lockdown. Alongside profound changes in my daily life, my thesis required some methodological adaptations, detailed previously. Making major methodological changes required serious (re)considerations for the project. This created uncertainty, but ultimately reemphasised the importance of maintaining an adaptive and reflective research strategy. Although face-to-face interviewing would have been preferred for this type of research, the use of online interviews provided desirable depth of information and adhered to COVID-19 health and safety measures.

Overall, this research has been insightful and instructive. The learning opportunity presented by these in-depth interviews, combined with challenges unique to the pandemic has been instrumental in (re)affirming my interest in research psychology. My interactions with participants, and the time spent listening and relistening to their stories has made a profound impact on how I see the world and others in it, and I am truly grateful for this experience.

### 3.7 Ethical considerations

This study sought to explore the subjective lived experiences of fathers whose partner experienced a medically high-risk pregnancy. The inclusion of human participants in a research process necessitates careful consideration for the implementation and maintenance of legislation as enacted by the nation. These laws and best practices must be strictly adhered to safeguard the safety, integrity, and well-being of the participant. Thus, I endeavoured to conduct the present research in accordance with all the ethics guidelines and principles set out by the University of the Western Cape.



Permission to conduct this research was granted by the Community Health Science Faculty Research Committee, as well as the Biomedical Research Ethics Committee of the University of the Western Cape [Ethics approval: BM20/1/16, Appendix D]. Following the COVID-19 pandemic, and related health and safety legislation, a formal application for a protocol amendment was sought from the relevant ethics committee. The original research protocol proposed face-to-face interviews; however, data-collection protocols were formally amended to reflect health and safety measures set out in legislation regarding the COVID-19 pandemic (Republic of South Africa, 2020). Instead, all interviews were conducted remotely, either over the telephone or over a secure online platform.

Research only commenced once all the necessary organisational and institutional ethics approvals were obtained. In accordance with the ethical foundations of social research, I endeavoured to minimise potential harm, maximise confidentiality and anonymity, and protect the integrity of participants. The following section briefly outlines how the set out ethical guidelines were implemented.

**3.7.1 Beneficence.** Firstly, the research topic was guided by principles of beneficence. The overarching goal of the research is to contribute invaluable information about the experiences of thousands of overlooked fathers. Therefore, this research was inherently beneficent to the population.

**3.7.2 Informed consent.** Secondly, informed consent guided the inclusion of participants. Prior to the interviews, all participants received an information letter (in a language of their choosing) detailing important aspects of the research including: the purpose of the research, what their participation would entail, and what their rights were (Appendix H and Appendix I). Participants were informed that participation was strictly voluntary, and that they were free to terminate the interview without reason or prejudice. Participants were also advised about possible dissemination strategies, such as thesis publishing, conference presentations and journal articles. I explained that all personally identifying information would be altered, or omitted, thus ensuring anonymity. In addition, the anonymity of the participants was facilitated using pseudonyms. Participants were encouraged to ask questions about the research, which I answered honestly and plainly. Once satisfied, willing participants were asked to sign an informed consent letter (in a language of their choosing) which was emailed to each participant individually. This letter confirmed their consent to participate in the research and to have the interview audio recorded.

**3.7.3 Confidentiality.** Thirdly, confidentiality had to be maintained to protect the raw data elicited from the interviews. Audio recordings and soft-copies of research-related

documents were stored on my password-protected personal computer, in an encrypted file. Hard copies of the data were locked in a secure cupboard. All data will be permanently deleted, and destroyed, five years post-research. Participants were informed and accepted that due to the nature of this research, my research supervisor, Prof Michelle Andipatin, would have access to the data. I explained to the participants her role as my supervisor, and why their information may be shared with her. Participants were also informed, and agreed, that an external translator and transcriber (who has signed a non-disclosure) may be used to assist with data management.

**3.7.4 Non-maleficence.** Finally, as the purpose of this research was to explore potentially traumatic life experiences, it was essential to adhere to a principle of non-maleficence. To safeguard against psychological harm, participants were referred to free mental healthcare services. A consideration was made for the accessibility of the services in terms of cost, location, and availability. The mental health services included were Lifeline (0861 322 322), Hope House (021 522 9228), and the South African Depression and Anxiety Group (0800 456 789). Information for the mental healthcare services were included on the information sheet.



## 3.8 Conclusion

In this chapter, I provided an outline of the methodology used throughout this study. I adopted an exploratory, qualitative research design in order to meet the aims and objectives of the study. I purposively recruited eight participants for in-depth interviews, with the information elicited transcribed and analysed using an interpretive phenomenological framework. All research methods were employed in accordance with the ethics guidelines, as set out by the relevant institutions.

# CHAPTER FOUR: FINDINGS

This chapter discusses findings from the interpretative phenomenological analysis of interviews conducted with fathers whose partner experienced a MHRP in South Africa. Findings speak to the aim of this research, as well as specific objectives, including fathers' interactions with HCPs, their perceptions of receiving and providing social support, their experiences of fatherhood and the emotional experience of the entire process. In line with a phenomenological paradigm, findings are presented chronologically, sharing the fathers' experiences of each stage of the pregnancy.

The chapter is divided into three broad sections. The first section covers the antenatal stages, from conception to the onset of labour. The second section discusses experiences of labour, birth, and the NICU. The final section discusses the neonatal phase and early infancy, also highlighting how participants construct fatherhood and masculinity. Throughout this chapter many quotations are included verbatim with the intent to ground the experiences in the participants' own voices, illustrating how Schalk, Ricky, Adam, Zaid, Patton, Brian, Dawid, and Jacob made sense of their own subjective realities.



## 4.1 Antenatal period

### 4.1.1 Finding out about the pregnancy

For many fathers, the pregnancy journey officially began when they found out about the pregnancy. This marked the first official moment that the pregnancy, and their imminent fatherhood, was confirmed. In this study, most couples were either actively trying to conceive, or were not actively trying, but did have a desire to have a child (eventually). This

section tells the complex story of how different men reacted to the first time they found out that they might become fathers.

Many fathers described the moment they found out about their partner's pregnancy as being a mixed experience. Several fathers in this study wanted to become a father prior to the pregnancy, and many of them were actively trying to have a baby – therefore, for most, finding out about the pregnancy was underpinned by a sense of fulfilment and excitement. However, this excitement was frequently coupled with fear and anxiety. These mixed emotions were evident in Ricky's recollections of the moment. He and his wife were happily married and were actively trying to conceive when they found out she was expecting. He said the following,

> *I was very happy but because of the last experience, unfortunate experience, I was quite, … quite cautious about everything, quite nervous.* – Ricky

Ricky's concerns had been managed by their HCP who, after a previous miscarriage, gave the couple clearance to try conceive again. Despite his anxiety, Ricky was elated to find out about his wife's pregnancy.



Similarly, Schalk, was "*very excited*" when he discovered that his wife was pregnant again. The couple were very happy; however, Schalk explained that there was a certain degree of unease and concern regarding the pregnancy. This was undoubtedly influenced by their first pregnancy ending unsuccessfully, discussed later.

Adam mentioned how he and his wife wanted children, and how the pregnancy therefore came as a welcome surprise. The couple already had two children, and had experienced two miscarriages, but they were hopeful to welcome a third child into their home. Adam explained that for this, the couple's third pregnancy, he was less anxious than he had been for the couple's first pregnancy. Adam's emotional reaction to the pregnancy was primarily excitement, with him declaring, "*we were super excited*."

In telling his story, Zaid noted a mixed reaction when he found out about their first pregnancy while going through a separation with his wife. He said, "*I was happy and stunned at the same time*." Zaid highlighted how finding out about the pregnancy was characterised by mixed emotions. Much of the excitement and happiness was influenced by the fact that Zaid "*always wanted children*"; however, the moment was shocking since he and his wife were separated at the time. Five months after the birth of their son, Zaid and his wife found out they were expecting again. For Zaid, finding out about the second pregnancy was to a large extent similar to the previous experience. Again, Zaid and his wife were in the process of separation, with the added strain of caring for their infant son. For Zaid, finding out about his wife's pregnancies was characterised by two distinct emotions: excitement and shock.

Similarly, Patton, had "*wanted kids for ages,*" and was excited to find out that he would become a father. He explained that while on their honeymoon his wife had a positive pregnancy test, and that immediately "*we were both very excited to be pregnant*," and that he "*wanted to be part of the process*." He further recalled that they were informed very early on that his wife was expecting twins, but the HCPs cautioned that sometimes a foetus may spontaneously "*absorb*." Patton and his wife were elated to find out that they were expecting, and suddenly found themselves hoping for twins. When they returned for a follow-up appointment a few weeks later,

> *There wasn't two kids anymore, there was actually <u>three</u>. So, we went the wrong way from being absorbed. We went to doubling up and that was when they were pregnant with triplets, naturally occurring.* – Patton

Patton's hopes for twins were surpassed when the doctor indicated that his wife was pregnant with triplets; this in itself came as a surprise, as natural triplets account for a small percentage of natural conceptions.

For other fathers, finding out about their partner's pregnancy was not initially accompanied by excitement; this was found to be true for Brian and Dawid, who were both

shocked by finding out that their wives were pregnant with twins. Like some other couples, Brian and his wife were planning on having children – the "*next step*" in marriage. This again highlights the importance that the men place on becoming a father- a fulfilment of manhood. For Brian, finding out that he and his wife were expecting was not much of a surprise, nor did it come paired with negative feelings. However, the shock was associated with the fact that there were two babies, not one. Brian said, "*Jislaaik! This is crazy!*" Brian's experiences can be compared to those of Dawid, as both men found out that they were expecting twins within their first year of marriage. Dawid said,

> *It wasn't really planned. … Let me tell you, when, uhm, she, uhm, informed me, I said, 'It can't be, are you sure?' and she said, 'Yes'. … When we went for the sonar, and the doctor said there were two heads, and I asked what he meant by two heads, and he said its twins, and I said, 'Oh please,' and I laughed… It took a week to sink in, but then when it finally sank in then I said, 'Okay, right.'… So, it wasn't a disappointment or anything, it was a surprise.* – Dawid

When Dawid found out about his wife's pregnancy, he too was in disbelief. His immediate rection was, like Brian's, humorous, questioning the validity of what he had just been told by the doctor. Dawid's disbelief was also grounded in the finances needed to care for two children, saying "*this is what caring for two children will cost*," alluding to his recognition of masculine norms which place the father as the provider.

For Jacob, finding out about his girlfriend's pregnancy was very stressful as he was twenty years old, described it as "*a very, very vulnerable age*." When I asked him whether he remembered finding out about the pregnancy, after his girlfriend took an at-home pregnancy test, he recalled that,

> *I remember it as if, as if it was yesterday, uhm, it happened early in the morning, you know, the sun wasn't even out yet. … I remember her coming back from the, from the toilet, uhm, with tears in her eyes, you know, kind of, in that moment I knew that she was pregnant, and uhm, all of the uncertainty just waved, the uncertainty just hit me, seriously, from every*

> *angle. I didn't know what to do, and uhm, it was a, it was a powerful experience, a mixed experience, uhm, but a powerful one indeed.* – Jacob

The fine detail with which Jacob recalled this intense moment – one which would leave him feeling "*just lost, seriously, I was just lost*" and "*afraid,*" demonstrates the significance he attributed to it. At the time, Jacob reported a lot of "*uncertainty around financial, financial support, emotional support, all of those things you know, it was, it was a roller-coaster so to speak.*" Jacob explained that a large part of his anxiety arose from the fact that he and his young partner had to inform both their parents about the pregnancy. Although his and his partner's parents were supportive, Jacob reiterates the reality that it was challenging to approach their parents for help, and that they were fearful of stigma from the community, as it was regarded as "*really shameful*." Jacob highlighted how he tried to cope with his impending fatherhood by relying on negative coping strategies, such as substance use. He later attributed this habituation of negative coping behaviours to socio-cultural constructions of men as strong, silent, and emotionally unaffected. He stated, "*I come from a family where, you know, the expression of feelings and, you know, having certain feelings is not, is not desirable*." This demonstrates the negative impact that restrictive gender norms had on Jacob's ability to express and manage his emotions.

In this study, some fathers were immediately overjoyed when finding out about their partner's pregnancy; however, all reported some feelings of unease, anxiety, or uncertainty. For Adam, Schalk, Ricky, this unease was influenced by a cautious fear of another pregnancy loss; for Dawid, Brian and Patton, this stress was induced by finding out that their partner was expecting multiple babies; while for Jacob and Zaid, the shock was compounded by the unexpected nature of the pregnancy combined with an unstable homelife. The clarity with which fathers were able to articulate the moment they found out about the pregnancy is demonstrative of the significance that fathers attribute to this event. This signified the official

start of the pregnancy, indicating to many of the men that their acceptance of fatherhood and involvement in antenatal care was to begin.

### 4.1.2 Attending antenatal check-ups

One of the key indicators of good commitment to maternal and foetal health are the attendance of regular antenatal check-ups at recognised and reputable healthcare facilities. Although obstetric spaces are often feminised, all fathers in this study reported having joined the antenatal appointments, with some expressing that they attended every antenatal check-up. Men's desire to accompany their partner to antenatal care reflects a commitment to the health and well-being of their partner and unborn child. Therefore, it becomes important to understand how fathers experience the healthcare system and HCPs, which also serves as a prime setting to motivate continuous learning and paternal involvement in the pregnancy and infancy. This section presents fathers' experiences of antenatal care; broadly divided into those who were satisfied with the care they received, and those who reported that not all their needs were met. Fathers' recollections of the quality of the healthcare services varied significantly, largely demonstrating differences between care received at public versus private hospitals.



Fathers were mostly satisfied with the healthcare they received from private facilities. For example, Schalk explained that he attended every antenatal check and ultrasound for all his wife's pregnancies. He described that their HCP was very informative and that she spent time briefing the couple on the risks of having another miscarriage, as well as preventative measures which could be taken to promote a healthy pregnancy. Ricky was also happy with the quality of healthcare service provision that he and his wife experienced at their private hospital, stating that they received "*excellent moral support from the doctors*."

Ricky and his wife had a close relationship with their HCP which further enabled Ricky to feel comfortable in attending antenatal checks.

Brian maintained a similar stance as Ricky towards his HCPs. Brian and his wife decided to use the same HCP that his wife's sister had used, which meant that the doctor already had a good rapport with the family. Brian explained that their HCP provided them with thorough, accurate information about what to expect while expecting twins, as he was the father of twins himself. Brian said, the HCP "*gave us good information about where to go. [The HCP] gave [my wife] good information on what to eat, gave us some solutions for the nausea*." Throughout the interview, Brian spoke fondly of their HCP. Also, being a twin father meant that Brian was able to relate to him, and he was able to give 'insider' tips.

For Zaid, joining his wife to the antenatal checks at their local private hospital was important, not only to support her, but for his own engagement and attachment to the unborn baby. He stated that,

> *That's a part of me, in her! I also want to see! I don't know why men don't get involved in that. Some people just send their wives or partners, 'You go its fine!' I wanna see the scan! I wanna hear the heartbeat!* – Zaid

During the couple's second pregnancy, Zaid's enthusiasm for hearing the baby's heartbeat and seeing the scan was met with enthusiasm from the doctor, who actively encouraged him (and other fathers) to be involved. Their HCP's active efforts to involve Zaid in the entire process was well received. Zaid further explained that he never felt excluded during the antenatal check-ups for their second pregnancy, and that his entire experience was very positive. From these fathers, it is clear that supportive and informative HCPs impact their approach to the pregnancy, pushing them to become even more involved. Fathers recalled specific instances where HCPs provided guidance and practical solutions to pregnancy-related pains, nausea, and other ailments. Not all fathers had such positive experiences with their HCPs. The next section tells their stories.

For some fathers the quality of care they received did not meet their needs. This was true for three fathers, Zaid, Dawid and Jacob, all of whom made use of public healthcare facilities.

When the couple were expecting their first child, Zaid and his wife made use of a public healthcare facility. I asked Zaid whether the HCP spoke to them about labour, birth, and birth complications. He said,

> *They would ask, 'Are you planning to have normal birth or Caesarean?' and they would, if you say 'normal birth' they would always just say, 'Look in the event of an emergency you need to also think of that it could turn into a Caesarean, uhm, so you need to come to terms with that as well, and what would be required in the sense of after a Caesarean you have to attend to the stitches.' What you'd need to do, how to clean, etcetera. But nothing in-depth, just like a 'by the way'.* – Zaid

Here, Zaid highlights an interesting trend in birthing, where, in South Africa, women are afforded the choice of whether to deliver vaginally or through a C-section. Given the prevalence of C-sections, I asked Zaid whether the HCPs provided them with adequate information on their options, and the implications of each. He responded as follows,

> *With the state facility it was available to you, but they wouldn't offer it, it's basically, 'There's all the pamphlets you can see it, use it, don't use it, it's up to you.' But they wouldn't point you in that direction.* – Zaid

Overall, Zaid had a mixed experience with HCPs during his wife's two pregnancies. With his first child they used the public healthcare system, reporting that although staff were informative, there was more that could be done. With their second pregnancy, Zaid and his family moved to private healthcare. He explained the difference in experience, "*I just feel difference in- let's call it customer service…it's like from going to Shoprite to Woolworths. It just- it was two different experiences*." Zaid's words sum up the dissimilarities in experience between public and private healthcare systems in South Africa.

Dawid experienced a similar lack of support from his experience at a public hospital. Dawid's wife's pregnancy with the twins was challenging from day one. One of the twins was persistently less developed than the other. Clear while talking about this, Dawid was emotional, plainly still affected by the lingering fears that he experienced for the welfare of the babies. Compounding the stress of the health of his family was the fact that he experienced the HCPs to be unsupportive, he said, "*They weren't supportive*." He provided an example of how the HCPs acted towards them when their daughter continued to stay underdeveloped. He expressed that,

> *At one stage they went as far as to ask [my wife], 'Do you smoke, or do you drink? Because it is those types of things that lead to the baby's underdevelopment and everything,' and we said that we don't do these types of things. … It was more of an accusation. … And I would say it happened every single time we went for the sonar, then they would say that things haven't improved, and uhm, accuse us!* – Dawid

Clear from his choice of words and tone during the conversation, Dawid was very frustrated with the HCPs during the pregnancy. HCPs were perceived as unsupportive which caused further distress. Owing to poor patterns of communication, Dawid and his wife did not feel that they received adequate information from their HCPs regarding a twin pregnancy.

