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Importance of Social Support System on Maternal Experiences of Pediatric Department in the Northern Regional Hospital, Ghana

Lukman Amadu [a], Keren-Happuch Twumasiwaa Boateng [b*], Vida Nyagre Yakong [c], Williams Kwame Boateng [d], Ani-Amponsah, Mary [e], Richardson Doris [f], Theresa Abena Jamebe Antwi [g] and Dzigbordi Kpikpitse [f]

[a] Paediatric Department, Tamale Central Hospital, Ghana College of Nurses and Midwives, Accra, Ghana.
[b] Midwifery and Women's Health Department, School of Nursing and Midwifery, University for Development Studies, Tamale, Ghana College of Nurses and Midwives, Accra, Ghana.
[c] Department of Preventive Health Nursing, School of Nursing and Midwifery, University for Development Studies, Tamale, Ghana.
[d] Amity University, Noida, India.
[e] Maternal and Child Health Department, School of Nursing and Midwifery, University of Ghana, Legon, Accra, Ghana College of Nurses and Midwives, Accra, Ghana.
[f] Ghana College of Nurses and Midwives, Accra, Ghana.
[g] Teshie Nursing and Midwifery Training College, West African College of Nursing, Ghana College of Nurses and Midwives, Ghana.

Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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**Corresponding author: Email: khappuch89@gmail.com;*

ABSTRACT

Background: Mothers who give birth to low birth weight or premature babies who are therefore highly delicate may experience shock and depression as a result of having their newborns hospitalised in NICUs. This kind of hospitalisation ruins the family dynamic and throws the parents of these infants into chaos and distress. These difficulties span a variety of domains, including social, economic, physical, and psychological ones. For mothers of preterm infants, there are no support groups where they may talk about their suffering, interact with other women who have similar issues, or share experiences. Overall, whilst the issue of preterm births may be getting worse, the Ghanaian environment does not adequately capture it.
Purpose: This study attempts to analyse the importance of social support system on maternal experiences.
Methods: The study, which targeted women with preterm newborns receiving care at the Northern Regional Hospital, used a descriptive design and was carried out in Tamale Metropolis. The purposive sample strategy was utilised to recruit participants for the study. Face-to-face interviews with participants were conducted using a semi-structured interview guide, and the findings were examined using theme analysis.
Results: The study's conclusions showed that when participants received knowledge on how to care for their preterm baby and were also shown how to offer the caring activities, they became more confident in doing so.
C**onclusions:** Support from the staff, other newborn mothers, and the participants' families made it easier for them to cope and encouraged bonding. In order to facilitate newborn care and reduce the length of time preterm hospitalised infants spend in the neonatal intensive care units, management should supply enough logistics and supplies to all neonatal intensive care centres.

Keywords: Experience; mothers; preterm babies; paediatric department.

1. BACKGROUND

According to Schenk and Kelley [1], mothers of preterm newborns in hospitals expressed a desire for individualised social and psychological care in order to help them form close bonds and connections with their preterm children. Ionio et al. [2] reported once more on the difficulties moms with preterm newborns in neonatal critical care units encountered. The admittance of the neonates and its associated issues had a significant negative impact on the degree of interaction between preterm newborns as well as between mothers themselves and health personnel [2,3,4]. Healthcare professionals in neonatal intensive care units did not always notice underlying issues that mothers of premature newborns in hospitals experienced. When the women's comments were examined more closely, it became clear that they required interpersonal ties with established foundations and communication regarding the preterm birth in order to feel supported psychologically and socially [2,5]. Mothers of hospitalised preterm newborns experienced both good and bad things in the NICU, according to a study by Aliabadi et al. [6]. This emphasised the necessity of empowering and collaborating with moms when caring for preterm infants in order to minimise the unpleasant experiences [6,7]. Creating social support networks for moms of preterm infants in hospitals could aid them emotionally and function as a sort of collaboration in the care of the newborns [2,5,8]. Not to mention, Jarrett & Ollendick [9] observed that moms supported the initiative because they believed it would raise the calibre of the services offered. Additionally, they thought implementing a support programme would increase the facility's capacity to serve more patients in a competitive industry [9,2,10].

