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RESEARCH ARTICLE **OPEN ACCESS**

Mothers' Experiences Regarding the Care of Preterm Babies Admitted in Neonatal Intensive Care Unit in Capricorn District, Limpopo Province, and South Africa: A Phenomenological Study

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Abstract:

Background: Globally, an estimated 13.4 million babies were born prematurely; it is a global health burden that accounts for the death of one million preterm neonates every year. In South Africa, approximately 84,000 preterm babies are born each year. Yet, there is a huge gap in the literature on the experiences of mothers in the care of preterm babies in Limpopo province.

Objectives: To explore and describe the experiences of the mothers of Pre-term babies admitted in Neonatal Intensive Care Unit in Capricorn District, Limpopo Province, South Africa.

Methods: A phenomenological research design was used in this study to describe and explore the experiences of mothers caring for preterm babies. This study adopted purposive sampling to select mothers with direct experience in the care of preterm infants in the Intensive Care unit in Capricorn District, Limpopo province. Data were collected through one-on-one semi-structured interviews; saturation was reached at participant 12, when no new information emerged. The data were analysed using a thematic approach inspired by Tesch's qualitative analysis method.

Results: Four major themes emerged from the study: Anxiety Experience, Trauma Experience, Loss of Hope, and Hospitalization Experience. Mothers reported high levels of anxiety, feeling afraid to hold, feed, or bathe their babies, which hindered early bonding. Initial exposure to their fragile infants triggered feelings of shock, fear, guilt, and emotional trauma. Others described the sense of Hopelessness especially when seeing their babies in critical condition, which led to fearing the worst, making it difficult to bond or remain optimistic. Mothers struggled to adjust to the stressful Intensive Care Unit, strict routines, and prolonged hospital stays, which further impacted their emotional well-being.

Discussion: Four central themes aligned with the study's aim by conveying emotional and psychological challenges, where anxiety, trauma responses, loss of hope, and challenging hospitalization experiences all compromise mother-infant bonding as well as caregiving belief in a resource-limited NICU. Results emphasize the importance of early mental health interventions and structured educational support to promote maternal coping and involvement in neonatal care. These findings emphasize the need for context-specific, family-centred care support and for health systems change in Limpopo. In summary, the study generates policy-relevant evidence for decision-makers and healthcare providers who are seeking to enhance maternal and newborn health outcomes in low-resource settings

Conclusion: Mothers of preterm babies admitted in the Neonatal Intensive Care Unit face emotional and psychological challenges such as Anxiety, Trauma experiences, Loss of Hope and difficulty in adjusting to a long hospital stay. The study recommends strengthening emotional and psychological support for mothers through regular counseling and peer support programs, as well as family-centered policies.

Keywords: Preterm babies, Mothers, Neonatal intensive unit, Emotional well-being, Psychological support for mothers, Hospitalization experience, Trauma experience.

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1. INTRODUCTION AND BACKGROUND

The arrival of a newborn is typically anticipated with joy and excitement; however, for mothers of preterm infants, this experience is often intertwined with heightened anxiety, uncertainty, and unique challenges [1]. Preterm birth, defined as birth occurring before 37 weeks of gestation, disrupts the expected trajectory of early parenthood and thrusts mothers into an intense and often prolonged period of caregiving within Neonatal Intensive Care Units (NICUs) and beyond [2, 3]. Globally, an estimated 13.4 million babies were born prematurely in 2020, and it is a global health burden that accounts for the death of one million preterm neonates every year, about 78,9% of these deaths occur in Africa [4, 5]. Complications of preterm constituted the primary cause of mortality among children under five years old. Those who survived faced lifelong disabilities, including cognitive impairments and visual and auditory deficits [5]. In South Africa, approximately 84,000 preterm babies are born each year, and 10% of them are at increased risk of death [5].

On the other hand, studies revealed that preterm birth remains a significant determinant of adverse outcomes concerning neonatal survival, long-term health, and developmental trajectories. It also has profound psychosocial and emotional repercussions for parents [6]. The birth and hospitalisation experience of preterm birth is an unforeseen hurdle for parents; it can be very distressing, especially for the mother [7]. A study focusing on isiXhosa-speaking mothers of preterm infants in the Western Cape province revealed that social support and religious beliefs positively influenced maternal coping mechanisms [8]. Mothers expressed primary concern for their infants' medical stability, with less emphasis on developmental issues.