Jacob's experience echoes that of Dawid, where he also explained that their experience of the public healthcare system was poor as there was a definite lack of information transfer from the HCPs to the couple. Jacob explained that during the third trimester,

> *The doctors placed her immediately, uhm, under high-risk and we didn't, we didn't exactly understand it. … We didn't really understand what it means so that why we thought, I formulated my own perception and uhm, and we immediately thought uhm, you know, this was something that was going to take my girlfriend as well as my unborn child away, uhm, and obviously that thought, that perception, was very, very, anxiety provoking.* – Jacob

Jacob highlights how when they found that the pregnancy was classified as high-risk in the third trimester, he and his partner were uninformed about the nature and consequences of this classification. This meant that the couple were left to form their own opinions, which was based off what little they knew about pregnancy – resulting in heightened anxiety. This demonstrates the impact that accurate and realistic information can have on a couple's experience of a pregnancy – suggesting that it is important for practitioners to ensure that patients leave the facility with adequate information and an understanding of the diagnosis. A lack of understanding meant that Jacob became gravely concerned for the welfare of his partner and his baby, asserting, "*The perception of high-risk, you know, to me at the time, it was like death you know*." Jacob further described this experience as "*very, very daunting and very anxiety provoking*." When I asked him about his experience of the HCPs at public facilities he said,

> *Public hospitals were very, very inundated with patients, sick people and you know it's only normal so to say, to sort of just like move through the system very quickly, and we just saw a doctor and the doctor told us that uhm, that she was going to place us under the high-risk, and what that essentially means is that, that my partner will have to receive a C-section and, and that's that, no pamphlets, no extra information really.* – Jacob

Jacobs' description of his experience of the HCPs at the public facility closely resembles that of Dawid. In both instances, interactions with HCPs were regarded as inadequate, particularly when it came to providing expectant couples with additional information to further increase their understanding of the pregnancy.

For many, the intense anxiety that the pregnancy caused was greatly impacted by a lack of realistic information and adequate understanding of the pregnancy complication. What became clear in fathers' discussions of joining their partner to her antenatal check-ups was that it was regarded as important. Fathers were satisfied with the antenatal care process to various degrees, which largely maps out to the use of private versus public healthcare

facilities. This demonstrates that HCPs are a vital source of information and support, and should therefore use their influence to encourage continuous, active paternal involvement.

### 4.1.3 Getting informed

This section details fathers' reported sources of information. During the interviews, it became clear that fathers relied on various sources of information to improve their understanding of their partner's pregnancy. In this research, three fathers attended at least one antenatal class, one father attended a once-off information session, and the others did not attend any sessions. Nearly all fathers relied on the internet for guidance; however, several cautioned about the use of the internet.

**4.1.3.1 Antenatal classes.** During our conversations I asked all the fathers whether they, or their partner, attended any antenatal classes. Overall, four fathers attended formal antenatal classes with their partner, while the rest did not, and nor did their partner. First-time-father Ricky recalled having attended several antenatal classes at a private hospital alongside his wife. He said the classes gave them "*a bit clearer idea about C-section and normal birth*." Interestingly, although Ricky and his wife were planning on having a natural birth, the antenatal classes they attended also educated parents on the procedures and risks involved in a C-section – which the couple ultimately ended up having. I asked Ricky whether their HCP recommended that they take classes, or if they did it of their own accord. Ricky stated he and his wife asked their HCP for information on antenatal classes, and that a specific midwife was then recommended. Similarly, Schalk and his wife attended a few antenatal classes, and were satisfied with the information they received.

Dawid also explained that he and his wife went to antenatal classes. They attended approximately six or seven classes but were limited in choice as they could only attend a few

free classes offered by a local private hospital. He explained that although they attended antenatal classes, the sessions were mostly directed at the mothers, and he was one of very few men who attended the sessions. Moreover, Dawid recalled that the content of the sessions was inadequate and did not suit their needs as parents expecting twins. Overall, despite being informative, Dawid and his wife required additional information to understand what their pregnancy would entail.

In contrast, several fathers decided not to attend formal antenatal classes. When Zaid and his wife were expecting their first child, they did not attend any antenatal classes. However, for their second child, they went to a private hospital for their antenatal care. He said that the private hospital hosted various antenatal classes, but that he and his wife decided not to attend, as they felt adequately prepared for what lay ahead. Zaid explained that the hospital also recommended that couples attend a once-off information session, which they did. Zaid remembered the session as being "*boring*"; however, he concluded by stating that it was "*informative*." Zaid later pointed out that had they been recommended to attend such an information session during their first pregnancy, they would have.

Like Zaid, when asked about attending antenatal classes, Brian said, "*I think that was offered, but no, we just didn't do it*." Comparably, Adam and his wife did not attend any classes. This was attributed to the fact that they had already had two children and were therefore able to draw on previous experience. Finally, neither Patton nor Jacob attended any formal antenatal classes.

In contrast to the other fathers, Jacob made extensive use of community resources in providing them with helpful information about the pregnancy. He said,

> *All the classes, the prenatal classes, that we needed was found by the women in our community, they provided us with all the necessary information that we needed in order to get through the pregnancy.* – Jacob

For Jacob, women in the community became a key resource for assisting and informing the young couple through the pregnancy. Therefore, although Jacob did not have access to formal antenatal classes, the couple received guidance elsewhere.

Some couples went to antenatal classes, one of which were not satisfied with the information they received, as the session was centred on a singleton birth – not on multiples. In addition, the tone of the session was orientated towards the mother, leaving the father somewhat excluded. Other fathers explained that they chose not to attend antenatal classes. In two instances this was because the participant had already been a father and was familiar with what to expect. What became clear in their conversations, was that fathers relied heavily on another source of information – the internet.

**4.1.3.2 The internet.** Six fathers confirmed that they conducted Google searches to gather more information about the pregnancy. Out of this, five stated that the additional information was beneficial, helping them gain a better understanding of what lay ahead. One participant averred that the sheer amount of information available from the internet was ultimately not beneficial, highlighting that it created anxieties, which is the same reason given by another father for not having googled at all. Finally, one father (Adam) had limited access to the internet as his wife's MHRP occurred in 1995.



Dawid and his wife attended antenatal classes, but these did not cater to their specific needs. Thus, David sought guidance from the internet. Dawid said that he used Google searches extensively, and said, "*If it wasn't for Google, I wouldn't have known about others' experiences with twins*."

Like Dawid, first-time father Zaid also turned to the internet for information. He explained,

> *I used to google video clips on normal birth and things like that. Yeah, just to- because I didn't want to be one of those daddies that fainted. So, I wanted to be prepared and know what I am going to be seeing and, wow!* – Zaid

The internet proved to be an important resource for Zaid, informing him about pregnancy, and what to expect during labour and birth. This highlights that Zaid was preparing for the birth of his children months before. The quote above is also demonstrative of masculinity norms held by Zaid, revealing that fainting at the birth is un-masculine, and therefore undesirable.

Despite some fathers reporting that the additional information gained from the internet helped to improve their understanding of the pregnancy, birth and what lay ahead, other fathers felt different. Ricky and his wife also used Google to gather more information about the pregnancy, stating, "*I did my research myself*." He cautioned that,

> *There are lots of information, and, uhm, if you go through everything you have to google, but you have to control yourself you have to be rational at the same time. Which is scientific, which is not.* – Ricky

Here, Ricky pointed to the fact that men should use the internet, and all its resources, with caution, as you can be overwhelmed and misled by some of the information. Jacob's words echoed that of Ricky, who also cautioned against an overreliance on the internet. Jacob explained that he used Google to get more information about the pregnancy, and what a high-risk pregnancy entailed. He explained, "*It felt like doing the extra research and getting all the daunting information sort of increased my anxiety*." Schalk felt similar, and therefore did not Google anything himself, and advised me that it is best to ignore everything else and focus on what your HCP says. He stated the following,

> *People are looking for answers. … 'Google says this, Google said that.' Google is a very dangerous thing. Anything that you Google, comes up. So, I would strongly advise not to do it. … Stay with one doctor, ask one person, and let people support you morally, but don't Google.* – Schalk

Schalk spoke harshly of the sheer volume and contradictions in information available online. He cautioned against seeking too many sources of information, and instead suggested that fathers rely on their HCP for information.

Gaining information was important for all fathers. Many fathers attended formal antenatal classes, while others relied on the internet and community resources. Due to the volume and nature of online resources, gaining information from an educated/experienced person was valued, however, this was not always possible for couples who relied on public healthcare facilities.

### 4.1.4 Receiving social support

Throughout our conversations, fathers spoke of receiving varying types of social support. Many fathers verbalised receiving overt social support from family and friends. For Dawid, his primary source of support, other than his wife, was from her parents, his in-laws, with whom they were residing during the pregnancy. Dawid said his in-laws reached out to other couples who had twins and asked them for information and guidance regarding twin pregnancies and twin parenthood. In this way, Dawid's in-laws were able to fulfil an instrumental function in gathering realistic information for the couple, compensating for the couple's strained interactions with the HCPs. His in-laws' support continued to play an important role in Dawid's life during the first years of their children's lives, as he explained that they would counsel and motivate Dawid when he became "*very morbid or stressed*." During our conversation, Dawid spoke of his parents in-law with much reverence, verbalising, "*I love them a lot, we have a very good relationship*."

Similar to Dawid, Jacob was also living with his parents when his partner became pregnant. As highlighted earlier, Jacob felt a sense of shame when his girlfriend became

pregnant as they were both were newly out of high school. He said, "*I was really nervous, you know, we planned to run away… the pressure was, was, it was too much*." Although they feared telling their parents, the couple were welcomed with open arms. He stated that,

> *I actually feel kind of, uhm, kind of grateful at this time just to say this, my mom and our parents was sort of like our anchors during the stormy waters. You know, uhm, we, we, we draw a lot of support from them, so my counselling came from my parents.* – Jacob

Jacob's figurative depiction of his parents and in-laws as "*anchors*" highlights that he felt that they kept him from becoming overwhelmed with the situation, and that "*it gave us a sense that you are not going through this alone*." Jacob described his parents and in-laws as his main sources of support outside his partner.

Other fathers described that although they felt supported, this support was implied, and not explicit. Ricky mentioned that he felt that his "*family and friends were very supportive*," however, he clarified that this support was not necessarily overt. He said,

> *All the family or friends goes directly to the wife…. It happens but I can understand that. I can understand that silent sympathy or silent something support that is with me. I can feel that.* – Ricky



Similarly, Schalk explained that he received social support from his family, however, not all of it would be explicit. He noted, "*If there were ten family members, five would ask me how I was and the other five won't*." This was also verbalised by Zaid who said, "*Nobody really asks the male partner, 'are you coping?' Because I am the man, I am supposed to be okay with everything*." He further made his point by drawing on socio-cultural constructions of manhood,

> *It's not that people don't care it's more like a society thing, 'We don't need to ask you; we need to ask <u>her</u>! <u>She's</u> the one carrying the child, she's basically the oven so we need to watch that the oven is fine, the temperature and everything is okay.' But the person turning the knob it's just like, you doing you, just stand one side we talking to her now. … You didn't think much of the fact that nobody is asking you, it's the norm.* – Zaid

Not receiving overt social support was not described by Zaid as problematic, as this need did not arise due to an emotional suppression by socio-cultural constructions of strong, stoic masculinity. Brian verbalised similar thoughts,

> *I'm not like the one who, like, I didn't need the support. No, no, no, no, I didn't need the support. It wasn't, it wasn't important for me to have that support. My support is me and I was busy supporting [my wife]. And that was but yes, I did have support. I had my mother, and I had my parents and my brother. My whole family was behind us. Everyone was there. But uhm then I didn't feel like I needed it, I didn't feel excluded at all. No, not at all. I think. I think everyone. No, and maybe I just had it and I didn't realise it, now I'm saying I don't need it, but it was there, if makes sense.* – Brian

Brian begins by stating that he did not rely on support from others, but that it was available. However, as he reflected, he realised that explicit reliance on social support was not a prerequisite for confirming that the available support benefited him. The sheer presence of support structures may sometimes play a supportive function in itself.



### 4.1.5 Supporting your wife

Many participants spoke in-depth about their experiences supporting their partners during the pregnancy. This was primarily related to providing emotional and instrumental support throughout the pregnancy. For example, Dawid spoke about his close relationship with his wife, and how they were each other's primary source of support, particularly during her pregnancy. He said,

> *We depended on one another. Look, she is my wife, that's my children, my family, you know, so I remember every night [my wife] laid down, then she had terrible backpain, then I had to smear her back, and I had to massage her back, you know, because the two children were heavy, and you could feel them lay and kick.* – Dawid

Dawid explained that his wife became increasingly uncomfortable as the pregnancy progressed, saying, "*She wanted to cry, you know, because of the pain*." He further

recollected how she struggled with nausea and vomiting, affirming, "*I helped to clean up… because it was very close to my heart. As I said, it's my family. … It is my duty*." Dawid's recollection of providing his wife with support highlights how important it was for him to promote the health (and comfort) of his wife, and unborn children. He expressed this involvement as being a "*duty*," clearly indicating his perception of fatherhood beginning long before the birth of a child.

Brian's experience was like Dawid's; both their wives were expecting twins and struggling with persistent nausea. Throughout the pregnancy Brian was in tune with the recommendations that their obstetrician made, assisting in efforts to promote the health of his wife and the babies by giving her specific foods and smoothies. However, due to his wife's nausea, she struggled to take in the nutrients that Brian was so desperately trying to give her. He said the following of experiencing a sense of helplessness and frustration,

> *Me as a father, I'm doing this to help you, to help the babies. And I can't help you if you don't keep it down to help the baby. So that was the, not stressful part, but the most concerning part.* – Brian



Ultimately, Brian's wife became so ill that she was admitted to hospital twice for dehydration. This whole experience made Brian starkly aware of the challenges of a multiple pregnancy.

Zaid's description of his wife's sickness is like that of Dawid's and Brian's. Zaid supported his wife through her pregnancy, trying to get her as healthy and comfortable as possible. During this time, Zaid also supported his wife emotionally. He said the following of supporting his wife during her pregnancies,

> *Don't listen to react, listen to understand what she's saying because we tend to react first. … She's maybe tired, she vomiting whole day, she's got pains and she just wants to offload that on you but you also come with your own work stress or whatever stress you had before coming in that door to meet her for the first time the evening. You need to understand, you need to be*

> *there for her as well. Listen, you don't need to respond first, listen take a breather take a step back and then say, 'Okay I understand what you saying, let's try it this way, let's do this, let me do the dishes, let me make supper, you just relax.' Kind of thing. It's about working hand-in-hand. People always say it's about communication, but you need to understand first.* – Zaid

In his advice to expectant fathers, Zaid continuously emphasised the importance of understanding and being available to your partner. This includes emotional availability, as well as providing instrumental support by, for example, taking responsibility of household chores. Schalk noted that although his wife was not experiencing any serious conditions during her pregnancy, they adapted their household roles, and he became more involved in housework. Similarly, Ricky stated that he would help her when asked, but that his wife wanted to keep busy.

Patton told of how his wife also continued her daily activities, including daily commutes to work. Patton recalled how his wife had a scare when she was three or four months pregnant, noticing spotting. At the time, Patton was overseas to attend a wedding. He received a call from his wife, but he was "*hungover*" from the night before, and therefore was not able to provide her with the emotional support that she needed. He stated, "*I was the world's worst husband basically at that point*." Upon reflection Patton confessed that he handled the situation poorly and should have been there; a *good husband* would have been. Not considering the impact that his wife's active lifestyle was having on the pregnancy, as well as the inherent complexities and challenges associated with multiple pregnancies, the couple were finally shocked into understanding the immense risk associated with this pregnancy when she was diagnosed with acute appendicitis. Patton recalled that,

> *At one point it was mentioned that none of them might come out of surgery, that there was a fifty-fifty chance that only she would come out of surgery, and so that was pretty hectic.* – Patton

Patton's wife's surgery was completed successfully; she and all three babies were in a stable condition. The way Patton described the experience of waiting during his wife's surgery indicates feelings of frustration, concern, and helplessness. He was unable to contribute to the situation, the fate of his family lay in the hands of strangers. He later described the situation by saying, "*It made me worry, made me felt useless, there's nothing I could do about it*." This final statement encapsulated what many fathers experienced when their wife or partner were sick: being unable to adequately assist their partner in alleviating the ills, many fathers felt powerless.

Like Patton, Jacob also recalled being unavailable to his pregnant partner during the early stages of the pregnancy. He stated, "*I was always trying to avoid these feelings, and not try to, and not trying to work through [them],*" and that the situation was ultimately "*very anxiety provoking*." In hindsight, he asserted that,

> *I probably should have handled that better. You know, the way I handled it was through partying, three, four nights a week, you know, that that kind of thing. I wasn't really there to support, and, and sort of like empathise with her. I was really selfish at that time, uhm, with my emotions.* – Jacob

Fathers spoke extensively of providing emotional and instrumental support to their expecting partner. This often manifested as taking care of household chores and providing backrubs and massages. Few fathers verbalised that they felt they were emotional unavailable or that they felt they should have been more attentive at the time. This was attributed to their inability to adequately cope with their own emotional states.

### 4.1.6 Preparing for the baby's arrival

In addition, attending antenatal classes and doing research, couples began to prepare for the baby's arrival in different ways; including buying baby items, preparing a baby room,

saving up money, and making lifestyle changes to promote the health and well-being of the mother and child.

Jacob reported that throughout the beginning of his partner's pregnancy, he struggled to come to terms with his future as a father and explained that there was an "*uncertainty regarding whether I can take care of a child*." He further described that finding out about the baby's sex was a pivotal moment in cementing the reality that he was becoming a father – prompting him to engage more keenly in preparing for the baby.