Based on this justification, an increasing number of studies have used qualitative methodologies to look into what the medical staff can do to help parents of preterm infants have a better stay in the neonatal unit and to pinpoint areas that are particularly important for their care. The NICU personnel might get insight into mothers' experiences during the admission of their babies to intensive care in order to better organise activities and handle the situation with respect and safety for the hospitalised newborns [1,2,11]. In Northern Ghana, when a healthy baby is born, it is typically honoured with pomp and circumstance throughout the course of a week-long celebration. The parents of these newborns typically show their pride in their accomplishment and make big plans for the future for their child.

However, premature infant parents frequently experience stress and trauma [12]. In addition, preterm babies are frequently taken away from their parents as soon as they are born and placed in neonatal critical care for urgent intense care. Parent-infant bonding processes are seriously jeopardised by this forced separation, which also seriously jeopardises the parents' capacity to take on their parental responsibilities in the way that healthy term-baby parents generally do at delivery. These parents thus frequently have their infants spend lengthy hospital stays in the NICU, where the advanced atmosphere and activities present parents with a traditional parenting role [6,13,14].

2. METHODS

The study's target population was women with preterm infants receiving care at the Northern Regional Hospital in the Tamale Metropolis. The study environment must be carefully chosen in order to have a good chance of producing sufficient data that will allow for a thorough knowledge of the phenomenon under study [15].

Setting: Tamale serves as the regional capital for one of Ghana's 16 regions, which make up the Northern Region. It is located between 00.36 and 00.57o West and 9.16 and 9.34 North. The Metropolis is located on ground that is 731 km2 in size and 180 m above sea level. Its borders are the Savelugu-Nanton District to the north, the Central and East Gonja Districts to the south, the Yendi Municipal to the east, and the Tolon and Kumbungu Districts to the west. Tamale Central Hospital was established in 1928 and operated until 1974 when it was closed down and later reopened in 2005, 31 years later. Also, known as the Regional Hospital has 186 beds, 8 functional wards and provides a 24hour service. The hospital provides services such as OPD, Pharmacy, antenatal care, laboratory service, theatre service, Ear, Nose and Throat care, psychiatry and maintenance care and among others. This study focused on a group of parents whose newborns were admitted to the paediatric unit of Northern Regional Hospital.

The study included mothers of newborns whose infants were admitted to the paediatric unit of the Northern Regional Hospital for a minimum of three days. The study included mothers who could communicate in either the Dagbanli or English languages.

Mothers who had post-delivery difficulties and were in the hospital were excluded from the study.

Sample Size and Sampling Method: Purposive sampling, commonly referred to as judgmental sampling, is a non-probability sampling method. This strategy is said to offer the flexibility to select a subset from the entire population based on the researcher's comprehension of the subject [16,15]. Additionally, the investigator can use purposeful sampling to create selection criteria based on parameters that reflect the characteristics of the target group [17]. In order to find participants for the study, the researcher used the purposive sampling technique. The method enables and directs the selection of moms whose premature children are hospitalised.

Data collection tool: A semi-structured interview guide was utilised to focus and direct the format of the comprehensive face-to-face meeting in order to elicit the participants' highly useful information [15]. Additionally, the data collecting tool employed was suitable for retrieving data that would answer the research objectives [18]. The structure of the interview guide was determined by the study's goals. Sections A (Demographic Characteristic Data) and B of the semi-structured interview guide were designated for open-ended inquiries (Experiences of admission into NICU).

Data gathering process: An introduction letter from the Ghana College of Nurses and Midwives and a research proposal were submitted to the Ethics Review Committee of the Ghana Health Service to obtain the ethical clearance and administrative approval. More crucially, a formal request was made to the head of the paediatric department at the Northern Regional Hospital to use the nurses' rest room so that the interviews could be conducted in a private setting with few or no interruptions.