Similarly, research from Ghana highlighted that mothers experienced significant anxiety regarding their preterm infants' survival. Interactions such as kangaroo mother care and breastfeeding were cherished, fostering bonding and providing emotional relief. While mothers praised nurses' professional competence, they expressed concerns about inadequate accommodation, high costs, and limited opportunities for mother-infant interaction within the hospital setting [9]. For this effect, in the Neonatal Intensive Care Unit (NICU), mothers often play a reduced role in caring for their babies [10]. This is because healthcare professionals, such as neonatal nurses, registered nurses, and neonatologists, are more actively involved in infants' care. Additionally, the babies' unstable health conditions can make it challenging, potentially leading to a traumatic experience for the premature infants in the nursery. These traumatic experiences can have a long–term effect on the mental and physical functioning of the mother of preterm babies in the nursery.

Other studies argue that prolonged stay in hospitalisation can have a negative impact on both the mother and their preterm babies. Premature infants are at risk of presenting with feeding difficulties, and Mothers of premature babies with feeding difficulties often perceive interactions during feeding to be negative and frustrating [11]. This intrigued the scholars to delve into exploring the experiences of mothers in the care of preterm babies. In conjunction, there's an enormous contextual and methodological gap in the literature on the experiences of mothers in the care of preterm babies in Limpopo province. In the literature, no narrative studies were found reporting on the experiences of mothers in the care of preterm babies in the Capricorn district, Limpopo province. It is against this background that this study delves into exploring the experiences of mothers in the care of preterm babies.

2. MATERIAL AND METHODS

2.1. Study Material

A phenomenological research design was used in this study to describe and explore the experiences of mothers caring for preterm babies. The research design enabled the author to describe and explore the challenges mothers face in caring for their preterm babies. The participants were given the chance to describe their challenges regarding the care of preterm babies in the hospital. This design helped the author gather factual data from participants and was deemed legitimate because it enabled the primary author to explore and obtain new information about the experiences of mothers of preterm babies. The mothers of the preterm babies described their challenges regarding caring for the preterm babies through their lived experiences.

2.2. Study Setting Population

The study was conducted at a selected district hospital located in the Capricorn District Municipality of the Limpopo Province, South Africa. The hospital serves a

predominantly urban and peri-urban population and is one of the district's major referral centers. It has both a Neonatal Intensive Care Unit (NICU) and a Paediatric Ward, with a total of six neonatal beds and six crib beds. The hospital admits an average of 35 pre-term infants in 3 months, providing specialized care to neonates with complications associated with prematurity. The surrounding area, including local townships with an estimated population of over 80,000, forms a key part of the hospital's catchment area. The population in the study was 35 mothers of the pre-term babies aged between 18 and 35 years admitted in neonatal ward and paediatric ward within the period of three months. The study setting was selected due to its high neonatal admission rate and accessibility to mothers from both rural and urban areas. Conducting the study in this context enabled an in-depth understanding of how mothers navigate caregiving challenges in a setting with constrained healthcare resources. Additionally, the site's accessibility to both rural and urban mothers made it an ideal location to capture diverse experiences and perspectives. Focusing on a single hospital ensured contextual depth and consistency in exploring mothers' lived experiences while maintaining feasibility and ethical manageability in data collection.

2.3. Sampling

This study adopted purposive sampling to recruit participants who have direct experience with the phenomenon under investigation-specifically, mothers who have cared for preterm infants admitted to the neonatal intensive care unit (NICU). Purposive sampling is appropriate for this study, as the aim is to obtain rich, detailed, and context-specific data from individuals with firsthand knowledge relevant to the research question [12]. The mothers of pre-term babies in the NICU and paediatrics ward were purposively selected to participate in this study. Mothers who delivered preterm babies and were caring for them in neonatal units were included in the study, as they have relevant data to be collected regarding their challenges in the care of preterm babies. All mothers who declined to participate were excluded from the study. Participants were approached individually to explain the purpose of the study and obtain informed consent. Data collection continued until saturation was reached with participant number 10, after which two additional interviews were conducted to confirm the stability and completeness of the themes. Decisions about inclusion or exclusion were guided by voluntary participation, ethical considerations, and the relevance of participants' lived experiences to the research question.