> *There was just a sort of unreality regarding, uhm, regarding the pregnancy. Uhm, it wasn't real, it simply wasn't real, it didn't exist for me psychologically but, but when I, when we went, when we went to the uhm, to the ultrasound, to the doctor for the ultrasound to find out the sex of the baby that's when it dawned on me, like you are going to be a parent now, it's getting real now. Now you have to pull up your socks and you have to prepare.* – Jacob

Jacob said that he, his partner, and their parents "*bought a lot of baby stuff and you know, tried as much to save up for, for, uhm, medical, medical care for the baby and everything*." Similarly, Zaid and his wife started "*stockpiling on the wet wipes, nappies, the different types of nappies just in case they end up having a rash*." Likewise, Ricky and his wife were also preparing for the baby. He stated,

> *Luckily, we had some uhm baby shower, by ourselves before lockdown so we had quite a good kit. Yeah, so most of the essentials are with us, then after, then from May onwards I am able to buy some of the stuff, most of the essential items.* – Ricky

Here Ricky highlighted that he and his wife were gifted baby items from their baby shower, and that they were well stocked before the birth of their child. Ricky's ability to purchase additional baby items was hampered by national lockdown regulations which came

into effect in March 2020 (Republic of South Africa, 2020).[10] Schalk and his partner were similarly affected by the lockdown regulations on consumer goods; however, they purchased and were gifted plenty of baby items prior to lockdown.

In this study, most families began preparing for the arrival of the baby months in advance. This typically involved readying the baby room as well as purchasing clothing, diapers, toiletries, and toys. For many, the act of readying the space represented a tangible commitment to the child, a build-up of anticipation for the new family member coming home. Unfortunately, not all pregnancies resulted in a live birth.

### 4.1.7 Experiencing a pregnancy loss

One of the conditions for a pregnancy to be classified as high-risk is a previous pregnancy loss, either classified as a miscarriage or a stillbirth. In this study, three fathers – Adam, Ricky, and Schalk – each experienced at least one pregnancy loss. All three men's wives experienced at least one miscarriage, and Schalk's wife also had a stillbirth. This section highlights how the fathers reacted to their loss in two different ways.

Adam, whose wife had two miscarriages, one before the birth of their first child, and one after it, described the situation by stating, "*It wasn't so terrible, we could, uhm, process it and it didn't stop us from trying again*." He explained that both miscarriages occurred very early in the pregnancy, and although they were not unaffected, they were able to work

[10] The first government gazette detailing lockdown regulations following the COVID-19 pandemic did not provide explicit detail pertaining to the sale of infant and toddler items, leading to a nationwide cease of sales for such items (excluding baby food, which was permitted under the broad exemption for food, and items such as nappies and wipes, which were exempt under the broad category of hygiene items) (Republic of South Africa, 2020). Therefore, no baby clothing, furniture, toys, and similar products were on sale, resulting in a nationwide outcry over the inaccessibility to essential infant and toddler products.

through their emotions and try to fall pregnant again. Similarly, Schalk explained that his wife's first two pregnancies ended in a spontaneous miscarriage, but as disappointing as it was, it was not described as being traumatic, unlike the couple's third pregnancy, detailed later.

In juxtaposition, when Ricky's wife had a miscarriage in the first three months of pregnancy, it was challenging for him to come to terms with it. Finding out that the pregnancy was miscarried was described as "*traumatic*." Ricky mentioned that there were no real explanations for the spontaneous abortion, but that the HCPs were supportive, he stated, "*We are in trauma of course and at that time they supported us a lot and they explained everything*." Ricky again described their HCPs as being very supportive, not only providing them with information, but also encouragement. In addition, Ricky referred to the fact that he was able to discuss his experiences with a friend, as well as his brother-in-law, both of whom had also experienced a miscarriage with their partner. This support was later described as aiding in helping to manage his feelings of loss – again highlighting the importance of social support in fathers' experiences of their partner's pregnancy.



Schalk and his wife's third pregnancy ended with a stillbirth. During the sixth month of pregnancy, she went into labour on the highway and the couple raced to the nearest hospital thirty kilometres away where "*she gave birth to our son, our first son, but he didn't make it*." Schalk poignantly said, "*You held him. He was dead in your hands. It was very, very traumatic*." Schalk explained that,

> *Until this day no one knows why he came early. Sometimes in life there just is no answer for everything and it is important that parents accept this.* – Schalk

Schalk's assertion that people should stop seeking answers for everything echoes what he had previously said about guarding oneself from information overload. He previously described Google, and speaking to too many people, as harmful, again reflected in

the above statement. He summed up his experience quite simply as follows, "*It's just very sensitive, because you have lost your first child*." This shows that Schalk already identified his fatherhood during the pregnancy. For Schalk, losing his first child was traumatic. He reflected that,

> *My personality type is one of burying something, to be strong and be strong for my wife and this, the psychologists expect, will manifest itself later and that I would then struggle. … Actually, I'm having flashbacks already. –* Schalk

Several times during the conversation, Schalk mentioned that "*men are very proud and hard-headed, so they prefer to be strong*," and that "*they don't want to talk about it*." This is indicative of deep gendered values that inform Schalk's experience of the loss of his first child, but also highlights the growth that he experienced, identifying that men who suppress these strong emotions "*really struggle*" later in their lives. Schalk reiterated that,

> *Everyone thinks you are special, or it happens only to you, but if someone just says it's okay and some days it feels like it, then you think you're just going to give up, it is okay. In other words, talk about it, discuss it, rather get help earlier then later. You need not struggle with it. The rest of your life lies ahead of you.* – Schalk

Schalk explained that he and his wife were able to discuss their grief with another couple who had experienced a similar loss during the same time. This social support was invaluable in making him realise that they did not have to suffer alone. Schalk finally stated, "*It wasn't easy, was never easy for anybody, it only gets better*."

Conversations with Adam, Ricky and Schalk about their experiences of their partner's pregnancy loss highlights how diverse men's experiences can be.

## 4.2 Labour and birth

Most fathers characterised their experience of their partner's labour and birth as being anxiety-provoking, climaxing with a huge sigh of relief once the birth was over. For many fathers this symbolised the end of their partner's difficult pregnancy and the start of a happy, healthy life, yet for others, further challenges lay ahead as they had to take care of medically vulnerable babies.

### 4.2.1 Labour and birth

Most of the participants' wives gave birth through C-section, which, as a medical procedure, comes with inherent risks (and accompanying stress). In addition, the conditions under which the birth took place made an impact, with emergency birth evoking additional fears. For some fathers, their experience of their child(ren)'s births were overwhelmingly positive. Schalk described how his wife's labour progressed. As a result of their previous pregnancy losses, Schalk explained that "*the gynae[cologist] managed our expectations from about 30 weeks*," therefore the couple felt well-informed of the different ways in which the labour could progress. He further explained that,

> *We gave birth in a COVID ward – which was not pleasant at all – but my wife gave birth naturally, inside of half an hour. Thus, our experience was amazing.* – Schalk

When I asked Schalk what his first reaction was following the birth, he said, "*I was very glad, I was relieved and excited*." Schalk further explained that the medical team was "*Very, very good. They calmed us down. Which was very good*." Overall Schalk had an "*amazing*" experience. Despite occurring during a pandemic, the couple was satisfied with the quality of care they received at the hospital, which increased the couple's satisfaction with the birth experience.

Like Schalk, Ricky and his wife were planning to deliver naturally during the lockdown. They had spoken to their HCP about this decision, and she agreed that this would be a safe course of action. A week before the due date, Ricky accompanied his wife to their HCP. During the check-up, the doctor identified that the baby's amniotic fluid was low and suggested they perform a C-section immediately. Ricky and his wife agreed, and within two to three hours, his wife was taken in for the procedure. Ricky explained, "*At that time my full concern was with my wife and she very brave*" and that they "*were just positively thinking about the new member is coming*." Ricky described how their entire birth experience was enhanced by the high quality of care they received from the HCPs. He stated, "*We have a good faith in these doctor[s] and [they] explained everything beforehand*." This open and trusting relationship with the HCPs mitigated the couple's stress levels, as they felt assured that they were in capable hands.

In comparison to the short time that elapsed between Ricky finding out about the upcoming birth and the birth itself, Zaid's wife went into long labour, spending an entire weekend waiting for the labour to progress. He narrated the start of labour of his first child,

> *It was a Friday evening she was feeling the labour pains, rushed to the hospital. They said, 'No she hasn't dilated enough, you need to come back in four hours.' Did that, second time around they told us again 'not dilated enough come back in four hours.' I even got to a point to ask, 'How do I check if she's dilated enough? Because I don't know what I'm looking for,' and all they told me was, 'Just come back after four hours.' I'm like, 'But we driving up and down, it's– it's frustrating can't we just stay here?' Like, 'Nope, no beds available,' and it's a public hospital, that time I never had medical aid. It was quite frustrating. … It was Sunday evening up until late afternoon when I told them, 'Look I'm not leaving here quite a few times whether I stay here or sit in the car the whole time I'm not leaving cause this is now becoming ridiculous.'* – Zaid

The length of the labour, as well as the couple's experience of the public healthcare system, left them frustrated and seeking a solution. Zaid explained that on the Monday, the HCPs decided to deliver the baby via a C-section. Zaid further described how shocking it was

to witness his wife receiving an epidural. He recalled the procedure as being more "*aggressive*" than he expected. Although Zaid had prepared for attending the birth, he was not prepared for how his firstborn's birth was about to unfold. He communicated the following,

> *The doctor still said, 'Don't look yet.' Because they had the veil up and I was like, 'Okay cool I'm going to record the baby coming out' because I had my phone and a camera with me. Uhm but me being me and curious, because I could see how her body is shaking I looked over the veil, and I actually saw how they did the cut and I just froze with the cameras both standing there and frozen just staring how they doing it and how they pulling him out of her body.* – Zaid

Zaid vividly recalls the moment his son was born. The entire process shocked him, rendering him unable to record the birth as planned. I asked Zaid what his first reactions were once the initial shock of witnessing the C-section wore off and he was able to find himself in the moment. First-time-father Zaid explained that his first reaction was, "*I made that!*" Zaid immediately recognised his son as a part of himself, having built up this feeling throughout the pregnancy. He said,



> *You are responsible for this little human being. ... Am I capable of this job that's been given to me? Am I going to be good enough? And just right you make up your mind and say, 'Look I'm gonna try my best, because I need to raise you to be somebody else's husband, father.'* – Zaid

Within the first moments of meeting his son, Zaid envisioned his son's future – already identifying the immense responsibility that rests on his shoulders, as a parent, as a father. This demonstrates the immense emotional attachment between a father and his new-born, a family member beyond his reach until now.

In his description of his second child's birth, Zaid explains they were planning a C-section, but his daughter ended up being born in an emergency C-section three days prior to the scheduled procedure. He said, "*That evening she woke me up to say, 'I'm in pain, I think I must go to the hospital'*." Within two hours of arriving at the hospital, the pair became

parents again, welcoming a baby girl into the world. This time around, Zaid humorously recalls how he was able to record the birth, he stated,

> *I had my camera again and doctor said, 'Daddy don't look!' I said, 'No guy, I've seen this, I'm ready!'* – Zaid

Zaid averred that he was better prepared for the birth of the couple's second child, than for their first. Despite the support from the HCPs, Zaid's experience of the second birth was depicted as being paradoxically both more and less stressful than their first. Zaid stated, "*It was a bit stressful cause like I said it was an emergency*," but that on the other hand he felt "*more prepared, because I knew what I was expecting*." Although the couple were prepared for the C-section, the fact that this birth was an emergency heightened Zaid's anxiety. Unlike the previous birth which progressed over days, this birth occurred within a matter of hours. Finding out that the baby had to be delivered as soon as possible created unease, thrusting into the foreground that this birth could potentially be dangerous for his wife, their baby, or both. Ultimately, the C-section progressed smoothly, and his daughter was born healthy. He expressed that, it "*was like a sigh of relief, everything's okay, she's-everybody is okay we don't need to stress*." Relieved that the birth went well, I asked Zaid how this experience compared to that of the couple's firstborn, he disclosed that he was "*more jovial I would say because- because I knew what I was getting into, I was more…not happy but jovial*." The second birth was an emergency, and unlike with their previous, Zaid pointed out that the quality of care they received from the private hospital, as mentioned earlier, was better than that from the public hospital.



> *I felt better cause we went to the hospital. … It was nice it was like a hotel compared to the public hospital. … And I felt like doctors and nurses were a lot more accommodating and compassionate.* – Zaid

In his assessment of the care they received at the private versus public hospitals, Zaid again used a simile to describe his experiences. He reflected on the fact that he made

sure that following the birth of their first child, the family got medical aid, and that he was ultimately unwilling to relive the care they received at the state hospital for their firstborn – again alluding to their dissatisfaction with the previous birth process.

In contrast to the other fathers, Brian, Dawid and Patton's wives were pregnant with multiple babies. Brian and his wife had been prepared to deliver their twins through a C-section, as their HCP advised them that it is standard due to the risks associated with vaginal delivery of multiple babies. Their HCP also prepared them for the possibility that other complications may arise during the course of the labour or the birth. Brian stated,

> *And they always say something will go wrong or something might go wrong because it's twins, you know, they prepare you for these things, they tell you about it. So, your whole dynamic of having a baby now has changed.* – Brian

Brian was prepared for the worst. He was informed of the risks involved in a multiple birth. He goes on to explain that prior to the birth, he considered what he would do in the worst-case scenario, he commented,

> *In your head, how do you choose? How do you choose if something goes wrong? How do you choose your kids, over your wife?* – Brian

Brian realised, that as the father, if the situation arose, he would have to make a difficult decision; choose the life of his wife, or the lives of his unborn children. For Brian and his wife, luckily, he never had to make that decision. On the contrary, he indicated that the labour and birth progressed with minimal complications. He recalled that,

> *I did watch them cut her open. I did watch them pull them out. And that wasn't as bad as what I thought. I'm very squeamish when it comes to that type of stuff, but still this was different, I could handle it.* – Brian

Like several other fathers interviewed, Brian referred to the medicalisation of his wife's delivery, highlighting that he witnessed the entire procedure, and that although he could handle it, it etched a lasting image into his memory. Following the birth of their twins,

the baby girl was placed on a respirator as her lungs were underdeveloped. The HCPs advised Brian and his wife that the twins would be staying in the NICU for at least a week, however, Brian recalled, "*The kids were strong after three days and we left the hospital*." Overall, Brian's birth experience was positive, representing a major relief to the end of a difficult pregnancy.

Triplet father, Patton, had a comparable birth experience. The birth itself was relatively complication free, despite occurring fourteen weeks too early, when one of the babies' water broke. This resulted in the couple rushing to the hospital, with doctors delivering the first baby, and inducing labour for the remaining two. The birth itself progressed smoothly, and Patton's wife recovered quickly and left the hospital a few days later. Conversely, their babies were rushed to NICU, and would not leave the hospital for several months.

In stark contrast to Patton's experience of his wife's multiple births, Dawid's wife's labour was induced a month early due to the risk that extending the pregnancy posed to the twins. Dawid explained the birth as "*the most traumatic experience I have ever had*." I asked him whether he was always planning on being present. He asserted, "*I wanted to be there when they take their first, uhm, breath, you know and when they came into the world, I wanted to be there*." When Dawid arrived at the hospital, he sat in the waiting room while his wife was being prepared for the C-section, he recalled the following impactful moment,

> *What was quite difficult for me was the morning when, [my wife] went into theatre, and then I sat outside and I waited for them to call me to put on the clothes, or the, the gown and the other stuff, the guy who sat next to me, whose partner went in when [my wife] went in, their baby died.* – Dawid

Vicariously experiencing the pain of the father with whom he was sitting impacted Dawid greatly. Leading up to that point, he, and the stranger beside him were waiting for the same thing, the long-awaited birth of their first child. In an instant, the stranger entered a state

of grief, leaving Dawid fearing for the worst. Dawid went into theatre and sat beside his wife, holding her hand through the entire process, saying of the birth, "*I shall never forget it, it was one of the most special experiences that [my wife] and I shared*." Dawid recalled his wife's C-section in vivid detail. Watching the whole procedure was described as having shocked him, and he identified that a big part of the reason was his previous lack of interaction with medical procedures – he was not only stressing about the health of his wife and children, but he was also witnessing, for the first time, another person being cut open and operated on. However, as soon as the babies were delivered, he stated, "*It was a huge relief for me, I immediately thanked God. … I was truly thankful*." Dawid further recalled that,

> *The moment they did the C-section, and you see this baby coming out, you know. I'll never forget, I started crying, no one laughed at me. … I started crying when I saw my children, it was very emotional for me.* – Dawid

Dawid remembered how the birth of his children was so emotionally overwhelming that he started crying – something which he implies is an inappropriate male response by justifying that no one laughed at him. Dawid's initial relief that the birth proceeded without complication was suddenly replaced by fear when his children were taken to NICU. The month premature babies were underdeveloped, with his daughter having breathing difficulties, Dawid said, "*It was very difficult for me. … It bothered me terribly*." The birth of his babies had marked the end of a difficult pregnancy. However, it also marked the start of several months of intensive care, and several years of health difficulties for the twins.