The Ghana Health Service's Ethics Review Committee provided the administrative and ethical clearance. Mothers who had been admitted for at least three days in the ward were located utilising the patient folders with the assistance of the NICU nurse in charge. After introductions and the development of a rapport, interviews with the willing participants were conducted. The interview was conducted following a detailed description of the study's goals and advantages to the participants, as well as after obtaining their verbal and written agreement. In order to keep important information, their consent was also requested in order to audio record and take notes during

observations that the device was unable to record.

The interviews lasted between 30 and 60 minutes and were conducted primarily in Dagbanli with a small number of participants using English. Within five weeks, the data collection was complete. Using the interview outline, the investigator personally performed the interviews. The thoroughness used in the data collection method helped to minimise any potential bias in the study's findings. The participants' lost time was much appreciated and thanked.

Methodological rigour: Integrity is crucial for determining the usefulness of a qualitative study [19]. Furthermore, they caution that respect for participants and research ethics should be used as criteria for evaluating qualitative research. The reliability of this study has been assessed using the four criteria developed by pioneers of qualitative research, namely credibility, transferability, dependability, and confirmability.

The facts presented show the participants' actual data while also highlighting the importance of the data and its clarification. The researcher's built relationship with the participants prior to the interview to foster trust and ensure that the findings and interpretation are valid. Field notes were recorded throughout the face-to-face in-depth interview in order to document non-verbal cues that the audio recorder was unable to pick up on. This was then utilised for the transcription and summary of the interviews.

As a result, the detailed report of the procedures was transferred, paying particular attention to the context and the participants. This will help the reader determine whether the strategy may be applied to a populace with a diverse setting but comparable features. By reviewing the investigator's data record notes, demonstration is accomplished. As a result, member checking was carried out, and the methodologies (data collection, analysis, and interpretation) were rigorously applied step-by-step to provide a thorough grasp of the procedure.

Confirmability demonstrates that the participant viewpoints, not those of the researcher, are used to evaluate the data and derive the conclusions [20,21]. In order to lessen potential subjectivity on the side of the researcher, the data and findings were reviewed by the participants.

In addition to requesting permission from the Northern Regional Hospital's hospital authorities, the Ghana Health Service Ethics Review Committee's Ethics Clearance was also requested before data collection, with clearance obtained. Respondents suffered no harm as a result of this study. No physical harm was done to the respondents, other than the time that was used. Before being given the option to participate or not in the study, all respondents received a thorough description of it. Copies of the participant information sheets were supplied to those who could read them to read at their leisure. Only the times that the participants (participants) felt were appropriate for such interviews were used to interview everyone. A copy of the informed consent form was made available to those who consented to be recruited, and they were required to sign it. To prevent eavesdropping, all interviews took place in the nurses' chamber of NICU at the Northern Regional Hospital. Only after providing them with all the information, they required about the study were respondents recruited for this study. They were prompted that because their contribution was charitable, they were free to leave the interview at any time without fear of intimidation or punishment.

3. RESULTS

The participant's interview experiences revealed three themes. They were interactions with healthcare professionals, social support for experiences, and unfavourable interactions with healthcare professionals. The newborns were seen by their mothers in the delivery room, but they were then taken right away to the newborn unit to be nursed in incubators. Parents visited the neonatal ward every three hours to visit with the baby, feed him or her, sponge the baby's body, and change his or her diaper since they were involved in the care of their preterm children. The paediatric atmosphere at first exacerbated the participants' worry and anxiety since they were wary of the tools in the unit and other unexpected items they observed there. It was difficult for moms to interact with their infants, but with support from the staff, other mothers, and their families, women finally developed an emotional connection with their kids. The joy of being released from the hospital was of utmost importance to the mother since she now had hope since the baby, who she continued to feed, had survived the initial stressful and important period in the NICU; yet,

moms were worried that something might happen to the baby while at home.

Mothers discussed how their preterm kids were actually cared for by the neonatal unit. Interviews with fifteen mothers of premature babies were done.

Before being enrolled in the study, every participant provided their informed consent. Participants were introduced to the researcher, then told about the study and given the opportunity to offer feedback on it (purposive sampling). After giving their consent to take part in the study, all participants were interrogated in a private, quiet area of the newborn critical care unit.