2.4. Data Collection

The primary author collected data through one-on-one semi-structured interviews in a private room. The author used a semi-structured interview to ask the same question in the same manner to all respondents. Each in depth face to face interview took 30-45 minutes. The mothers were given consent forms before participating in the study; the aim of the study was explained in detail, and the primary author provided information on ethical standards. Data were collected by the author from mothers of preterm babies using a voice recorder. Probing questions were asked to gather more information. Field notes were taken to assist the author in noting non-verbal reactions during the interview. Data collection ended at participant 12, when no new information emerged. Data was collected over a period of three months. An in-depth one-on-one interview was used to collect data from participants in Sepedi.

2.5. Data Analysis

In this study, data were analysed using a thematic approach inspired by Tesch's method of qualitative analysis, grounded in an interpretive paradigm that emphasises' subjective meanings and contextual experiences of participants. The analysis focused on prioritising mothers' experiences of the care of their preterm babies admitted to NICU rather than generalised results. The primary author began by thoroughly reading all the transcribed interviews to gain a general sense of the data. Initial thoughts and emerging ideas were noted in the margins to capture early impressions. One transcript, typically the shortest or most straightforward, was selected for detailed review. The author asked, "What is this participant talking about?" and wrote down initial thoughts to begin forming codes. The process was repeated for several transcripts. A list of all emerging topics was compiled, and similar ideas were grouped [13]. Coding and theme development were conducted collaboratively: the primary author led the process, while three co-authors independently reviewed the coded transcript, discussed interpretation, and contributed to refining categories and themes. These were then organized into columns representing major topics, unique perspectives, and miscellaneous items. Topics were abbreviated into codes and applied to relevant text segments. This preliminary coding scheme was reviewed and revised to reflect any newly emerging categories or patterns. The primary author refined the codes into descriptive categories, ensuring they accurately captured the meaning of the data. Related categories were grouped to reduce redundancy and create a clearer thematic structure [14]. Categories were examined for interrelationships. Conceptual lines were drawn to illustrate connections and hierarchies among themes. A final decision was made on the abbreviated codes, which were alphabetized for consistency. These were then applied systematically across the entire dataset. All data segments belonging to each category were collated to facilitate thematic analysis [14]. The authors engaged in reflexive discussions and collaborative coding throughout the analysis to ensure that the findings reflected participants' perspectives rather than the researchers' assumptions, and used dialogue with co-authors to verify and refine the meanings. This helped identify patterns across participants' responses. To enhance the trustworthiness of the analysis, verbatim transcripts, field notes, and audio recordings were submitted to an independent coder. This step ensured inter-coder reliability and supported the credibility of the findings.

2.6. Measures to Ensure Trustworthiness

The study followed Lincoln and Guba's criteria to ensure trustworthiness. In this study, the following four criteria-credibility, transferability, dependability, and confirmability-were used to ensure the trustworthiness of the findings. Credibility was ensured through prolonged engagement with the participants in the study field to enable the researcher to capture the true reality of the study. The primary author enhanced the transferability of the study by providing a detailed thick description of the research methodology, ensuring data quality and the reliability of the results. Records of raw data, voice records, and written field notes were kept, ensuring confirmability. Records of research findings, conclusions, and the final report of the research study were kept by the primary author for a period of five years. In this study, the researcher employed a descriptive approach, ensuring a thorough assessment of the quality and coherence of the data collection, analysis, and theory development processes.