Adam and his wife had a similar experience, with their baby being taken to NICU immediately after birth. However, they did not have a C-section. The birth of their third baby was vaginal and uncomplicated. Yet, as Adam said, "*The trauma only started with the birth of the child*." Adam told their story,

> *What I remember clearly, is that I looked at her, and when they said, 'Here comes the baby.' I looked down and then the sister held uhm, this cut-up*

> *child and there's blood everywhere you look. The next moment they stormed out of the ward with the child, without really communicating what is going on. … Because of my work I deal with children with different handicaps and retardation quite a lot, and birth trauma, and such, so I knew shit when I saw it.* – Adam

The couple felt uneasy during the pregnancy, uncomfortable with how the baby had been moving, yet nothing had been indicated on any of the scans or tests. Adam's intimate professional knowledge of child development and child psychology meant that he was able to identify quickly that their son was in a life-threatening condition. His understanding of the prognosis of children born with such disfigurements led him to one conclusion, he explained,

> *Then the frustration at that stage was, uhm, that they came back at that stage, and said that they, uhm, are struggling to get him to breathe and uhm, he is extensively damaged, and I told them, y'know, they should let him die, and they did, most probably because of their Hippocratic Oath, not listen to me and continued to try to resuscitate the child.* – Adam

Adam's professional assessment of the situation led him to conclude that the most merciful future was to cease resuscitation efforts. Despite his requests, the medical team continued their attempts, successfully placing the baby on life-support in the NICU. Adam expressed his frustration with the situation, but also commented that he understood that doctors had a duty to save lives. I asked him to elaborate on his statement that the HCPs failed to communicate with the couple immediately after the birth, he avouched,

> *I think they were shocked witless. They were in a panic themselves. And, and, I think the gynae[cologist] was careful to uhm, make a decision because he called on one or other professor from [another hospital] to come and have a look and all that they could say, was 'doctor will speak to you,' uhm, but I knew what was going on, so, uhm, as I have explained to you, the irritation was the waiting.* – Adam

The whole experience left Adam irritated with the healthcare system, and "*really worried*" about his wife. Following the birth of their child, Adam and his wife returned home, leaving their child in an unknown condition at hospital – waiting anxiously as HCPs ran tests and did assessments on their new-born. The couple returned the following day to meet their

child for the first time, and to have a consultation with the paediatrician – discussed in a later section.

Jacob's experience of the birth of his first child was also traumatic, but for different reasons. Jacob and his partner were "*told about the C-section months before,*" as their HCP identified that their baby had macrosomia. When his partner went into labour, Jacob said that nothing could prepare him for that moment. He described a "*very chaotic*" morning, rushing to get to the hospital, a 40-kilometre train ride away, to be present for the birth of his first child. He continued,

> *I was blocked at the, at the, the, the maternity room, which wasn't very nice. And we weren't married and uhm, I simply wasn't allowed inside. … I basically missed it, the, the whole thing. … She was alone.* – Jacob

Jacob was not allowed to attend the birth of his child. Although the months leading up to this moment were draped in anxieties, he steadfastly knew he would be attending the birth. He said,

> *I fantasized months before, you know, what my role would be like in the ward, uhm, to have that uhm, sort of fantasy, that privilege taken away from me. … I was devastated. I was very, very devastated.* – Jacob

Jacob had envisioned the birth of his son in a very specific way, already aware of the C-section, he was able to envision what his role in the theatre would be. However, this dream did not actualise, leaving him feeling "*devastated*" and "*really disappointed in the healthcare system, seriously, I was disappointed in the, in the healthcare system all together*." Jacob reiterated the fact that his partner gave birth alone and was the only one who experienced it in its entirety. He explained,

> *My knowledge of, of what happened there, was nearly, it came from her, you know, her experience in the ward. Uhm, and that's how I, that's how I experienced it. I experienced it vicariously. … The only, the only experience I have of my child's birth, the actual birth, is to through language, so, I have to fill the gaps with my imagination.* – Jacob

Jacob's partner, and the HCPs, reported back that the C-section was completed without a problem. In effect, Jacob attended his child's birth, but did so from the waiting room. He was determined to be physically present, however, was barred from doing so. Approximately twenty minutes after the C-section, Jacob was able to see his partner and child for the first time- discussed in the following section. This experience had a deep impact on Jacob, reinforcing his earlier dissatisfactions with how the couple was treated by the HCPs during the pregnancy.

This section highlighted the complexities in birth experiences. Fathers' experience was deeply impacted by the health of their partner and the child(ren), the perceived support and availability of the HCPs, as well as the nature of the birth process itself. Fathers of neonates who were born full-term and healthy reported a more positive birthing experience than fathers whose children were born premature, and/or in need of resuscitation or other lifesaving medical interventions. All but one father attended the birth of their children, demonstrating the importance these fathers place on being present for their partner and baby – the only father who did not attend did not do so out of his own accord – being physically denied entry into the operating theatre.



### 4.2.2 Holding the baby for the first time

Many fathers' narrations of the birth of their children were punctuated with the experience of holding the baby for the first time. For them, this was where the entire birth process climaxed. Fathers' narrations of their first time holding their baby highlight how impactful the moment was; many of them were able to clearly articulate every minute detail. Overall, holding their child(ren) for the first time was a very special experience for each father.

Several fathers recalled being allowed to hold their baby immediately after birth. Brian mentioned that he was able to hold the babies immediately after they were born. I asked Brian to describe this moment. He expressed it as follows,

> *I didn't have any feelings, it was quiet. Everything was quiet. Nothing. Nothing was that I was aware of nothing but my child when I held [my son], it was [with my son] was just there was nothing going on. It was just. It's a feeling you can't describe it. ... Because for me as a father, it's the first time I'm seeing him and, uhm, feeling him and actually have him. ... It was just tranquillity. And it was just bliss, it's just nothing was happening.* – Brian

Brian detailed how his first time holding the babies elicited an emotion that he had not experienced before and did not have the vocabulary to explain. He said repeatedly,

> *I don't know how to explain it. I have tried to explain this is just I can't, I can't explain it. ... It's a feeling that you can't describe something that you that you just experience when you experience it. It's, it's everything in one, happiness and, excitement, and you know you're scared. It's weird. I am becoming emotional about it, I just, I didn't think I'd be.* – Brian

Again, Brian reiterated that he cannot describe his feelings, demonstrating that the whole experience was a strange combination of emotions, ultimately being characterised as so powerful that he became quiet. When talking about this experience, Brian became emotional, admitting that he did not think that this conversation would stir this reaction. He explains it away by relying on traditional ideals of stoic masculinity, highlighting that men are less equipped to deal with strong emotions, he stated that, men "*don't know what to do with it [strong emotions]*." Brian concluded by stating, "*They don't have to tell you how you feel it, on you as a father, you like 'Yoh!' And that's, that's I think love*." In the end, Brian sums up his emotions by labelling it as pure love – a profound statement encapsulating his first experience of holding his children.

Like Brian, Dawid was also able to hold his twins for the first time immediately after they were born, despite being so premature. I asked Dawid if he remembered the exact moment that he first held the twins, he affirmed, "*I'll never forget it – there wasn't another*

*experience like that*." Dawid recalled how unique this experience was for him, starting at witnessing the birth of his children, and then being able to hold them before they were taken to the NICU. He spoke of how he formed a bond with the twins the instant he held them,

> *The minute I got them in my arms, I already had this bond. … They took the children to another room, and they placed them together in an incubator. … And I, I wanted to stay, I didn't want to leave my children alone, so they had to physically remove me from the room.* – Dawid

Dawid's connection with his children was so strong that he did not want to leave the NICU, resulting in him being taken out of the room. Like Brian and Dawid, Schalk was also able to hold his baby immediately after the birth, describing it as a special experience. Similarly, Ricky described the experience by stating, "*I cannot remember what I was doing*." He elaborated,

> *I can't tell it because I was quite numb at the time when I cannot, it's, I was not prepared that, hmm, I was thinking so many things that first time I see him. … I was completely blank; I just feel that I, I am holding somebody, so I cannot explain those feelings.* – Ricky



Ricky's words echoed that of Brian, expressing that the whole experience was indefinable, ultimately resulting in a feeling of numbness. Likewise, Jacob, who was barred from attending the birth of his child, was first able to hold his baby twenty minutes after the birth. He described the moment as follows,

> *Up until the day, seriously, you wouldn't expect it, I still can't put that feeling into words, and I don't, I don't, I don't try to put it into words because it's something that is indescribable. I mean, I was just overwhelmed with joy, fear, uhm, you know, overprotective. All of those feelings in one, just one big overwhelming feeling of being a dad.* – Jacob

Here, like the others, Jacob attested that the first time he held his baby he was overwhelmed. This mixed bag of emotions ranged from joy to fear, with the latter largely being aroused by his realisation that he had become a father at the tender age of twenty.

In contrast to all the other fathers, Adam and his wife were unable to hold and see their new-born immediately. Likewise, Patton (nor his wife) was not able to hold his babies until they were three months old, as they were "*too fragile to hold*." Patton confirmed that this was a challenging situation; although their babies had been born, the couple was unable to fulfil the traditional roles of new parents, as their babies were being cared for by the NICU staff – elaborated on in another section.

What became apparent in our conversations was that fathers vividly recalled the first moment they held their baby – and that this was considered a very special experience. Some fathers were able to hold their children immediately after birth, while others were not. Overall, holding their child for the first time was characterised as being an indescribable moment filled with overwhelming joy and bliss.



## 4.3 Neonatal involvement and fatherhood

This section presents fathers' stories following the birth of their child(ren). This section is divided into three key themes: fathers' experiences of the NICU, their experiences of early postnatal involvement, and narratives of fatherhood.

### 4.3.1 Experience of the NICU

For many couples, the birth of their child represented the end to a difficult pregnancy; however, for some, it represented the start of a new phase of their child's life, being taken care of not by their parents, but by trained medical professionals. In this study, four fathers indicated that their child(ren) was taken to the NICU immediately after birth. These fathers were Dawid, Adam, Patton, and Brian. Unlike the other participants, whose

children's hospitalisation ranged from three weeks to six months, Brian's twins were in the NICU for three days only. This section presents the experiences of fathers whose neonates were in NICU for an extended period, highlighting how for each of them the experience was characterised by stress, trauma, and uncertainty.

Dawid's initial relief that the birth proceeded without complication was suddenly replaced by fear when his children were rushed to the NICU. The month-premature babies were underdeveloped, with his daughter having difficulty breathing. Dawid said that seeing his children on life-support "*bothered me terribly*" and that "*it was very difficult*." This marked the start of several weeks of intensive care, and several years of health problems for the twins. Dawid vividly remembered his daughter in the NICU, speaking with eyes full of tears he said,

> *She had an awful lot of drips. They inserted drips in her head, they inserted drips in her, in her little feet, in her little hands, it was in her little arms, everywhere they could insert drips.* – Dawid

Several aspects of Dawid's experience with NICU were described as stressful. Dawid painted in fine detail a precise image of what his daughter was going through after birth, with all the life-support equipment. Seeing his child in such a critical condition was explicitly described as being "*very traumatic*." Dawid further explained that the couple received a daily phone call early in the morning updating them on how the children fared through the night. He described hearing the phone ring by stating, "*You have this terror running through you, that it's the hospital phoning to tell you that during the night your child, you know, so it was very traumatic*." Here, Dawid attempted to describe the intense fear they experienced with every phone call; however, he falls short when wanting to verbalise that they feared that their children would die, a phrase that he could not get past his lips, becoming visibly upset.

Dawid and his wife went to the NICU three times a day for weeks on end, resulting in prolonged interactions with the NICU staff. When I asked how their experience with the NICU staff compared to their experience of the antenatal care they received, Dawid said, "*looked after the children very well*." Dawid explained that the care they received at the NICU was good, with nurses knitting jerseys for the premature babies. Dawid and his wife had to relinquish care of their children every time they went home and described the process as "*quite stressful*." Having his children in the NICU was very stressful for Dawid, for many reasons.[11] Despite the stressful situation he found himself in, Dawid continued to be actively engaged in taking care of his babies at the NICU, until they were finally discharged and taken home – where Dawid and his wife continued to work as a team to raise their children – discussed in a later section.

Like Dawid, Adam's neonate was rushed to the NICU immediately after birth. However, unlike Dawid, Adam and his wife were not able to hold or see their child that day. Adam explained the frustration of leaving the hospital with an empty bassinet and a sedated wife, while their new-born was in an unknown condition in the NICU. This moment starkly contrasted against their previous experiences with their other two children; this time Adam and his wife had to return to the hospital to see their new-born. He described the moment,

> *When we eventually reached the ward, it was the longest passage that I have walked in my life. Uhm, uhm, it is actually metaphorically really terrible because you cannot turn off, but you want to turn off, uhm, but you have to go through this passage. Well, my personal experience was that it strips you of all the bullshit, y'know, this is it. And no IQ or skill [can prepare you].*

[11] A few days after the birth of his children, Dawid would suffer a personal tragedy, the passing of his father. Compounded by the stress of new fatherhood, having two children in critical condition in the NICU, and balancing his work, the death of his father proved to be another traumatising experience. Dawid's emotional state during the interview, when speaking about his father's passing, was further heightened by a recent loss of his mother and sister, both of whom died of COVID-19 complications with the most recent being one month prior to the interview. In a follow-up interview with Dawid, he recognised that his intense emotional reaction while speaking about his father was undoubtedly influenced by the grief he was experiencing for his mother and sister at the time, also highlighting how his personal losses triggered unpleasant thoughts of how very easily his children's fate could have been different.

> *... When we came into the ward and saw the amount of damage, and the paediatrician told us that the child had amnion band syndrome, and uhm, informed us that, uhm, [short pause] You know, uhm, he obviously breathes dependently, because the 'fokkers' [fuckers] didn't listen to me.* – Adam

Adam verbalised his experience of seeing the baby for the first time in the NICU on the day following his birth. Drawing on his blunt description of the HCPs as being "*fokkers*" [fuckers], I asked Adam how he felt about the fact that their baby had been taken to the NICU despite his requests to discontinue resuscitation efforts. He exclaimed that,

> *It was terribly frustrating, I, uhm, cannot describe to you the amount of frustration and anger and, uhm, hopelessness that I had experienced, that I could not get them to do what I had asked them. Uhm, because I know, I know what awaits you when you have to live with such a child.* – Adam

The HCPs' disregard for Adam's wishes culminated in frustration, anger, and hopelessness, later describing the situation was "*emotionally too warped*." Being a professional in the field of children with disabilities, Adam understood the future that lay ahead of them, a difficult future with a severely disabled child. He further iterated that it is "*something that threatens the wellbeing of your family and on a very primitive level*." Recognising this, Adam made a difficult decision, he confessed that,

> *At that stage, when he told us that the child cannot breathe independently when he is on his back, then we said, you know, 'Give us a private ward, we, we will turn him on his back and allow him to die, uhm and, uhm, then it is done.' Then <u>they</u> did not have to do anything, then <u>I</u> will do it, uhm, and uhm, when we made the arrangement, 'die klein kak' [the little shit] started breathing on his own while lying on his back [humorous].* – Adam

Deciding to end the life of your child crosses many taboos. An impossible decision in a "*warped*" situation, Adam felt that this would be the most merciful ending, as "*the child's prognosis was not even nil, it is in the minus numbers*." Despite convincing the HCPs to allow the couple to grant their child a merciful death, their attempts were ultimately unsuccessful. Somewhat humorously calling the baby a "little shit" when he defied the odds and breathed independently while on his back, Adam expressed that they would let the child

live. After leaving the NICU, Adam and his wife placed the baby in a specialised care facility.

Like Dawid's twins, Patton's triplets (two boys and a girl) had come early, fourteen weeks too early, and like Adam's, Patton's children required resuscitation after birth. The triplets were rushed to the NICU, and would not leave the hospital for months, a period described as being "*hectic*." The neonates required extensive medical treatment after their severely premature births. One baby needed major reconstructive surgery on his digestive tract. Patton explained the procedure in detail and elaborated on the fact that although the surgery was successful, initially they had trouble recruiting HCPs to operate on their son. He recounted that,

> *That was like a mental you know, the fact that anaesthetists were coming up and said, 'I'm not touching it because it's going to affect my insurance' basically. I mean, the doctor. … He was basically saying, you know, 'Your kid needs to go in now, but we're having trouble finding a doctor.' And he was pissed because basically the chances are that [my son is] not going to come out of the surgery because he's so small.* – Patton

This indicates that the couple's stress was induced not only by having severely premature triplets who required life-saving medical interventions, but also by their inability to quickly recruit a medical team willing to operate. Patton explained that they faced similar challenges when recruiting HCPs for their daughter's heart surgery. The baby girl was born weighing 680 grams and had a hole in her heart which had to be corrected as soon as possible. Patton evinced that after calling in some favours, their paediatrician was able to recruit a team of cardiologists from a leading cardiology hospital in Cape Town to break protocol, and operate on the neonate at an external hospital, as the infant could not be transported for surgery. Patton relayed how the surgeons struggled during the procedure, having to eventually stop the baby's heart to complete the operation, and then resuscitate the neonate afterwards. As Patton affirmed, stopping the heart of a premature baby is extremely

risky, but he concluded that the surgery was ultimately successful. Patton described the care he received from their paediatrician, as well as the collective efforts of the HCPs from other hospitals, as being "*fabulous.*"

Unfortunately, the couple's third baby, a boy, only lived a few days after birth. Patton chronicled this traumatic experience as follows,

> *We basically had the option to turn off the machine. [Our HCP] and one of the other doctors came in and explained his condition and the options. And that one was, that, it was a sign that it pointed to only one decision being made. ... There's not much pre-support you can get for that as we, we obviously weren't preparing for that. There wasn't any support at all. ... And so, yeah, we got to hold him for an hour or so and then give him back. And then you have to concentrate on the other two.* – Patton

Patton expressed that nothing could prepare a couple to make the decision to end their child's life. However, the couple acknowledged that in this situation, it was the best decision they could make. The grief of losing one of their babies was somewhat softened by the fact that they had two more babies to focus on, Patton indicated that,

> *We talked about it, we actually think that the other two being alive helped help us concentrate on those where, you know, maybe if we were only had one kid and that kid had passed away, then we would have had to deal with the whole grief thing there and then rather than we were able to sort of deal with it over a longer period of time. ... I'm not sure if, if should there had only been one kid and it had been dealt with in the, you know, three to six months after the passing, and maybe it would have been less sore, and now it's just a little bit sore sometimes.* – Patton

Patton reflected on their experience, recognising that their grieving process was disrupted by the ill health of their other two babies. This distracted them from the heartache, resulting in both experiencing some unresolved grief. Patton admitted that losing his son continues to be challenging more than a decade after the fact.