The fifteen participants' demographic data are shown in the table below; the mean age was 29.9 +/- 6.0. 19 (95%) of them were married, and 8 (40%) of them had no formal education of any kind. A full 50% of them gave birth to children weighing between 1.41 and 2.0 kg.

3.1 Support from Society for Maternal Experiences

Emotional Experiences: Getting over fear The participants were first taken aback by the birth of their babies because they had not anticipated giving birth so quickly. Their parents' psychological preparing process was halted. Their deliveries began abruptly and swiftly, and they weren't emotionally ready for it. The participants were taken aback by their young newborns' size when they first laid eyes on them.

> *I didn't anticipate giving birth to a child that small. I have no idea why the infant is so tiny; it makes handling him or her challenging. I was unaware that the baby would be little. I started off crying since the baby is so little. What should I do? I'll accept it in that way (P2).*

As it was their first-time giving birth to preterm kids, Participants who had previously given birth to full-term children were more traumatised by preterm birth. Their hopes of seeing a normal-term baby delivered vanished right away. Participants were astonished because it was unexpected and questioned why they delivered preterm babies:

> *My own experience is that I never anticipated giving birth to a preterm child because it has never occurred to me. I was really shocked by it. My mind is being disturbed by this because the infant is so little. Because the infant was having trouble breathing, they placed him in an incubator (P7).*

Participants found it challenging to accept the newborns after first viewing them. Due to the babies' small size, they had a hard time accepting them and understanding what was going on. They reacted poorly because they were unable to deal with the reality of the situation, such as running away from the babies to avoid seeing them. They felt confused, anxious, and emotional, and they blamed themselves:

> *I was pondering why I had to give birth to such a small kid and why, after being overly upset, I had to leave him. To care for the tiny infant, I shall be at the hospital. The infant is smaller and less robust than other infants (P2).*

This individual broke down in tears because they were unable to handle the circumstance. She struggled to believe that this tiny infant was actually hers because she could not picture it as the baby she had anticipated:

> *I sobbed as I stared at him, wondering if he wasn't a baby despite what people would say. Sad, huh. My heart is racing as I try to figure out why the baby is so little and what might be causing it. The infant is little, (P7).*

The participants overcame their fear as they interacted with their infants over time. They could now grip and touch them. This brought about a feeling of connection and stability:

> *Since it wasn't the first time, I was glad that I could now hold my child. When I first started visiting the neonatal ICU, I would simply stand next to him without touching him and contemplate my next move. I therefore felt relieved that I could finally hold the infant (P1).*

When a participant felt that her infant's condition had improved because the child was awake, she held the infant. The participant felt different from the earlier period when she was unable to touch or hold the baby, which gave her an emotional fulfilment as she held the child:

> *Mmm! When I noticed that she was awake, I initially held her. The day I felt better was*

that one. I meant to say that I felt like I was getting happier. I felt something different from what I had previously. I have optimism that the infant is okay and will stop wailing if I take him up (P6).

The fear of handling the tiny infants diminished as the participants' attitudes toward their baby shifted from fear to acceptance. Their feelings for the babies had altered, thus holding the baby gave them a chance to accept them. They could now embrace and adore their infants and desired to always be close to them, changing the earlier sensation of fear and uncertainty:

As I previously stated, I was first terrified of him but have subsequently come to accept him. When I get there, I'm able to lift him. I miss him even when I'm in the space. He has my acceptance and my love (P2).

The participants realised that, despite being small and preterm, their newborns were much like any other baby when they continued to touch and handle them:

As time passes, you come to terms with the baby and realise that everything is good. Term babies might also vary in size. I've observed that the infant is doing OK, so this one can also grow. Insha Allah, I am patient and will tend to the young child (P5).

The relationship with them became palpable and real when I was able to feed their young children. Because they could touch them, participants could actually express their love for the babies. The participants' interaction with their kids and ongoing contact with them helped them form positive relationships with their children:

I could finally touch him when I started feeding him, hee! I showered him with affection. The infant was sobbing, but stopped when I tried to nurse him from the breast. The infant is now crying again (P3).