2.6.1. Researcher Reflexivity

Reflexivity was maintained throughout the research process to ensure credibility and transparency. The primary author is a registered nurse with experience in a Neonatal Intensive Care Unit (NICU), which provided valuable contextual understanding of preterm babies' care but also introduced potential bias due to her professional role within the hospital setting. To minimise undue influence, several strategies were applied. First, the primary author maintained a reflexive journal to document assumptions, expectations, and evolving interpretations during data collection and analysis. Second, bracketing was practiced by consciously setting aside prior professional knowledge and focusing on participants' lived experiences rather than clinical perspectives. Third, peer debriefing was conducted with co-authors not employed at the same facility to challenge interpretations and promote critical reflection.

2.7. Ethical Considerations

Permission was obtained from the Turfloop Research and Ethics Committee (TREC/158/2018:PGD), which grants ethical clearance. Permission from the Department of Health was also requested to undertake the research study. The Hospital's CEO was also informed in writing, requesting that a study be conducted at the Hospital. The author explained to the participants that they are not forced to participate in the study. Necessary information was provided to participants to ensure they understood that they are not required to participate in the study and can withdraw or terminate at any time if they feel uncomfortable.

3. RESULTS

Four major themes were identified during the data analysis. They reflected the lived experience of parents with premature babies in the neonatal unit. These themes and sub-themes are given below.

3.1. Theme 1: The Anxiety Experience

This theme reflects mothers' intense fear, uncertainty, and self-doubt when caring for their premature babies. The fragility of the preterm baby and the mothers' lack of confidence in handling them lead to anxiety about performing basic maternal duties. This experience highlights how premature birth disrupts a mother's sense of competence and preparedness, often requiring reassurance, guidance, and emotional support from healthcare providers.

3.1.1. Sub-theme 1.1: Fear of Carrying out the Maternal Role

Mothers expressed fear in performing maternal duties such as holding, bathing, and feeding their preterm babies.

Mother no. 1 shared: *"Bathing the baby was difficult because he is small... scared to hold him, thinking the neck will break."*

Mother no. 2 reported: *"Another thing that was difficult, inside there (referring to the neonatal unit), it was difficult when we start feeding the baby. When we start to feed they teach us on how a premature baby is supposed to be fed. Sometimes we make the baby aspirate feed, not even aware that the baby has aspirated and changing condition."*

3.2. Theme 2: Traumatic Experience

The psychological anguish and emotional shock that this theme symbolizes mothers experience after giving birth to a premature baby. The sudden, unexpected nature of premature delivery and exposure to medical interventions evokes feelings of confusion, helplessness, and emotional pain. For many mothers, seeing their babies connected to machines triggers trauma and fear of loss, reflecting the deep emotional toll of the neonatal intensive care experience.

3.2.1. Sub-theme 2.1: Shock and Anger

Mothers experienced shock and anger immediately after birth due to unexpected premature delivery and medical interventions.

Mother no. 3 expressed: *"Eee! First reaction when they gave me the baby, I saw him, he was too small, and I did not think he was going to be small like that. When the doctor came to check the baby, and put up a drip, my mind was off and everything the doctor was saying, I could not hear as I was just looking at the baby, asking myself what is happening, and a certain tube was also inserted... I was so confused, not understanding what is happening."*

3.2.2. Sub-theme: 2.2: Emotional Trauma

Mothers expressed deep emotional distress, including crying and feelings of helplessness, upon seeing their fragile babies.

Mother no. 4 recalled: *"When I arrived in the neonatal ward they showed me my baby, like I was so shocked because the baby was small and tiny, not holdable. When I see the baby, I could not hold myself, I cried a lot."*

Mother no. 5 shared: *"After I gave birth, they told me that the baby is very small and cannot breathe on its own. That gave me a shock and lose hope thinking that I'm going to lose her. The nurses and the doctors took my baby to where they keep premature babies, and after some time, they called me to come and see my baby. Jooh! When I arrived there, I could not believe my eyes. The baby was on a big machine, and pipes inserted in the nostrils. When I asked them, they reported that the baby is unable to breath at her own."*

3.3. Theme 3: Loss of Hope

This theme captures mothers' feelings of despair and hopelessness about their babies' survival and development. The uncertainty surrounding the health and future of their preterm babies leads to emotional exhaustion and diminished hope. However, as some mothers observe gradual improvement in their babies, this hopelessness begins to shift toward renewed optimism and resilience, reflecting an evolving emotional journey from despair to hope.