Approximately three months after their children's births, Patton and his wife were able to hold them for the first time. Patton described that he was "*pretty emotional, we had*

*waited a long time for them*." Shortly thereafter, when given the opportunity to give kangaroo care to their babies, Patton immediately became involved, saying that the experience was "*brilliant*," but that the process was hampered by physiological challenges associated with being a man and providing kangaroo care. Patton stated, "*Having a hairy chest is bit of a problem. … Because like you put them on the chest and their tickling their nose, and then there's hair in their mouth*." Providing kangaroo care to his babies served as an important bonding opportunity for Patton. Overall, despite being a very stressful and traumatic experience, Patton recognises that they were in a position of privilege to receive such extensive medical care.

In listening to the fathers describe their experience of the NICU, it is clear that the situation was very anxiety provoking. For Dawid, the process was not only emotionally intensive, but also time intensive, requiring multiple daily trips to the NICU for a prolonged period. Similarly, Patton's experience of the NICU was very intense, with two of the triplets requiring major surgery shortly after their birth – and their third child passing away days later. Finally, Adam's experience of the NICU was challenging, they were not wholly satisfied with the fact that the NICU made such extensive efforts to resuscitate a "*broken*" child, and in the end, their child never made it home (which will be discussed in the next section).



### 4.3.2 Early paternal involvement

Fathers whose wives and children were able to come home within days of the birth described that they were very involved in the early postnatal period. This manifested as providing instrumental support to their partner, as well as sharing the responsibility of caring for the infant. Towards the end of our conversations, I asked the participants to reflect on

their roles, responsibilities, views, and perceptions of fatherhood over the years, and what it meant to be a father. Participants answered me in various ways, reflecting on their ideological values, as well as highlighting how different aspects of fatherhood manifested itself in their lives.

**4.3.2.1 Bringing a singleton home.** When Jacob described his experience of the first few months after the birth of their child, he stated, "*It swallowed my whole life up,*" and "*I simply wasn't ready*." At the time he and his partner were living with their respective parents, but Jacob decided to spend as much time as possible with his partner and the baby. He asserted, "*I couldn't go back home, you know, I had a responsibility, to take care of her, as well as the, the new-born child, as well as my son*." Jacob explained that he was determined to be a present, involved father. He stated that he frequently travelled long distances, commuting the forty kilometres between his parents' house and her parents' house. He further illustrated his involvement by stating that while his partner was healing from the C-section,



> *Naturally I had to, I had to check in, you know I had to bathe the infant, I had to feed the infant, you know. My, my child was on breast, he, he was feeding off, off his mother, and uhm, obviously I couldn't give him that, but everything else I did. Everything that I possibly could, I did it. And there was no strain attached, you know. … I simply felt as a dad, being responsible for his child.* – Jacob

Jacob described how, because of his partner's recovery, he was involved in the daily caretaking activities of the neonate. Jacob describes his involvement as being natural and did not regard it with displeasure – it was his responsibility as a father to be active, and he fulfilled his role without hesitation.

Schalk's baby came home a few days after birth. He recalled that even though their son was at home, feelings of fatherhood "*didn't kick in immediately*." He said, "*Then you*

*realise 'I am a father now', a few days later*." At the time of the interview, Schalk's son was only a few months old. He reported that he is very involved in childcare, clarifying that,

> *Our baby is bottle fed, so I give him a bottle in the mornings, at lunch time I go home, and then, in the evening I give him a bottle. We bathe him at six, and I try to be involved. That is the plus of my work; I don't have to be there twenty-four-seven, and when I have free time, I prefer to be with him.* – Schalk

Schalk explained how he tries to be as involved as possible, helping with feeding, and bathing the baby. He highlighted that as a business owner, he was able to work flexible hours, therefore giving him the opportunity to be an involved father.

Ricky's baby, like Schalk's, was only a few months old at the time of the interview. When asked about the first time Ricky felt like a father, he related that this newfound "*greater responsibility*" took a few days to set in, reflecting, "*You can call it fatherhood*." Using knowledge gained in the ante- and postnatal classes, Ricky was able to be increasingly involved in taking care of their baby, stating that he assists with "*almost everything*." Ricky demonstrated how he has played an important role in taking care of the couple's firstborn, particularly in the days leading up to the interview. He stated that it had been challenging to take care of the colic baby, describing the previous days as being "*a bit stressful* ."[12] I asked Ricky whether he was able to take paternity leave, and he explained that the COVID-19 lockdown enabled him to spend more time with his wife and baby, as he was working from home. This also meant that he did not have to apply for paternity leave; however, he disclosed that he thought the standard 10 days of paternity leave would have been insufficient. Ricky further noted that prior to the birth, his parents were visiting from India to help the soon-to-be parents; however, due to national lockdown regulations, they were unable

[12] Colic is when a well-fed, healthy baby cries for prolonged periods without apparent cause (Johns Hopkins Medicine, n.d.).

to return home, and had been living with the couple for several months prior to the interview. Ricky explained that his parents being here was "*also helping us a lot*," pointing to the benefits of having a strong social network in place which can assist with childrearing when needed.

Like Ricky and Jacob, Zaid avouched to his involvement during his children's infancy. Zaid explained that the first few days after the babies came home, his wife was primarily responsible for caring for them, explaining that as a father, he chose to give his wife some more alone-time with their baby. Thereafter, he made active attempts to be involved in caring for the new-borns. He declared that,

> *I was one of <u>those</u> dads, I would change the diaper, I would do all the bathing and things like that I would like I was doing it wrong all the time because I was scolded. … With my son, he peed on me my daughter did the same thing as well, but she pooed on me, [I'm] not afraid to change a nappy, to bathe a child. … Look initially like I would say the first two or three days I was a bit scared to do it because I felt they were a bit too fragile and I might just hurt them but once that feeling is gone then it's like, 'Okay cool let's do this!'* – Zaid



Unlike Ricky, Zaid had not attended ante- or postnatal classes, and therefore relied on his wife for guidance on taking care of their baby. His wife became a gatekeeper for initial interactions with the neonates. He confessed that he struggled with some of the duties; however, once he gained his confidence, he humorously recalled how he was excited to be involved. Zaid explained that he received three days of paternity leave for the birth of each child, standard at the time. Three days to help his wife recover, three days to bond with this new-born – considering his wife's long labour and recovery in hospital, this amounted to one day at home with his baby. Overall, Zaid described new fatherhood by saying, "*Its tiring, you wanna pull out your hair*." This was a sentiment shared by Brian and Dawid, first-time fathers of twins, discussed below.

**4.3.2.2 Bringing twins home.** First-time-fathers of twins, Brian, Dawid and Patton, expressed the challenges of bringing home multiple babies simultaneously. Brian highlighted that "*no one prepares you for twins*." He elaborated that although he previously reported that their HCP was exceptionally informative and gave them realistic advice and expectations, the reality of being a father of twins exceeded what they could have prepared for. Brian revealed that,

> *If I have to think about it as a single[ton] dad, it would be easier to stand back and let the mom do the work. But as a twin father, you don't have that – you have to you know, you have to take the child. You have to take one of them. … Help the wife out because she can't deal with two nagging kids at the same time as a person twenty-four seven. … I think that's where we have to, as a twin father, you have to step in and, you know, you have to really help out either with the house chores or whatever, whatever it is.* – Brian

Brian explained that being the father of twins means that you do not have any other option but to be one hundred percent involved. Brian expanded by indicating that he was able to spend so much time at home with his wife and children due to his employment in their family business, granting him an opportunity to be involved in childcare, and creating an opportunity for the new father to bond with his neonates.

In contrast to Brian, Dawid's twins continued to require medical care, first in the NICU, and then when they left the hospital. Mirroring what Brian stated about twin parenting requiring teamwork as a couple, Dawid said, "*There is <u>no way</u> that one person can sit with two sick children that, you know, cry and vomit and stuff, and then I <u>had</u> to help*." He further stated that their children required constant care, with Dawid summarising his experience of the first year of parenthood,

> *We were not really prepared to raise two children. … We were both tense you know, uhm, I will tell you, the first year was really, really difficult.* – Dawid

Dawid expressed that being a father of infant twins was challenging, describing it as the "*hardest year of my life, because you, we were stressed*." Dawid explained that his employer understood his situation, and allowed him to take leave in advance, when needed. However, for the remainder of time, Dawid worked long hours, returning home only to pick up the shift with the children. During this time, he said that he had "*slept very little*." A severe lack of sleep, combined with the stress of having crying babies, was very testing for Dawid, and for his wife. Dawid admitted that "*at a stage both of us had deep depression*." He stated that,

> *It was very bad, it was very, very bad. She was very emotional. She needed a lot of support, and I couldn't always provide her with that support, because I was very emotional myself.* – Dawid

Dawid spoke with openness about the couple's struggles during the first year, further disclosing that he and his wife suffered from a series of breakdowns, resulting in voluntary admissions at a local clinic. Both Dawid and his wife were diagnosed with post-partum depression.



Like Dawid, Patton's children were born premature, and faced several life-threatening situations from the moment they were born, as detailed previously. After being discharged from the NICU, Patton's children came home, still requiring full-time medical care. Only when the children were a year old were they officially diagnosed with cerebral palsy.[13] Patton chronicled how they found out,

> *[My son] went back in for some other procedure, I can't remember exactly what, that, on the sheet someone had written 'cerebral palsy', on, on a sort of nurse's sheet that they took in. And then we were reading this and going, 'Uhm I think it's been a mistake over here, mean someone's written cerebral palsy. Sure, this for our kids? You have given us some other child's write-up here.' And the nurses looking at me like, 'No, your kid's got cerebral*

[13] "Cerebral palsy (CP) refers to a group of disorders that affect muscle movement and coordination. In many cases, vision, hearing, and sensation are also affected" (Johns Hopkins Medicine, n.d.).

> *palsy.' And you like, 'What!? No one has told us that before.' … [My wife] went off with the paediatrician to say, 'What the heck is this?' And they were like, 'Has no one told you this? Your kids have got cerebral palsy.'* – Patton

Patton clarified that he and his wife had not been prepared to receive such a devastating diagnosis so offhandedly. This created stress, as the couple suddenly had to make sense of what lay ahead of them. Patton told me that in addition to finding out about the cerebral palsy, they were unaware of the specific treatments they had access to, meaning that his children missed a critical period of occupational therapy which could have increased their quality of life. This experience illustrated to Patton how important access to information is, and he reiterated, "*It's about being aware of the issue and understanding that it's an issue*." Patton said that he felt there was a "*gap in in an understanding of what lay ahead of us for us*." The couple envisaged a very different life from the one they now have, with Patton explaining that their initial family goals were influenced by societal ideas, he stated that,

> *The job is to have these wonderful children that will then go out into the world. You know, that's the Hollywood idea. But suddenly when, when something happens, like having special needs kids, that you have to reimagine that whole idea.* – Patton



What became clear in listening to fathers of twins speak about their experiences of fatherhood was that having two new-borns simultaneously was a challenging task, requiring the constant attention of both parents, instead of an alternating role as with singleton babies. Twin parents face a unique challenge when caring for the neonates, as there are greater chances that the babies would be premature (therefore requiring medical interventions), and that both parents are needed constantly.

**4.3.2.3 Placing the baby in care.** Finally, in a stark contrast to the other fathers, Adam's child needed extensive medical care, and therefore did not reside in the family home. Adam said the following striking words about their reality, "*One part of you had to make things work, and the other part of you just wanted to shout in misery, uhm, about this terrible*

*thing that is playing out*." Adam recalled that after seeing their baby for the first time, he insisted "*the child is not going to come home, there is just no way*." Carefully considering what would be best for the family as a collective, Adam decided to place the baby in a reputable residential care facility. Adam explained that the couple brought their son home once as a trial run so see whether they could integrate him into their homelife. Adam vividly recalled a few disastrous hours their child spent at home, finally exclaiming that "*I did not think we had to bring that kind of trauma into our home*."

Although their son was not living with them, Adam explained that he and his wife tried to visit the baby as much as possible. Adam described that this period was very stressful, as he was concerned for his wife's well-being. He revealed that "*it was absolutely exhausting*." Adam, his wife and their two eldest children continued to include their youngest in the family by creating a routine that enbled them to spend time together as a family on a weekly basis. Adam refered to this as being a "*bizarre reality*," a reality which would end nearly two years after it started. Their son died from general organ failure shortly before his second birthday. The life and death of their son had a profound impact on Adam and his wife.

Clear throughout the interviews was that parenthood is exhausting. This was true for singleton fathers, as well as fathers of twins. When the neonates returned home, all fathers were actively involved in the daily care activities; to varying degrees. For all fathers, these basic care activities were recollected with fondness and regarded as a part of their fatherly duties.

### 4.3.3 The father as the provider

Throughout our conversations, participants often made mention of the financial implications of childbearing and childrearing. In their narrations, it became evident that all felt that a *good* father provides for his family – a value in line with traditional socio-contextual constructions of masculinity and fatherhood. For most, recognition of their financial obligation towards their family was accompanied by anxiety; having children was described as an expensive endeavour. As highlighted previously, several fathers first started thinking about money as soon as the pregnancy was confirmed.

This was true for Brian, who, during our conversation, twice raised the issue of the costs involved in having twins. He commented, "*It's definitely a lot of extra pressure. … If a man can't support his own family, he feels like a failure*." It is evident that there are strong conceptions that tie success as a father/man to his ability to take care of his family financially. Similarly, Schalk maintained, "*[Men face] huge stress factors, the underlying pressure on men is… finances, you know, it is extremely stressful*." The emotional burden of being unable to provide for your family's financial needs was also discussed by Patton, who further commented, "*It's still a very masculine thing that you are the provider for your family*."

Much like Patton, Jacob recognised the traditional gender norm of men as being the providers for the family, and he reflected, "*The financial aspect of it that is something that I can't change, you know it's, I subscribe to that, you know, I had to, I had to support financially*." Jacob's identification with a masculine role that carries financial responsibility as a father explained why he did not run away when he found out about the pregnancy, he stated, "*I sort of like imagined that, you know, being a, a dad, being a <u>real</u> man, so I have to stand my man and be a real man*." Jacob stated that he abandoned his academic pursuits "*in*

*search of work*." Jacob presented this as a defining moment in his transition to fatherhood, pointing out, "*That's when my life just started to change*."

One of the most prevalent gender roles is that of the man as the provider. This generally translates to a financial responsibility towards one's children and partner, as verbalised my most participants in this study. What makes this section particularly interesting is that most fathers mentioned financial implications of fatherhood without being prompted or asked during the interview. This indicates the importance of financial provision in the men's constructions of fatherhood.

### 4.3.4 Fatherhood and self-growth

Beyond the newfound responsibility of taking care of another human life, most fathers reported some form of transformation in their lives during this period. Jacob explained that,

> *[Becoming a father] takes a lot of reflection and it forced me, as a as a, as a young dad to become reflective, very, very early in my life and uhm, that sort of like motivated me to understand where I came from, why I wasn't really, uhm, I wasn't really prepared to, to, while I was very unprepared to be a father, why I didn't understand my own emotions, why I became a father in the first place, at such a young age and, uhm, you know, it just gave me a deeper sense of, of self, you know and it sort of illuminated a lot of my past relationships with, with my own father, and, and my own mother as well.* – Jacob

In this passage, Jacob reflected on the impact that fatherhood had on his development as a man, given his immaturity when his partner became pregnant. He asserted that becoming a father granted him an opportunity to reflect on his upbringing and use his experiences to inform how he would behave as a father himself. Similarly, Adam recalled, "*I must tell you, for the twenty-two months that [my son] lived, he taught me more than my*

*other children had taught me*." Adam stated that his experience with his son, "*Took me into a world with which I could not only identify with emotionally, but it also gave me specific skills and insights that I can still use*."

Likewise, Brian affirmed that since becoming a parent he has learned to prioritise his children and family's needs above his own, highlighting that he made sacrifices for the benefit of his family. Similarly, Schalk said, "*I have definitely changed. I looked at myself to be more patient, to be calmer and to be more careful with him, so, yes, I have definitely changed*." Schalk further spoke about the change in his perception of emotionality – highlighting, as mentioned earlier, the importance of emotional reflection. He stated,

> *[Men] reach their 40's and 50's and are depressed and in a mid-life crisis. I see this with family and friends. Therefore, I try to be proactive now to talk about everything, to help other people and tackle it now. This doesn't mean I'll be successful; it just gives me a chance to survive better.* – Schalk

This excerpt highlights that Schalk has used his experiences of the miscarriage and the stillbirth as an opportunity to grow and be proactive in managing mental health and wellbeing.



Men found the transition to fatherhood to be transformative. As expressed previously, several fathers used this as an opportunity for self-growth, particularly in terms of becoming more reflective around their emotions and using this to engage in (mental) health promoting activities.

## 4.4 Conclusion

This chapter presented findings from interviews with eight fathers whose partner experienced a MHRP. The purpose of the interviews was to elicit in-depth information on the fathers' interactions with HCPs, their perceptions of providing and receiving social support,

their experiences of fatherhood and the emotional experience of the entire process. This chapter followed their experiences chronologically and grounded the narrative in ample direct quotes to retain the participants' voices when telling their story. This chapter evidences the importance of examining fathers' perceptions of and reactions to their partner's MHRP(s), by demonstrating how profoundly the experience could impact their lives.

The following chapter will contextualise and synthesise findings from this study and present it alongside findings from previous research to illustrate how this research corresponds to and complements existing research.

# CHAPTER FIVE: DISCUSSION

The previous chapter provided thick descriptions of the complex experiences of each participant. It highlighted how fathers constructed each phase of the pregnancy, and specific events. Men's experiences were unique, each emphasising moments in the pregnancy and in their journey to fatherhood which proved to be particularly formative experiences.

In listening to and analysing each father's narrative, despite obvious dissimilarities, several commonalities exist in their experience of becoming parents (conception to early infancy). Fathers' experiences were grounded in key emotional and experiential themes: stress, trauma, and fulfilment. The following chapter will uncover each theme and demonstrate how its manifestation in this study compares to findings from previous research.

(Throughout our conversations, fathers' narratives of their experiences of their partner's pregnancy and the first years spent with their child were imbued with notions of gender ideologies. These did not always manifest as explicit assertions of values, but instead were often subtly demonstrated in the way participants coloured their stories. In their discussions, several prominent themes relating to the (de)construction of fatherhood and masculinity became evident. These includes the man as the provider, the man as the protector, gender roles, and (appropriate) male emotionality. These specific notions relating to masculinity and fatherhood underpinned much of fathers' experiences – and are therefore discussed throughout this chapter.)