The participant who had previously lost a kid put off building a relationship with her new child out of worry that she would also lose this one. As she began to engage with her baby, this terror evolved into love:

I grew to love him. Because I had a baby who passed away, I initially gave up. I don't want the baby to be lost. I don't want to lose him, and the babies are so little and frail. I am caring for him, but I don't really handle her (P8).

When they could watch their babies' reactions, such opening their eyes, the participants loved their newborns even more. Although the participants had previously caressed their kids, they felt differently when they saw their newborns' reactions. They were overjoyed and encouraged that their children would live as a result:

Since I used to just stare at him there, there was no show of affection previously, so it was good to see it. Even when I touched him earlier, I could see that although he was still alive, there wasn't any... But I wasn't at all frightened when I first saw him open his eyes (P7).

Despite their initial concerns, the participants' emotional connection to their offspring was strengthened by the affection that grew between them. The staff members' support allowed the participants to develop an emotional bond with their infants.

There is a nurse who told me not to be afraid of him because it is me who is going to take care of him while they show us how to take care of them. I ended up being acquainted with him until he was able ... we got used to each other (P1).

The participants believed that bonding had taken some time because various factors, such as fear and worry, had delayed the emergence of a relationship between them and the infants:

As time passed, I began to love him since I had already accepted him as a baby. As time passed, I eventually began to get used to him. (P5).

It's not easy for the family either because we're on admittance, spend a lot of money on medications and lab tests, and I started feeling that love and attachment to the baby. The money may not always be available. The worst part is not knowing when day you will return home. (P6).

Table 1. Demographic characteristics of participants

Characteristic	Frequency i(n=15)	Percentage i(%
Mean Age i(SD)	29.3(6.0)	
Age group (Years)		
20-25	7	35
26-30	7	35
31-35	2	10
36-40	4	20
Marital Status i		
Married	19	95
Single	1	5
Number of Children		
1	4	20
2	6	30
3	6	30
4	3	15
6	1	5
Level of Education		
None	8	40
Primary	5	25
JHS	2	10
SHS	1	5
Occupation i		
Caterer	1	5
Farmer	2	10
House Wife	6	30
Nurse	1	5
Seamstress	4	20
Teacher	1	5
Trader i	5	25
Religion i		
Christianity i i	1	5
Islam	19	95
Ethnicity		
Dagomba	16	80
Frafra	1	5
Moshi	1	5
Sisala	1	5
Tampilma	1	5
Birth Weight (Kgs)		
0.68-1.2	3	15
1.23-1.4	7	35
1.41-1.6	5	25
1.9-2.0	5	25
Gestational age (Wks)		
28	2	10
29	2	10
30	4	20
31	4	20
34	2	10
35	5	25
37	1	5
Length of Stay (Wks)		
2	1	5
3	9	45
4	2	10
6	2	10
7	2	10
8	1	5
14	1	5
21	2	10

The participants emphasised the need for being given a sizable amount of time to remain in the unit and hold or cuddle the infants. However, they exhibited a variety of sentiments when they claimed that the infants were too small to be handled as infants.

3.2 Interaction with Health Care Personnel

Participants' interactions with staff were different. While most participants believed that staff members connected well with them, several participants voiced concerns about their interactions with the staff. Both good and negative interactions between participants and staff have been classified.

3.3 Positive Interactions with Health Care Personnel

They were able to overcome their anxiety and become competent in caring for their preterm babies thanks to positive interactions between staff and participants in the paediatric department. When the staff addressed their concerns and adequately addressed their questions, participants felt reassured. Participants thought nurses were being sympathetic and interacting with them as they expected when they provided explanations of what they needed to know.