3.3.1. Sub-theme 3.1: Fear that the Baby Might not Survive

Mothers feared that their preterm babies would not survive or achieve milestones, which led to loss of hope.

Mother no. 4 said: *"When I see the small baby, I asked myself that 'Is my baby going to survive? ' I was thinking a lot of things during that time to an extent that I lost hope."*

Mother no. 5 added: *"I think sometimes you go into something that you don't know what is going to happen, and then, like now, this baby, I thought, because he is small, he is not going to achieve his milestone. I didn't think he will ever open his eyes, eat, or drinking anything. I was thinking of all the struggle that I will go through, such as not having enough sleep. But now he is growing, he is doing things like normal baby."*

3.4. Theme 4: Hospitalization Experience

This theme centers on mothers' struggles with the hospital setting, including strict routines, physical fatigue, and prolonged separation from family. The structured care schedules create fatigue and stress, while extended stays exacerbate feelings of isolation and burnout. Despite these challenges, mothers demonstrate endurance and commitment to their babies' recovery, emphasizing both the strain and strength inherent in the hospitalization experience.

3.4.1. Sub-theme 4.1: Adhering to the Hospital Routine

Mothers struggled to adapt to the hospital schedule, especially the need to feed every 3 hours, which led to fatigue.

Mother no. 6 explained: *"We have to wake up in night to feed our babies, and midnight hours are really a challenge to me. I just force myself because I want my baby to get out of this place."*

The same mother added, *"We have already accepted that we wake up every three hours to feed our babies. When a sister said wake up and say feed your baby, you can't just say I am sleeping. You just have to do like the way sister tells you."*

Mother no. 8 also shared: *"I wish nurses they could just let us sleep during midnight hours and early morning hours, and they feed our babies on our behalf so that we can get some rest."*

3.4.2. Sub-theme 4.2: Long-term Hospital Stay

Mothers found prolonged hospital stays stressful due to separation from family and continuous care demands.

Mother no. 9 recalled: *"Sister, having a premature baby is the end time for us mothers to get some rest. I came to this hospital when I was pregnant. The doctor checked me and said I'm having severe high blood pressure also my baby is very small. He then sends me to Mankweng hospital after 03 days of being admitted. At Mankweng hospital I spent about 14 days, and they operated. I gave birth to my baby boy whom weight was 1050g, and I spent another 05 weeks at Mankweng hospital because the baby was on oxygen all along. After 05 weeks, they sent me here and now I've been in hospital for 02 month and 02 weeks."*

4. DISCUSSION

The primary objective was to explore and describe the lived experiences of mothers of preterm babies admitted to the Neonatal Intensive Care Unit at the District Hospital in Capricorn District, Limpopo Province, South Africa. Specifically, the study sought to understand the emotional, psychological, and practical challenges these mothers faced in caring for their premature infants during hospitalization.

The study revealed four central themes capturing the core experiences of mothers: anxiety experience, trauma experience, loss of hope, and hospitalization experience. Mothers experienced significant anxiety regarding the care of their preterm infants, including fear of holding, feeding, and bathing their babies due to concerns over their fragility and risk of harm. This anxiety often hindered the early mother-infant bonding process. Such findings are consistent with the observations of Ncube, Barlow, and Mayers, who noted that fear of damaging preterm infants can prevent mothers from assuming their expected caregiving roles [15]. Recent research further supports these observations, emphasizing the critical role of supportive nursing interventions in alleviating maternal anxiety and enhancing confidence in neonatal care [16]. Other studies also highlight that education and emotional support can empower mothers, enabling them to overcome fears and actively participate in caregiving activities [17].

Alongside anxiety, mothers described experiencing intense trauma upon first encountering their preterm infants, marked by shock, anger, and self-blame. These responses can contribute to Post-Traumatic Stress Disorder (PTSD) symptoms such as avoidance and hyperarousal, which disrupt normative parental

attachment and adjustment processes. These findings align with the work of Brown and more recent studies by Lee and Kim, who underscore the long-term psychological impact of premature birth on mothers and the necessity of early mental health interventions [18].