## 5.1 Stress

Evident throughout the conversations with fathers whose partner experienced a MHRP was that this period represented a very stressful time for them. Fathers' experiences can be broadly described as stemming from a desperate desire for the well-being of their partner and unborn child. This stress manifested in different points across fathers' narrations of their experiences.

### 5.1.1 Interactions with HCPs

One of the main sources of stress during the antenatal stage was attributed to poor interactions with HCPs, during the pregnancy and up until labour and birth. In this study, several fathers felt that the HCPs were unsupportive and lacked empathy, which increased their anxieties about the pregnancy. Unaccommodating and inaccessible staff left fathers feeling frustrated and excluded from the process. This supports previous findings which identify HCPs to be a leading cause of fathers' feelings of exclusion (Bäckström & Wahn, 2011; Cosson & Graham, 2012; Fenwick et al., 2012; Matseke et al., 2017; Messner, 2010; Steen et al., 2012; Xue et al., 2018). In this study, descriptions of the couples' satisfaction with the healthcare they received was largely divided between private and public institutions.

In their stories, it became clear that public healthcare facilities were regarded as being inundated with patients, therefore diminishing the quality of care that each patient receives. Several participants commented on the lack of information transfer between the HCPs and the couple. What is evident is that expectant parents who obtained information from their public HCPs felt that they did not receive adequate, in-depth information regarding the pregnancy, such as health-promoting behaviours, caution against high-risk activities, and other pregnancy and birth specific information. Several fathers indicated that this lack of

information was a major cause of stress, mirroring findings from other studies (Cosson & Graham, 2012; Fenwick et al., 2012).

Conversely, accounts from those having access to private healthcare facilities yielded recollections of satisfactory, positive experiences with HCPs, described as a difference in "*customer service*." In this research, some fathers reported that they received satisfactory care and information from their HCPs, which put them at ease, therefore mitigating against excessive stress. These findings are supported by Elmir and Schmied's (2016) meta-ethnography which demonstrated that the presence of supportive and knowledgeable HCPs reduced fathers' stress levels. Having a supportive HCP frequently promoted fathers' antenatal involvement, encouraging them to actively participate in the pregnancy.

The impact that the presence of a supportive, available, knowledgeable HCP makes on the fathers' experience of the pregnancy is clear; a lack thereof may result in a negative pregnancy experience, one which becomes ever more severe as it becomes medically high-risk.



### 5.1.2 Information

Seeking information to assist in coping with stress was prevalent among the fathers interviewed. Several attended antenatal classes with their partner, while others relied more extensively on the internet for guidance. This is comparable to results from previous studies, where fathers sought out additional information as a strategy for coping with the situation (Dheensa et al., 2013; Forsyth et al., 2011; Johansson, 2012).

Fathers who were dissatisfied with the information they received from the antenatal classes primarily attributed this to a mismatch in content, as the classes they were able to

attend were orientated towards singleton births, but also to the fact that "*it was more directed to the mother*." This echoes previous research which indicated that fathers felt excluded from antenatal classes (Cosson & Graham, 2012; Premberg et al., 2008). In such cases, many men relied on the internet for informational support, as demonstrated in research by Dheensa and colleagues (2013). Notwithstanding, several fathers cautioned against an overreliance on data found online as the sheer volume of contradictory information heightened some fathers' anxiety.

### 5.1.3 Receiving social support

Results from this study mirror those from others, which demonstrated that fathers reported receiving varying levels of social support during the ante- and neonatal phase (Enderstein & Boonzaier, 2015; Forsyth et al., 2011; Poh et al., 2014). Fathers in this study relied on family and friends for social support. Most notably, support was conceptualised in two distinct ways: explicit and implicit.



Many fathers reported valuable social support from family and friends. The presence of a supportive social structure allowed fathers to realise that they were "*not alone*." Several fathers noted that they were able to speak to extended family and friends who had similar experiences, while others noted that although the support was there, it was not necessarily explicitly stated. This again points to the social construction of men being less emotionally driven, thus not requiring explicit social reinforcement. These sentiments reflect those portrayed in previous studies which demonstrate that fathers report receiving less explicit support than their pregnant partner (Forsyth et al., 2011). Despite receiving less overt support, fathers in this study expressed that they were satisfied with support received,

reflecting findings from previous studies (Enderstein & Boonzaier, 2015; Inglis et al., 2016; Poh et al., 2014).

### 5.1.4 Supporting your partner

In this research, all fathers indicated that they played a key supportive role to their partner during the pregnancy, as well as thereafter. Findings from this study mirror previous works which demonstrated that the father participated in a wide variety of activities, including taking care of their partner when she was feeling ill, giving her massages, providing her with vitamin supplements and healthy foods, and making lifestyle changes to allow her to rest (Ekström et al., 2013; Fenwick et al., 2012; Makhanya, 2018; Matseke et al., 2017; Poh et al., 2014; Swart, 2020). These strategies were all used to help mitigate feelings of alienation from the pregnancy, with many fathers taking measures to become increasingly involved during the perinatal stage of the pregnancy. For many, their commitment to their family also manifested in their resolute desire to be actively involved in the birth, with one father stating, "*I fantasised months before, you know, what my role would be like in the ward*." Being present for the birth of their children not only offered participants an opportunity to meet their new family members, but for many it represented a moment where they could offer emotional support to their partner.



Despite the efforts made to assist their expecting partner, fathers were often left feeling helpless when unable to assist her, which in turn increased their stress levels. These findings support those of Ekström et al. (2013) and McCain and Deatrick (1994).

### 5.1.5 Being a parent is stressful

**5.1.5.1 Parenting.** All fathers spoke of how stressful parenting can be. Challenges involving the pregnancy could only occur over a finite nine months – but next came another set of stress-inducing events: infancy. This timeframe was succinctly verbalised as being tiring, and that it makes you want to "*pull out your hair*." Other fathers in this study further verbalised that they felt inadequately prepared for taking care of a neonate, replicating previous findings (Chin et al., 2011; Matseke et al., 2017). As in previous research (e.g., Shorey & Ang, 2019), a (perceived) inability to take care of the neonate resulted in maternal gatekeeping. However, over time, fathers built up confidence in their parentcraft and became increasingly involved in childcare.

**5.1.5.2 Financial responsibilities.** Several fathers reiterated the fact that, as fathers, they felt it was their responsibility to take care of their family financially. Participants' notions of men as the provider reflects broader traditional constructions of gender responsibilities, also demonstrated in previous research (Clowes et al., 2013; Cosson & Graham, 2012; Enderstein & Boonzaier, 2015; Meyer, 2017). Like participants in Hosegood and Madhavan's (2012) study, some fathers reported that men are under a tremendous amount of pressure to provide financially – and that this creates stress. As with previous research, one of the manners in which this financial provision manifested during pregnancy was through preparation of the baby room (Makhanya, 2018; Swart, 2020). In this research, several fathers spoke of the cost and effort involved in readying the space – which is ultimately demonstrative of an investment in, and a build-up of anticipation for the baby.

**5.1.5.3. Paternity leave.** Several participants mentioned their experience of paternity leave days as being insufficient. Similar findings were reported previously in

research that highlighted father-child bonding restrictions due to work responsibilities (Matseke et al., 2017; Steen et al., 2012).

Stress was a prominent theme in fathers' narratives of their experience of their partner's MHRP. Stress was mitigated by the presence of supportive HCPs and access to appropriate information. Conversely, poor interactions with HCPs and contradictory and confusing information increased stress levels. Receiving and giving social support also mitigated against stress. Finally, many fathers expressed that being a parent was stressful, and that the financial implications for them, as men, compound their stress.

## 5.2 A traumatic experience

In this research, many fathers verbalised traumas they experienced along their journey to parenthood. Trauma was induced by an intense fear of death, as well as the occurrence of a pregnancy loss or an antenatal death.



### 5.2.1 Fear for the mother's or child's life

Many fathers expressed the intense terror they experienced when faced with the possibility of losing their partner and/or child. Reflecting findings from Etheridge and Slade's (2017) research, several fathers in this study intensely feared for the health and wellbeing of their partner and/or unborn child(ren), verbalising that the situation was overwhelming. Comparable to results from previous research, a fear for their partner's and/or child's lives was heightened when birthing complications resulted in an emergency procedure, resulting in a stressful, negative birthing experience (Elmir & Schmied, 2016; Fenwick et al., 2012; Johansson, 2012; Yokote, 2007). In this study, none of the mothers required resuscitation.

Several fathers however witnessed the medical team resuscitate their neonate(s). Speaking about this near-death experience elicited strong reactions from two fathers, each of whom became emotional when recalling the moment, with one of them describing it as "*the most traumatic experience*" he had ever had. These assertions are in line with feelings expressed by participants in another study (Harvey & Pattison, 2012).

For many fathers, their stress did not dissipate when their children were born, with several neonates being taken to the NICU for extended periods. The NICU was represented as a stressful and traumatic space. Findings from the present study replicate those elsewhere which demonstrate that the NICU environment, the interactions with staff, and the neonate's health were key factors contributing to, or mitigating from, a traumatic experience (Feeley et al., 2013; Lundqvist et al., 2007; Noergaard et al., 2018; Stefana et al., 2018).



### 5.2.2 Death

Findings from this research revealed that an antenatal or neonatal loss is traumatic for the father, supported in previous research (O'Leary & Thorwick, 2006; Swart, 2020; Williams et al., 2019). Pregnancy loss had varying impacts on fathers in this research. For some, a pregnancy loss was considered negative, but not necessarily traumatic. For others, any form of pregnancy loss was traumatic. This is firmly represented in one father's narrative who said, "*You held him. He was dead in your hands. It was very, very traumatic*."

All fathers in this research identified at least one moment in their partner's pregnancy and the neonatal stages that was experienced as being traumatic. The source of the trauma varied, ranging from a fear of the death of their partner and/or child, to the death of their child. Verbalised in this study, many fathers felt unable to adequately manage their emotions due to socio-cultural values which position men as unemotional, stoic, and strong.

This echoes other research which has demonstrated that masculine gender norms negatively affect the way in which men process trauma, leading to prolonged grief (O'Leary & Thorwick, 2006; Swart, 2020; Williams et al., 2019).

This research confirms that pregnancies, particularly MHRPs, are experienced to be traumatic life events, highlighting the need for greater awareness surrounding the emotional wellbeing of men during their partner's pregnancy. Despite being constructed as traumatic, all fathers expressed a deep sense of fulfilment stemming from their fatherhood, discussed next.

### 5.3 Fulfilment

Despite the stressful nature of fathers' experiences of their partner's MHRP, one thing became clear: becoming a father had a profound impact on these men's lives. Findings from this study emulate previous findings which highlight the importance that men attribute to fatherhood in their conceptualisations of successful manhood (Enderstein & Boonzaier, 2015; Hosegood & Madhavan, 2012; Richter et al., 2010). For some, fatherhood was seen as the logical "*next step*," therefore eliciting a strong positive emotion when the pregnancy was confirmed.

This sense of fulfilment also manifested as a sense of duty that fathers felt towards their partner and child(ren) during and after the pregnancy. All fathers had a strong desire to be present at the birth of their child, and for one, the moment proved to be overwhelming, with him stating "*I started crying when I saw my children, it was very emotional for me*." This is confirmed in previous studies which highlight the importance men place on being present at the birth (Ekström et al., 2013; Genesoni, 2009). This desire to be present and involved was sustained during the neonatal and early infancy stages, with fathers reporting

active involvement in taking care of their children. Although stressful (as discussed previously), this involvement was accompanied by a sense of fulfilment. This echoes previous findings which posit that fathers continue to push gender norms to become increasingly involved in parenting responsibilities (Enderstein & Boonzaier, 2015; Hosegood & Madhavan, 2012; Makusha et al., 2013; Swart, 2020).

Overall, the transition into fatherhood, and the experience of fatherhood has been immensely impactful on the self-growth and development of men involved in this research. All verbalised the profound changes they experienced, not only practically, as parents, but also emotionally and cognitively, as men. This research confirms previous studies which found that men report a greater sense of responsibility, being more empathic, more confident, and more patient after becoming fathers (Chin et al., 2011; Makusha et al., 2013; Premberg et al., 2008; Shorey & Ang, 2019; Steen et al., 2012).

All fathers were ultimately happy about becoming a father and enjoy fatherhood. Despite stress and mixed emotions, having children was represented in a good light, with one participant summing his experience up as "*fatherhood is love*."



## 5.4 Conclusion

This chapter sought to compare findings from this research to that conducted previously. This chapter demonstrated how fathers construct MHRPs. Specifically, it highlighted that fathers' lived experiences are grounded in stress, trauma, and fulfilment. Fathers described the importance of receiving informational and social support throughout the pregnancy and birth. Findings from this study are mostly congruent with previous research, confirming that MHRPs represent a potentially tumultuous period for the father.

# CHAPTER SIX: CONCLUSION

Despite literature indicating that fathers play an essential role in their partner's pregnancy, the experiences of the father are systematically neglected in obstetric research. Men play an important role in pregnancy. Therefore, it becomes necessary to closely examine factors that enhance positive paternal involvement, to improve overall family health and well-being. The aim of this research was to explore fathers' subjective lived experiences of their partner's MHRP. More specifically, this research explored fathers' experiences and perceptions of the pregnancy, their interactions with HCPs, their perceptions of support, and their experiences of fatherhood during the neonatal and infancy stages. This was accomplished by conducting semi-structured interviews with eight fathers. This research demonstrated that fathers' experiences are complex, grounded in a unique set of circumstances.



Fathers' experiences were described chronologically, starting at the point they found out about the pregnancy, and ending in the first few years of their child's life. Evident from the narratives was that fathers' experiences were grounded in stress, trauma, and fulfilment. These experiences occurred across the pregnancy, with fathers oscillating between feelings of stress, relief, joy, and fulfilment, whilst navigating (potentially) traumatic life events.

All fathers depicted the MHRP as being stressful. However, stress was shown to be mitigated by positive, attentive interactions with HCPs, where high quality information was verbalised. In some instances, information was said to have increased stress, but looking more closely at these assertions demonstrated that it was concerns over the quality and quantity of information which heightened anxieties. When fathers were well informed with accurate, easy to understand information, their stress levels were reported to have decreased.

The point of information was closely tied to fathers' experiences of HCPs. There was a clear divide between experiences of those who attended private healthcare facilities, and those who relied on state facilities. For the latter group, HCPs were described as being inundated with patients, resulting in lower quality of care being received. This left families confused and frustrated. In stark contrast, fathers who attended private facilities were vocal about their appreciation of the staff's attentiveness and the quality of care received – with several fathers able to name their partner's HCP, demonstrating the personal relationship they formed.

Fathers in this study narrated the ways in which they supported their partner during and after the pregnancy, confirming that men play a crucial supportive function. For all fathers, this supportive role was taken on gladly and regarded as being a part of the fatherhood process. This supportive role continued during the neonatal stages where fathers were actively involved in the daily caretaking of the baby. This was recalled as being stressful for most men, as they were unaccustomed to handling small, fragile babies. This was particularly true for fathers whose children were admitted to the NICU. The NICU was constructed as a particularly stressful and traumatic space – displaying both the fragility and resilience of the neonates. In this study, several fathers experienced loss during the pregnancy, in the form of miscarriages and stillbirths, as well as thereafter, with a neonatal and an infant death. These losses were particularly traumatic and painful, with fathers verbalising that they are still suffering the emotional consequences years after the fact.

Emotional expressions were greatly impacted by fathers' internalisation of masculinity norms, which position men as less expressive and emotional. Masculinity norms also presented as fathers affirming that they take on the role of the provider for their family, which was regarded as adding further strain.

Despite the stress and trauma, it was abundantly clear that all men in this research valued their duties and responsibilities as fathers, that they experienced a sense of fulfilment

stemming from fatherhood, and that they were dedicated to ensuring the health and wellbeing of their child(ren). Fatherhood was therefore constructed as a positive, rewarding experience.

This research demonstrates the profound impact that fatherhood has on men, and how many actively try to be attentive, engaged parents. This again highlights the need to adequately address challenges that fathers face in becoming involved in the pregnancy and developing their parentcraft. Fathers play a vital role in the health and wellbeing of an expecting mother and child, and therefore require various support services to enable them to fulfil their fatherly duties to the best of their ability.

### 6.1 Reflecting on methods

In line with the research aims and the theoretical orientation, this research utilised semi-structured interviews to collect data. This data collection strategy was well-suited for the purposes of this research. Prior to the interviews, I was anxious about whether each interview would yield rich, complex data, and whether the fathers would feel comfortable speaking about potentially emotive topics. Following the first interview, and transcription thereof, I was satisfied with the quality of information that the participant conveyed. After each interview, I reflected on how the conversation went and identified possible areas which could be improved upon for future interviews.

Although the interviews were initially intended to be face-to-face, this was amended to be health and safety conscious in light of the COVID-19 pandemic, with interviews carried out remotely. This added a further element of alienation from the research –not only did the participant and I live distinctly different lives, but this was not bridged by a sense of shared space, as would be the case in a face-to-face interview. This was partially overcome by using two-way video wherever possible. I felt that conducting interviews using two-way video was

preferable to audio-only, as the visual aspect of the interview improved rapport with participants and facilitated non-paralinguistic communications.

Finally, using a remote interview strategy was difficult for some, as there were pandemic-related movement restrictions in place, meaning that fathers had more difficulty finding a time and space where they could be interviewed in private. On several occasions, the interviews were interrupted by work or children. This meant that during the interviews, some fathers became distracted, taking a few minutes to neutralise the situation before re-establishing the conversation.

### 6.2 Reflecting on theory

This study was informed by an interpretive phenomenological philosophical orientation. As discussed previously, IPA is extensively used in the healthcare domain, proving itself to be a useful tool for deconstructing individuals' experiences with healthcare phenomena.