> *I got along well with the doctors and nurses. For instance, the nurses were patient enough to answer all of my questions and primarily described the baby's condition and progress to me (P8).*

It was simpler for participants to give the babies the support care they required when there was positive interaction, according to the participants. Participants thought that the staff related well to them and gave clear instructions on how to care for the infants:

> *Therefore, there is good communication with the nursing staff. They give us instructions on how to proceed. There is absolutely no issue between us. Few of them were challenging; the majority of them were kind to us and didn't yell at us when we asked them for something (P1).*

The participants were able to recognise that they were partners in the care of their newborns thanks to staff who effectively communicated with them:

> *Typically, we call a nurse; depending on what the nurse was doing, the infant may be ill. They will explain that they are still working on something and that you should wait for them to complete if they are still doing it. But they are occupied, so they deal with our issues right away. The nursing staff and patient get along well (P1).*

Participants generally found it difficult to wait when they wanted help, but they still valued the way staff kept in touch with them when they couldn't provide support right away:

> *Mothers and nurses communicate effectively with one another. Only occasionally is it exceedingly challenging to accept certain circumstances as they are; for example, sometimes they don't give the kids breastmilk in small cups and other times they do. They're not awful (P8).*

The participants felt encouraged, reassured, and confident in their ability to care for the babies after being given knowledge and instructions on how to do so. In order to stop the transmission of infection, they were advised to wash their hands before handling the babies:

> *I didn't aware you had to wash your hands before entering the unit, so I didn't know how to feed him. I was unaware that while he is still here, I am not required to bathe him. Since this is my first child, physicians and nurses instructed me. (P19). To prevent the transmission of infection, they taught me to wash my hands before handling the infant and even after feeding the child (P2).*

The unit's routine was explained to the participants. In order for them to visit the unit and help feed their baby, they were notified of the feeding hours. This made it possible for moms to fulfil their parental responsibilities while caring for their preterm children:

> *They will go over everything with you when you first enter the neonatal unit. They would advise you to wash your hands both before touching the baby and even before feeding it. The nurse will inform you of the feeding schedule, which includes times such as 6am, 9am, noon, and 3pm (P8).*

When the nurses and doctors revealed to the participants the condition of their babies and the treatments performed on them, the participants felt less anxious and were reassured. The participants' understanding of the babies' condition and their psychological preparation for potential difficulties were aided by the explanation of the babies' condition to the participants. Procedure explanations also reduced mothers' anxiety, which facilitated mother-infant contact.

When the duty team responded to their inquiries about the conditions of their infants, the treatments, and their justifications, the participants felt reassured. They were comforted when doctors described the potential explanations because they wanted to know what was causing their babies' conditions:

> *Every time doctors need to perform a surgery on my infant, they usually notify me beforehand. The previous time they performed a brain scan, I even asked them. They gave me an explanation of their motivation (P4.)*

> *They gave me an explanation of what led to and why that happened. I questioned what the dark colour in between was, and he responded by explaining that the blood that affected the brain is seen as a dark colour on the scan. The infant will be alright, I was also told, because he is receiving treatment. The colour was fading on the side the second time they scanned it, and the black colour was no longer as intensely dark as it had been. I inquired as to why the colour was not as black and was informed that it indicated the infant was responding to the medication (P5).*

Five of the participants thought the nurses were helpful, while four said the doctors were helpful. If the staff provided the participants' needs, such as an explanation or the information they needed to use while caring for the newborns, the participants evaluated them as being helpful. If nurses and doctors offered satisfactory solutions and assistance, they were viewed as helpful; otherwise, they were viewed as useless:

> *The previous time, they wanted to discharge the child, but I refused because the child had changed. They listened to me when I said that I did not want the nurse to act on my behalf. Then they instructed on how to take care of him. I was relieved that I could finally care for my own infant (P4).*

Six of the participants were satisfied, especially as their infants gained weight, with the way the team of doctors and nurses was caring for them. They were pleased that the medical staff had exceeded their expectations and had given their infants good treatment. They felt comforted by this and gained hope for the future health of their infants:

> *Okay, well. I feel fantastic, I feel wonderful, and as long as my baby is developing and receiving proper care, I do not have any issues. I've been pleased so far with the care. There is nothing I can say that would make me unhappy about how they are doing (P1)*
>
> .