A sense of loss of hope also emerged as mothers grappled with the uncertainty of their infants' survival, particularly when confronted with the babies' small size and dependence on life-supporting machines. Such experiences foster feelings of despair and emotional withdrawal, a phenomenon echoed by studies by Treyvaud *et al.*, and supported by Torbet *et al.*, who emphasize that maintaining maternal hope through compassionate care and communication is essential in the NICU context [19, 20]. Chen *et al.* similarly advocate for strategies that nurture hope and resilience among mothers during these critical periods [21].

Another important theme was the hospitalization experience, where mothers struggled to adjust to the NICU environment and adhere to demanding routines such as feeding every three hours. Prolonged hospitalization contributed to feelings of exhaustion, isolation, and disruption of maternal roles. These findings resonate with recent South African studies by Buissinne and Nyaloko *et al.*, which identify the NICU as a stressful and often alienating environment for parents [22, 23]. Family-centered care models have been proposed to mitigate these stressors by promoting parental involvement and emotional support, leading to improved maternal well-being and infant outcomes [24].

However, certain discrepancies emerged when comparing this study with existing literature. Unlike some studies emphasizing the protective role of extended family and community support in African settings, mothers in this study reported feelings of isolation and limited social support during hospitalization. This could be attributed to hospital policies restricting visitors or cultural expectations regarding maternal roles in the hospital environment, highlighting the need for context-specific interventions. Furthermore, while many studies promote family-centered care as a standard, participants in this study indicated limited opportunities for active involvement in caregiving due to staffing shortages and infrastructural constraints in the local hospital setting [25]. This gap suggests a systemic challenge distinct from those in better-resourced NICUs, underscoring the importance of addressing structural barriers in Limpopo's healthcare facilities.

5. STRENGTHS OF THE STUDY

A key strength of this study lies in its qualitative, phenomenological approach, which allows for a rich, in-depth exploration of mothers' lived experiences in a specific South African context that is underrepresented in the literature [26]. The researcher's professional background as a NICU nurse provided a valuable insider perspective, facilitating trust and rapport with participants and likely enhancing the authenticity of the data.

6. LIMITATIONS OF THE STUDY

However, the study had limitations that should be acknowledged. The sample was limited to mothers from a single hospital in the Capricorn District, which may limit the generalizability of the findings to other regions or healthcare settings. Social desirability bias may have influenced participants' responses, especially given the researcher's role as a nurse working in that hospital. Furthermore, the study focused exclusively on mothers, omitting fathers and other family members whose perspectives could provide a more holistic understanding of the familial experience in neonatal care. The study recommends strengthening emotional and psychological support for mothers through regular counseling and peer support programs, as well as family-centered policies.

CONCLUSION

The findings of this study revealed that there are challenges mothers experience when taking care of their premature babies in the hospital. Mothers become anxious, loss hope for their born premature babies, fear to hold them nor feeds them as they are very small, the situation makes them feel shocked and always tired because they don't get enough rest as they attend to their babies every 03 hours, day and night. Addressing these challenges requires tailored psychosocial support, peer support programs, enhanced family-centered care practices (family-centered policies), and systemic improvements in NICU environments to better support mothers and improve neonatal outcomes.

AUTHORS' CONTRIBUTIONS

The authors confirm contribution to the paper as follows: N.F.M., L.M.: Study conception and design; N.F.M.: Data collection; N.F.M., N.S.: Analysis and interpretation of results; N.S., M.W.N., P.M.: Draft manuscript. All fo the authors have reviewed the results and approved the final version of the manuscript.

LIST OF ABBREVIATIONS

NICU	=	Neonatal Intensive Care Unit
CEO	=	Chief Executive Officer
PTSD	=	Post Traumatic Stress Disorder

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was approved by Turfloop Research and Ethics Committee, South Africa (TREC/158/2018:PGD).

HUMAN AND ANIMAL RIGHTS

All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Participants' consent to publish was obtained through a detailed written consent form.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

The dataset used in this study is available upon reasonable request from the corresponding author [N.S].

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None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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