The benefit of grounding this research in a phenomenology was that it offered me an opportunity to delve deep into what each father experienced; building a cognitive map to illustrate how various individual components work together to inform an overall experience. This proved to be invaluable in deconstructing fathers' experiences and highlighted the complex nature of what men go through when their partner experiences a MHRP. Overall, I found IPA to be a useful and effective approach to uncovering the complex nature of fathers' lived experiences of their partner's MHRP. This is evident through the rich and in-depth data that the interviews yielded, and again through the similarities that my findings had with those from previous studies. IPA is a helpful tool for exploring health-related research topics, and if

applied correctly, will undoubtedly contribute to existing literature by creating more nuanced portrayals of what individuals experience when faced with specific phenomena.

## 6.3 Limitations

**6.3.1 Limitations of IPA.** IPA has been subjected to various criticisms. Firstly, IPA has been criticised for relying on participants to have the necessary communication skills to effectively convey their experiences (Tuffour, 2017). This criticism could be regarded as elitist, implying that only individuals with appropriate fluency and verbal skills are allowed to tell their story. This is highly problematic, as who is to determine who may or may not share their experiences. As evident in this study, although all fathers had adequate verbal skills to effectively communicate their story, not all had the ability to effectively verbalise their emotional experiences. This, however, did not mean that they were unable to contribute to this research. To promote participants' ability to verbalise their experiences, the decision was made to offer them the opportunity to decide which language they would like to be interviewed in. This allowed, for example, Afrikaans speaking fathers to communicate in the language they feel most comfortable with.



Secondly, IPA has been criticised for being unable to describe unique experiences and make generalisations simultaneously (Alase, 2017). Although this may be the case for projects with limited word counts, a thesis adequately allows researchers to explore both the unique and the general. To overcome this criticism, this paper divides the results and discussion; the former highlighting every father's unique experience, while the latter aims to create a coherent narrative – highlighting similarities and differences in experiences. Although one may argue that we cannot always compare experiences, it could evidently be done in this research, as there were many similarities present.

Finally, IPA has been criticised for allowing too much room for researcher subjectivities, allowing researchers to 'fill in the blanks' (Tuffour, 2017). I mitigated this through discussing my findings with my supervisor and individuals involved in the transcription and translation process. I had meetings to compare our interpretations of what the participant had said and had follow-up interviews with several participants to clarify information. Additionally, my findings were heavily grounded in direct quotes to remain as close to each participant's true narrative as possible– thus minimising the chance that my personal interpretations and biases may taint the intended meaning.

**6.3.2 Participant recruitment.** As noted earlier, difficulties arose when recruiting participants. Accessing qualifying fathers was challenging, despite the non-restrictive inclusion criteria. Although advertisements for the study were published on social media, very few men approached me regarding participation. In several instances, despite initial willingness to participate, men indicated that they had changed their mind and were unwilling to be interviewed. This was attributed to busy schedules, family responsibilities, and discomfort with sharing their story. Finally, during the course of data collection, one of the fathers who initially indicated a desire to participate was unfortunately unable to do so, being hospitalised and passing away due to COVID-19 complications prior to the scheduled interview date.



**6.3.3 Participant homogeneity**. This study sought to investigate fathers' lived experiences from a heterogenous group of men. This meant that I set out to interview fathers from diverse backgrounds in order to create a well-rounded picture of fathers' experiences. Ultimately, although fathers in this research have a certain degree of dissimilarity, the participants were not as diverse as I had originally hoped. For example, more than half of the participants were White, two were Coloured and one was Indian – thus not representative of

the demographic composition of the Western Cape.[14] Similarly, most fathers had some form of tertiary qualification, all fathers were employed, and most had access to private healthcare facilities; again, not representative of the general population. In addition, all but one father was legally married to their partner at the time of the pregnancy, therefore not adequately reflecting the fact that South Africa has a high rate of teenage and extramarital pregnancies. The fathers in this study therefore represent a very specific subset of the population, meaning their experiences cannot be generalised to those of unmarried and/or unemployed fathers and those who relied on public healthcare systems. This skew in participant demographics is undoubtedly influenced by the fact that I could not recruit participants through public hospital settings (due to COVID-19), instead relying mainly on social media (internet access) to recruit. Although the fathers in this research are not representative of the larger population of fathers in the country, their stories remain an important source of information.

**6.3.4 Protocol changes.** Due to the COVID-19 pandemic, various protocol changes were required. This necessitated a reconsideration of the appropriateness of conducting phenomenological interviews, as IPA examines not only verbal communication, but also takes note of non-verbal and paralinguistic cues to accurately represent what a participant was experiencing. To maintain the integrity of the interview method, the interview was conducted through a two-way video chat where possible. This allowed the participant and I to see each other, promoting a sense of shared company and making the experience more personal than one conducted through audio alone.

[14] I maintain the view that *race* is not biologically determined. Rather, it is a social and political construct which, in South Africa, manifested as a classification into four primary *racial groups;* Black, Indian, Coloured, and White. These rudimentary and highly problematic classifications are a remnant of the apartheid regime, which continue to be utilised in various spheres to reflect the differential way groups were treated during the apartheid era, and how this legacy continues to impact individuals today.

## 6.4 Recommendations

**6.4.1 Recommendations for HCPs**. Findings from this research motivate several recommendations for healthcare facilities and HCPs including:

- Healthcare facilities should implement strategies for information dissemination specific to the needs of the expectant father. This entails providing men with consistent and accessible information relating to the pregnancy, communicated through private consultations; inclusive antenatal classes; or with the aid of print media (posters, pamphlets, information brochures). This information should include a broad spectrum of obstetric processes and complications.
- HCPs should encourage fathers to join the antenatal check-ups. Fathers in attendance should be included in the conversation, sonars, and procedures as much as possible to promote attachment.
- Healthcare facilities should develop and implement support structures that suit the specific needs of fathers. These may serve various functions, including support for fathers who grieve after a miscarriage, stillbirth, or neonatal loss.
- Fathers' lack of neonatal parentcraft results in maternal gatekeeping and a fear of taking care of their neonates. To help prepare fathers better, they should be equipped with essential neonatal care skills, which can be facilitated through ante- and postnatal classes.

**6.4.2 Recommendations for future research**. Based on findings from this research, there is a need for more empirical evidence to understand how fathers interact with and perceive (medically high-risk) pregnancies, with the goal of promoting paternal involvement. I have the following recommendations for future research:

- Large-scale quantitative research on the prevalence of MHRPs in South Africa.
- Qualitative research that is more targeted on how specific aspects of a MHRP (for example antenatal appointments, antenatal testing, and different births) are experienced by the male partner.
- Research investigating HCPs' perceptions and understandings of paternal involvement during pregnancy and early infancy.
- Research on men's experiences of maternal near-misses.
- Further research on the role that restrictive masculinity norms play on men's ability to grieve for pregnancy and neonatal loss.
- Research on the impact of pregnancy-related stress and trauma on the mental health and wellbeing of fathers.
- Research on fathers' perceptions of their ability to provide care to new-borns.
- Research on parents' perceptions of standard paternity leave of ten days.
- Investigating men's experiences of being a father to a child in a residential care facility.
- Research on parents' experiences of ante- and postnatal care in the context of COVID-19.

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## APPENDIX A: Participant profiles

**Dawid.** Dawid is a 44-year-old, married, Afrikaans man. He and his wife had been married for six months when they found out she was expecting. Early scans indicated that she was expecting twins, a pigeon pair (one male and one female twin). The pregnancy was complicated from the first scan, constantly indicating that one of the babies were underdeveloped. What was supposed to be a routine check-up at eight months resulted in an emergency C-section and NICU admittance. Dawid and his wife were asked to go to NICU three times a day to feed their babies, until weeks later when the twins finally went home. A week thereafter, they were hospitalised again for jaundice. The babies continued to have health difficulties. The pressures of being new parents and having sickly twins became overwhelming for Dawid and his wife, and both were admitted to a clinic, suffering from postpartum depression. The twins, now aged ten, have both been diagnosed as being on the autism spectrum.



**Jacob**. Jacob is a 25-year-old English, married, man who experienced his first pregnancy with his high school sweetheart when he was 20 years old. The antenatal period was uncomplicated, however during the third trimester the couple were warned about the high likelihood of delivering through C-section, as the baby had macrosomia. When her water broke, Jacob's partner, now wife, got a lift to the nearest public hospital. Jacob rushed to take a train to accompany her during the birth. Despite arriving on time, Jacob was barred from entering the delivery room as he and the mother were not legally married at the time. He sat in the waiting room while his partner had a C-section, alone. Becoming a father at such a young age had a profound impact on Jacob's life and has required a complete reprioritisation of his goals and responsibilities. At the time of the interview, their child was five years old.

**Adam**. Adam is a 65-year-old, married, Afrikaans man who experienced a MHRP with his wife in 1995. After two successful pregnancies, and two miscarriages, the couple

were expecting again. Throughout the pregnancy Adam's wife noted that the baby moved oddly, but antenatal tests were inconclusive. She gave birth vaginally, with Adam at her side. Once the baby was delivered, he was rushed out of the room by frantic doctors. Despite Adam's requests to cease, the healthcare workers made several attempts to resuscitate the boy, eventually being successful and placing him on life-support in the NICU. The baby was critically injured by amniotic band syndrome. Adam and his wife were able to see their baby the following day. The extent of damage the baby suffered required around the clock professional care, and a decision was made to house him at a reputable care facility. They visited him often and built a unique relationship. As he grew, his condition worsened, concluding in his death shortly before his second birthday.

**Schalk**. Schalk is a 30-year-old, married, Afrikaans man. He and his wife experienced four pregnancies in total: two miscarriages, one stillbirth, and one live birth. During their third pregnancy, which resulted in a stillbirth, the couple and a family member were on the road when his wife went into labour. They were 30km away from the nearest hospital. The baby was delivered at a public hospital. This stillbirth had a deep impact on the couple, and it was challenging to come to terms with the loss of their child. Within a year they found out they were expecting again. During this pregnancy they made a more active effort to monitor and promote the health of the baby. The baby was born in a COVID-19 ward at a private hospital. Schalk was allowed to attend, and his wife and child came home after two days in hospital. At the time of the interview their baby was 5 months old.

**Brian**. Brian is a 33-year-old, married, English man. He and his wife experienced their first pregnancy together in 2018. The couple were stunned when they found out they were having twins. During the pregnancy, Brian's wife became increasingly sick, being hospitalised twice for dehydration. The pigeon pair were delivered at full-term through a C-section. At the time of the interview, the children were two years old.

**Ricky**. Ricky is a 36-year-old, married Bengali immigrant living and working in South Africa. He moved here with his wife so both of them could pursue academic careers at a university in Cape Town. The couple wanted to have children but were fearful that they wouldn't be able to, due to his wife's PCOS. They were excited when they found out that they were expecting, however, shortly thereafter, Ricky's wife had a miscarriage. Ricky described this as a traumatic experience, one which made them anxious about having a child in the future. A few months later, the couple became pregnant again. The baby was born following an emergency C-section in a COVID-19 ward. At the time of the interview, the baby was three months old.

**Zaid**. Zaid, a 39-year-old, divorced, English father, spoke about two MHRPs that he experienced with his then wife. After two years of unsuccessful attempts at having children, Zaid and his wife decided to separate. While separated they found out that she was expecting, and the couple rekindled their relationship. The pregnancy progressed relatively smoothly, with expected nausea and pains, and only became high-risk during labour. Zaid's wife experienced prolonged labour, ultimately needing a C-section. Shortly after their son's birth, the couple separated again, before finding out they were expecting again when their son was five months old. The couple stayed together and made active efforts to mend their relationship. The second pregnancy progressed smoothly, but the baby girl was delivered through an emergency C-section. Zaid spoke extensively of his experience of the labour and birth of his children – indicating the deep impact it had on him. Several months after the birth of their daughter, Zaid and his wife decided to get a divorce, and have been co-parenting with shared custody since then. At the time of the interview the children were aged eleven and twelve.

**Patton**. Patton is a 48-year-old, married, Irish immigrant, who has been living in South Africa for more than a decade. In total, he and his wife have experienced two

pregnancies, resulting in a total of five live births. Having wanted children, the couple was excited to be expecting, and found out that they were expecting natural triplets. The pregnancy was challenging and took a toll on his wife's body. At four months, following several small scares, his wife was hospitalised with appendicitis and had to have an emergency appendectomy. The procedure, although successful, placed the lives of the mother and all three children at risk. A few weeks later, Patton's wife's water broke fourteen weeks early. None of the babies weighed more than 900g, and therefore they were rushed to NICU. Within days of their birth, a decision was made to switch off the life-support of one of the babies. Pushing through the grief, Patton and his wife had to maintain their focus on their two surviving babies, both taken in for major surgery shortly after birth. Following a three month stay in NICU, the babies went home. When the children were young, they were both diagnosed with cerebral palsy, suffering from this condition to varying degrees. Adding to the pressures of parenthood, Patton and his wife found out they were expecting a second set of twins two years later. This pregnancy was high-risk because it was a multiple pregnancy. Patton however reported that it progressed without issue, and this set of twins were born full-term and healthy. At the time of the interview, Patton's sets of twins were aged seven and nine.

## APPENDIX B: Interview schedule

**Primary question:**

**Please tell me about your experiences of your partner's medically high-risk pregnancy.**
***Vertel my hoe jy jou metgesel se mediese hoë-risiko swangerskap ervaar het*.**

**Secondary questions and prompts:**

- How did you feel when you first found out about the pregnancy?
- *Hoe het jy gevoel toe jy uitgevind het van die swangerskap?*

  → What was your relationship with the mother at the time?
  → *Wat was jou verhouding met die moeder destyds?*

- How did you find out that the pregnancy was high-risk?
- *Hoe het jy uitgevind dat die swangerskap 'n hoë risiko geval was?*

  → How did you feel when you found out that the pregnancy was high-risk?
  → *Hoe het jy gevoel toe jy uitgevind het dat jou metgesel se swangerskap hoë-risiko was?*

- How did you experience the healthcare providers?
- *Hoe het jy die gesondheidsorgverskaffers ervaar?*

  → Did you attend ultrasounds/check-ups? Why/why not?
  → *Het u ultraklank / ondersoeke bygewoon? Waarom / waarom nie?*

  → Where did you receive healthcare? (State vs private)
  → *Waar het u gesondheidsorg ontvang? (Staat vs privaat)*

  → Did the health care staff explain to you what the implications were on your partner's or child's health?
  → *Het die gesondheidsorgpersoneel aan u verduidelik wat aangaan, wat die implikasies daarvan was?*

- Did you do further research on the condition?
- *Het u verdere navorsing gedoen oor die toestand?*

- Did you receive support from other people?
- *Het jy ondersteuning van ander mense ontvang?*

    → Do you have examples of support given?
    → *Het u voorbeelde van ondersteuning?*

- How did you experience the birthing process?
- *Hoe het jy die geboorteproses ervaar?*
    → Were you present? Why/why not?
    → *Was u teenwoordig? Waarom / waarom nie?*

- Were you able to take paternity leave? Was your paternity leave sufficient?
- *Kon u vaderskapsverlof neem? Was u vaderskapverlof voldoende?*

- What has your experiences of fatherhood been like following the birth, until now?
- *Hoe ondervind jy vaderskap sedert die geboorte?*

    → Do you think these experiences changed you as a man?
    → *Dink u dat hierdie ervarings u as man verander het?*

    → Do you have advice for other fathers who are going through the same experiences?
    → *Het u raad vir ander vaders wat dieselfde ervarings deurmaak?*

## APPENDIX C: Demographic questionairre

| | | | | |
|---|---|---|---|---|
| Participant code<br>*Kode* | | | | |
| Preferred pseudonym<br>*Skuilnaam van U keuse* | | | | |
| Reference<br>*Waar het jy gehoor van hierdie studie?* | Hospital | Print media | Online media | Other (specify): |

| | |
|---|---|
| Age<br>*Ouderdom* | |
| Home language<br>*Huis-taal* | |
| Marital status<br>*Huweliks status* | |
| Highest level of education<br>*Hoogste vlak van onderwys* | |
| Occupation<br>*Beroep* | |

| | |
|---|---|
| Total number of pregnancies with partner(s) overall<br>*Hoeveel keer het jy al 'n swangerskap met 'n vrou gehad?* | |
| Total number of live births with partner(s) overall<br>*Hoeveel van daai swangerskappe het in lewende geboortes geeindig?* | |
| Total number of high-risk pregnancies overall.<br>*Hoeveel van daai swangerskappe was hoe-risiko/ het kompikasies gehad?* | |
| Relation to partner at time of MHRP?<br>*Tydens die swangerskap, wat was jou verhouding met die ma?* | |
| Date of most recent MHRP<br>*Datum van mees onglangse hoe risiko swangerskap?* | |
| Nature of most recent MHRP<br>*Wat was die omstandighede van die mees onglangse hoe risiko swangerskap?* | |

## APPENDIX D: Ethics approval certificate

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

05 May 2020

Ms P Richardson
Psychology
**Faculty of Community and Health Sciences**

**Ethics Reference Number:** BM20/1/16

**Project Title:** Fathers' subjective lived experiences of their partners' high-risk pregnancy in the Western Cape.

**Approval Period:** 30 April 2020 – 30 April 2023

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

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

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

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

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

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

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

*NHREC Registration Number: BMREC-130416-050*

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

**APPENDIX E: Research advertising**

# HAS YOUR PARTNER EXPERIENCED A HIGH RISK PREGNANCY?

## We are researching fathers' experiences of their partner's high risk pregnancy in South Africa and would like to hear from YOU!

### What is the research about?

This research is being conducted by a student completing her Master's in Research Psychology at the University of the Western Cape. The aim of this research is to identify and explore fathers' subjective lived experiences of their partner's medically high- risk pregnancy in the Western Cape, South Africa. We hope that, in future, this information may contribute to the improved understanding of the experiences of paternal distress and the creation of tailored support structures.