When the personnel gave them assurances about the babies' conditions, 17 of the participants felt that they received emotional support from them. As the nurses urged them not to be terrified of their babies, this assisted women in fulfilling their parental roles:

> *Having a fear of him. I managed to touch him for the first time, but it was a little challenging. I shouldn't be terrified of him, the nurse assured me, because I'll be taking care of him while they demonstrate how to care for them (P17).*

One woman found it really difficult to bond with her newborn because she had already lost a child who had also been delivered preterm the year before. This brought back painful memories of the loss and stoked worries that the current baby would also pass away. The nurse gave her advice, and after reassuring her, she was able to interact with her child. The staff's assistance helped the participant get past her obstacles and interact with the baby:

> *She then gave me comfort and urged me to stop dwelling on the past and start living in the present. She advised us to look at the bright side and hold out hope that the kid will be healthy. After speaking with the nurse on the 27th, I felt better (P18).*

3.4 Bad Experiences with Medical and Nursing Staff

Despite the fact that three of the participants occasionally had unpleasant experiences with

the medical and nursing staff, they also admitted that some of the staff members got along well with them. 17 of the participants felt that they interacted with the staff members in a pleasant way. These participants felt it challenging to trust staff because of the disparities in interaction that employees displayed. Participants believed that few nurses imposed their personal issues on them:

Hey! Myself There doesn't appear to be any contact between... Some nurses would travel and return home in different moods. If you yell to some of them, they won't mind. Sometimes, yeah, we don't even ask them about the babies (P7).

Participants recognised the personality differences of the staff members who were on duty as well as their interactions with them. They believed that when the nurses interacted poorly, it significantly impacted how well they were able to deal with their current circumstances.

You see, the nurses are not the same. There are those who treat us well and people who do not at all treat us well. Poor treatment has an impact on us, notably on how effectively we can take care of our children (P14).

One participant felt that on her first day in the paediatric department, she was not given instructions on how to care for her premature kid. The participant's capacity to communicate with her infant was hampered by a lack of knowledge about how to care for the unwell preterm baby because she was new in the situation:

Heishi! No, on my first day here I was completely lost. There was no schooling available to me when I first entered the neonatal unit. Nothing about the upkeep of those infants was disclosed to us (P17).

When their babies experienced a difficulty and the team of doctors and nurses took some time to respond when they were contacted for help, two of the participants became worried and disturbed. They thought that the personnel "delayed" in replying to their request, which increased their anxiety: Mmm! Another issue is that when you call the nurse... He or she will act as though they are exhausted and have no idea why you are phoning them. She arrives at his own pace so frequently that perhaps it would be best if he responded to your call immediately. They take their time to respond to your demands (P17).

Two of the participants expressed dissatisfaction with the way their infants were being cared for, particularly when the moms and the staff did not interact well. Participants believed they did not receive enough assistance with regular care, such as changing diapers. They felt the infant might be neglected because there weren't many staff members on duty:

Mmm! You will find your infant there, unattended, with an unchanged diaper, which made me unhappy. The baby will still be in the same sheets and the diaper won't have been changed if you choose not to visit the unit since you weren't feeling well. To address the issue of insufficient staff and increased workload, the government must hire additional nurses (P6)

When the babies' treatments were not described to the participants, their anxiety increased because they felt unsure of whether a certain treatment (such a blood transfusion) was saving the baby's life or endangering it. Despite their perception that they were in the dark regarding the baby's treatment's purpose, they felt compelled to follow instructions out of concern for the babies' welfare:

Even when they administer drugs, they never explain their purpose.

"As a mother, you have not been informed that the baby is on a drip, so you are unaware of what the baby is missing" (P6).

3.5 Achieving Support

The participants received help from a variety of support networks to deal with their challenges as they provided care for their preterm newborns. Participants' ability to cope was aided by the staff members' support. After receiving information and instruction from professional personnel on how to do iso, the participants were able to care for their preterm newborns. This aided in their ability to become skilled carers for their premature infants. Additionally, staff personnel comforted moms when the babies' illnesses worsened and offered advice to them when they encountered challenges while delivering care. The participants' relationship with their newborns improved, and they eventually bonded with them, thanks to the staff's support:

Additionally, they support us and advise us that if he is like this, we should do this and that. They assure us that there is a chance the baby will live. They are the ones who always give us advice. Because of how well they are doing, they offer us hope (P2).