### Can I take part?

You can participate if:
- You are a male, over the age of 18
- Your partner had a high risk pregnancy
- You lived in South Africa during the pregnancy

### What will I have to do?

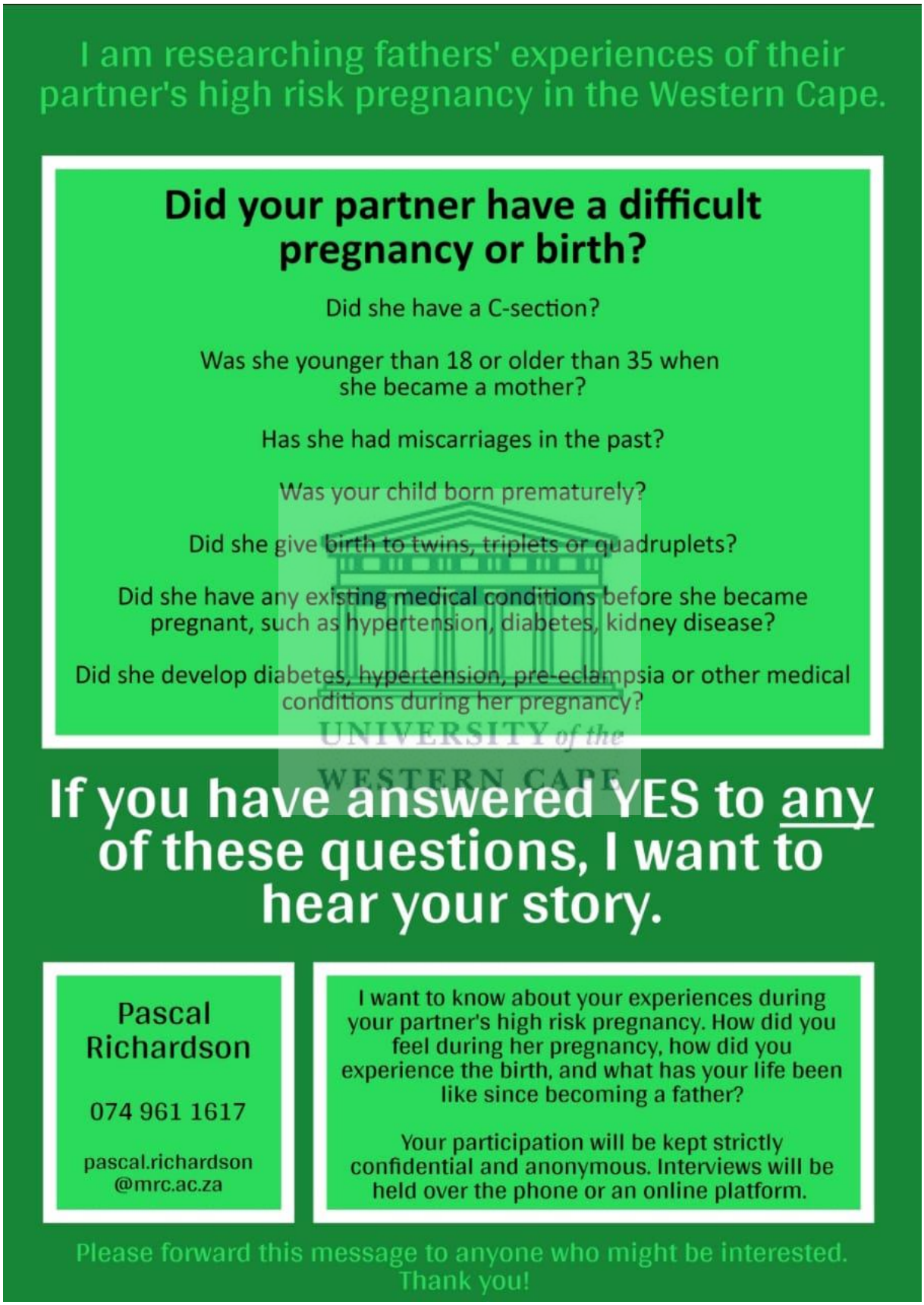
We will schedule a interview when it suits you. Due to the lockdown, interviews will be held over an online platform. Your participation will be anoynymous.

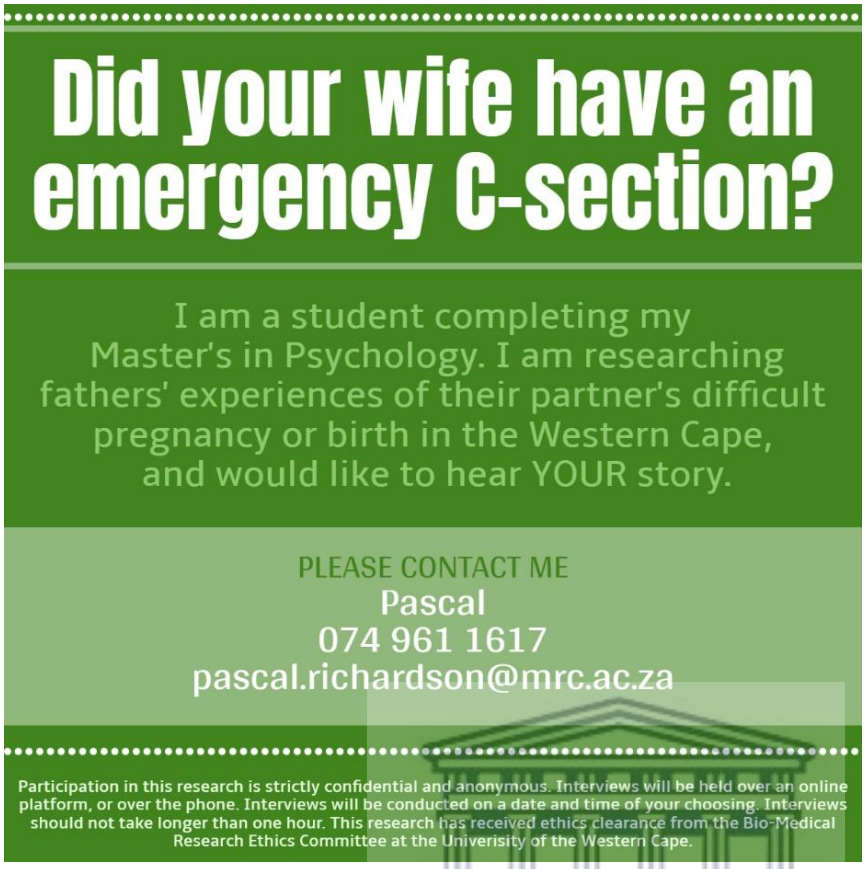
A medically high risk pregnancy occurs when one or more of the following criteria are met; the mother is under the age of 18, or over the age of 35; presence of pre-existing medical conditions; a history of complications during previous birth(s); the development of pregnancy- induced medical conditions; and unexpected birth- related complications

## IF YOU ARE INTERESTED, PLEASE CONTACT ME!

PASCAL RICHARDSON
074 961 1617 OR PASCAL.RICHARDSON@MRC.AC.ZA

Please forward this message to people you know who may be interested. Thank you!






## APPENDIX F: Information sheet (English)

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17,
Bellville 7535, South Africa
Tel: +27 219592453, Fax: 27 219593515

### Information Letter

Research Title: **Fathers' Subjective Lived Experiences of their Partner's High-Risk Pregnancy in the Western Cape, South Africa**

### What is this research about?

This research is being conducted by a student completing her Master's in Research Psychology at the University of the Western Cape. The aim of this research is to identify and explore fathers' subjective lived experiences of their partner's medically high- risk pregnancy in the Western Cape, South Africa.

### If I decide to participate, what will be asked of me?

If you decide to partake, you will be asked to participate in an interview with the primary researcher. Interviews will be conducted telephonically, or over a secure online platform, such as Skype, WhatsApp, or MS Teams. The interview will only be conducted in a when you have complete privacy at home or in another safe, private space. The interview will be held at a time of your choosing. The interview should take approximately one hour. The interview will be audio-recorded. The topic under investigation may be personal and sometimes sensitive. You may decline to answer any questions and may decide to withdraw from the study at any point in time without prejudice. Your participation is completely voluntary.

### Will my participation be kept confidential?

We will do everything in our power to protect your privacy. Your identity will not be made public. When findings are written up, we may quote you from the interview. In such an instance, to assure anonymity a pseudonym of your choosing will be used during discussion. To ensure confidentiality audio-recordings will be stored on an encrypted file on the primary researcher's computer. No one will have access to your information other than researchers working directly on this project, which includes peer reviews by experts. In accordance with legislation and professional standards, any information disclosed pertaining to child abuse or neglect must be reported to the appropriate authorities. In such an instance, the researcher will inform you that confidentiality will be broken due to the necessity to adhere to legislative and professional responsibilities. In rare instances the research may undergo an audit. This is completed by a regulatory institution (such as the

Offices of Human Research Protection) and will require confidentiality to be broken to the regulatory board to audit any information collected during the research process.

## What are some of the risks of participating in this research?

There may be some risks from participating in this research study. 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 study. If you experience any discomfort or distress during or after participation of this study, the following free counselling services can be contacted: Lifeline (0861 322 322), Hope House (021 522 9228), or South African Depression and Anxiety Group (0800 456 789).

## What are the benefits of this research?

This research is not designed to help you personally, but results may help the researchers learn more about fathers' subjective lived experiences of their partner's medically high- risk pregnancy. We hope that, in future, this information may contribute to the improved understanding of the experiences of paternal distress and the creation of tailored support structures.



## If I participate, may I withdraw at any given 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 penalised or lose any benefits to which you otherwise qualify.

## What if I have questions?

This research is being conducted by Pascal Richardson at the University of the Western Cape. She is under the direct supervision of Prof Michelle Andipatin, also at the University of the Western Cape. If you have any questions about the research study itself, please contact co-investigator Prof Michelle Andipatin on 021 959 2283. If you have any further inquiries, please feel free to contact one of the following individuals/institutions:

**Prof. Anita Padmanabhanunni**
Head of Psychology Department
University of the Western Cape
apadmana@uwc.ac.za

**Prof Anthea Rhoda**
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
chs-deansoffice@uwc.ac.za

**BMREC**
Research Development,
021 959 4111,
research-ethics@uwc.ac.za

This research has been approved by the University of the Western Cape's BioMedical Research Ethics Committee (BM20/1/16).

## APPENDIX G: Information sheet (Afrikaans)

Universiteit van Wes-Kaapland

Private Bag X 17, Bellville 7535, South Africa
*Tel: +27 219592453, Fax: 27 219593515*
E-mail: mandipatin@uwc.ac.za

### Informasie Blad

Navorsingstitel: **Vaders se subjektiewe ervarings van hul maat se hoërisiko-swangerskap in die Wes-Kaap, Suid-Afrika**

**Waaroor gaan hierdie navorsing?**

Die navorsing word gedoen deur 'n student van die Wes-Kaapse Universiteit wat tans besig is met die voltooiing van haar Meestersgraad studie in Navorsingsielkunde. Die doel van die navorsing is om die vader se subjektiewe ervaring van sy metgesel se medies hoë-risiko swangerskap in die Wes-Kaap, Suid-Afrika te identifiseer.



**As ek deelneem, wat sal ek moet doen?**

Sou jy besluit om deel te neem, sal jy gevra word om deel te neem aan 'n onderhoud met die hoof-navorser. As gevolg van die grendeltyd sal onderhoude telefonies of op 'n ander aanlyn-platform gehou word, soos Skype, WhatsApp of Google. Elke onderhoud word slegs gedoen wanneer u in totale privaatheid en in n veilige ruimte is. Dit sal op 'n tyd van jou keuse gedoen word. Die onderhoud sal ongeveer een uur duur. Daar sal 'n klankopname van die onderhoud geneem word. Die onderwerp wat ondersoek word mag persoonlik en somtyds sensitief van aard wees. Jy mag weier om vrae te beantwoord en mag op enige tydstip van die studie onttrek sonder enige gevolge. Jou deelname is heeltemal vrywillig.

**Sal my deelname vertroulik gehou word?**

Ons sal alles in ons mag doen om u privaatheid te beskerm. U identiteit sal nie bekend gemaak word in enige publikasie wat gebaseer is op hierdie navorsing nie. Ons mag dalk u woorde herhaal, maar sal ter alle tye 'n skuilnaam van u keuse gebruik. Om vertroulikheid te verseker sal alle vraelyste in 'n kluis gebêre word. Klankopnames sal in 'n "encrypted" lêr op die hoofnavorser se rekenaar gestoor word. Niemand het toegang tot u informasie nie, behalwe die navorsers betrokke by die projek. In ooreenstemming met wetlike vereistes en professionele standaarde moet ons ingligting oor kindermishandeling, -verwaarlosing of potensiële skade aan u, of ander, aan die aangewese owerheid bekend maak. In so 'n geval sal ons u inlig dat ons vertroulikheid moet breek om ons wetlike verantwoordelikhede na te kom. In rare gevalle moet navorsing 'n oudit of evalueering ondergaan. Dit word voltooi deur 'n toesighoudende agentskap (soos die Kantoor vir Menslike Navorsingsbeskerming) wat sal lei to die bekendmaking van u data asook enige ander inligting wat deur die navorser versamel was.

## Wat is die risiko's van hierde navorising?

Alle navorsing het sekere risiko's. Alle menslike interaksies en navorsingsdeelname dra 'n seker mate van risiko. Ons sal egter sulke risiko's verminder en sal dadelik optree om u te help sou u enige ongemak, sielkundig of andersins, ervaar tydens die proses van deelname. Waar nodig sal 'n gepaste verwysing gegee word aan 'n geskikte professionele person vir verdere hulp of ingryping. Indien u enige ongemak of wroeging tydens die deelname aan die studie ondervind, kan die volgende gratis beradingsdienste gekontak word: Lifeline (0861 322 322), Hope House (021 522 9228), of South African Depression and Anxiety Group (0800 456 789).

## Wat is die voordele van hierdie navorsing?

Hierdie navorsing is nie bedoel om u persoonlik te help nie, maar die uitslae kan navorsers help om meer te leer van die vader se subjektiewe lewenservaring van sy metgesel se mediese hoë-risiko swangerskap. Ons hoop dat hierdie inligting in die toekoms sal bydra tot beter insig van die vader se ongemak en die skep van doelgerigte ondersteuningstelsels.

## Moet ek aan hierdie navorsing deelneem, en mag ek op enige stadium deelname staak?

U deelname in hierdie navorsing is heeltemal vrywillig. U mag kies om glad nie deel te neem nie. As u belsuit om deel te neem mag u op enige punt deelname staak, sonder gevolge. U sal nie gepenaliseer word of enige voordele verloor waarvoor u andersins kwalifiseer nie.

## Wat as ek vrae het?

As u enige vrae het oor die Navorsingstudie self, kontak asseblief mede-ondersoeker, Prof Michelle Andipatin, by 021 959 2283 As u verdere navrae het, kontak asseblief een van die volgende individue / instansies:

**Prof. Anita Padmanabhanunni**
Head of Psychology Department
University of the Western Cape
apadmana@uwc.ac.za

**Prof Anthea Rhoda**
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
chs-deansoffice@uwc.ac.za

**BMREC**
Research Development,
021 959 4111,
research-ethics@uwc.ac.za



This research has been approved by the University of the Western Cape's Bio-Medical Research Ethics Committee (BM20/1/16).

## APPENDIX H: Informed consent letter (English)

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17,
Bellville 7535, South Africa
Tel: +27 219592453, Fax: 27 219593515

**CONSENT FORM**

Title of Research Project: **Fathers' Subjective Lived Experiences of their Partner's High Risk Pregnancy in the Western Cape, South Africa**

The study 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.

- ☐ I **agree** to be audiotaped during my participation in this study.
- ☐ I **do not agree** to be audiotaped during my participation in this study.

**Participant's name** .....

**Participant's signature** .....

**Date** .....



**Contact information:**

This research is being conducted by Pascal Richardson at the University of the Western Cape. She is under the direct supervision of Prof Michelle Andipatin, also at the University of the Western Cape.

Pascal Richardson | Primary Investigator | 074 961 1617 | pascal.richardson@mrc.ac.za

Prof Michelle Andipatin | Research Supervisor | 021 959 2283 | mandipatin@uwc.ac.za

**This research has received ethics clearance from:**
Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17, Bellville, 7535
Tel: 021 959 4111
E-mail: research-ethics@uwc.ac.za

## APPENDIX I: Informed consent letter (Afrikaans)

Universiteit van Wes-Kaapland

Private Bag X 17, Bellville 7535, South Africa
***Tel: +27 219592453, Fax: 27 219593515***
**E-mail: mandipatin@uwc.ac.za**

**VRYWARINGSVORM**

**Navorsings titel:** **Vaders se subjektiewe ervarings van hul maat se hoërisiko-swangerskap in die Wes-Kaap, Suid-Afrika**

Die studie aan my verduidelik is in 'n taal wat ek verstaan. My vrae oor die studie is almal beantwoord. Ek verstaan wat my deelname sal behels, en ek bevestig dat my deelname vrywilig is. Ek verstaan dat my identiteit aan niemand bekend gemaak sal word nie. Ek weet dat ek sonder rede ter enige tyd, aan die studie kan onttrek, sonder enige negatiewe gevolge of verlies aan voordele.

- ☐ Ek **stem in** dat daar 'n klankopname van my deelname gemaak kan word.
- ☐ Ek **stem nie in** dat daar 'n klankopname van my deelname gemaak word nie

**Naam van deelnemer** .....

**Handtekening van deelnemer** .....

**Datum** .....



**Kontak besonderhede:**

Die navorsing word gedoen deur 'n student van die Universiteit van Wes-Kaapland wat tans besig is met die voltooiing van haar Meestersgraad studie in Navorsingsielkunde. Sy is onder die direkte toesig van Prof Michelle Andipatin, ook by die Universiteit van Wes-Kaapland.

Pascal Richardson | Primêre ondersoeker | 074 961 1617 | pascal.richardson@mrc.ac.za

Prof Michelle Andipatin | Navorsing toesighouer | 021 959 2283 | mandipatin@uwc.ac.za

**Hierdie navorsing het etiese goedkeuring ontvang van:**
Komitee vir biomediese navorsing
Universiteit van Wes-Kaapland
Privaatsak X17, Bellville, 7535
Tel: 021 959 4111
Epos: research-ethics@uwc.ac.za