The staff members who offered them advice when they disagreed with other mothers in the facility helped the participants feel more at ease: "The other thing is that if someone hurt you I those women who supervise how we take care of babies... the nurses, they call you, sit down with you and talk to you in order to be reassured." They speak to us about little babies when they notice that we are depressed (P1)

While in the neonatal unit, the participants received advice, reassurance, and comfort from other moms. Mothers in the neonatal unit urged the participants to embrace and touch their infants:

Some of the mothers who were present were the ones who offered me consolation by pleading with me to touch and kiss him. I began stroking his toes and legs. Some of the other mothers are excellent, and I always talk to them because they seem to like me (P7).

Long-term mothers in the unit acted as comforters for new mothers by educating them on how to care for the infants and reassuring them because they had gone through a similar experience. The participants exhorted others to trust that their baby will eventually be healthy, to have hope, and to pray. This aided them in overcoming their worries and fears while they took care of their infant and helped them build a bond with him or her. Participants found that other people's assistance was highly beneficial:

The mother of the baby next to yours, who at first made me nervous, did a good job of assuaging my fears by assuring me that her baby wasn't always like that. She said she had not anticipated the kid being the way he or she was at that that moment. She advised you to calm down and pray, believing that the baby will be okay (P8)

When they were in the newborn unit, the participants supported one another by speaking up for and helping one another. Even though the participants received help from others, they would also provide various forms of support for other mothers. Even though the babies' situations weren't getting better, mothers were urged to hold onto hope thanks to the emotional support of others:

For instance, I can now comfort a grieving mother by reminding her that I once experienced a similar circumstance. It'll be alright. Even if a baby is in a coma, as in the case of one mother whose child is in a coma for the fourth day, I assure her that everything will be okay (P7).

The participants discovered how to set aside their differences and carry on with their journey until they arrived at their destination. They had the capacity to overlook the wrongdoings of others and concentrated on raising their young. If the participants learned that she had failed to arrive to nurse her child, especially if the child was wailing, they would go and contact the other participants from the postnatal ward:

If someone has offended you, you must be able to forgive them and communicate with them. For example, if a baby is wailing and someone has not yet arrived at the apartment, you can go and call them, especially late at night. They sometimes spend a lot of time outside (P1)

During the hospitalisation of the babies, family members provided the study participants with social and emotional assistance. They accomplished this by paying them hospital visits. The participants forgot about being away from their relatives and felt less alone when family members visited them. This enabled them to concentrate on taking care of their infants:

When they came to check on us, their presence was crucial because I would forget about my position when I saw them. I didn't feel too much pain. They will advise me to take my time returning home. I must properly care for the infant (P6).

By calling them, the participants' family members were also able to reassure, console, and inspire hope in them through trying moments. In order to reassure them and offer them hope that their baby will also survive, family members shared with the participants stories of people they knew who had been born prematurely:

More frequently, my mother called to reassure me that I shouldn't be afraid because the baby survives exactly like the offspring of ISO and ISO. Despite being born too soon, he or she is now supporting themselves. There are no issues in their lives (P7).

Since the participants believed that God was with them, their religious beliefs provided them tremendous support. They asked for God to act in their circumstances. God answered their prayers, and the participants felt His presence:

God is wonderful because even while I was giving birth, although I don't usually pray, I did after learning that the baby had died. God heard my petitions, and I prayed. (P3)

When faced with challenges, participants entirely submitted everything to God. When they prayed, they had faith that God would not abandon them. They were able to deal emotionally and psychologically thanks to this:

My faith in God, my practise of praying, and my conviction that everything would work out was what gave me comfort. Only God has knowledge of everything that will happen to me. I have confidence in God, so I accept whatever gifts He offers me. That is life (P6).

3.6 Mothers' Reactions to Admission

Every participant reported having a bad experience with the admittance of their infants. The majority of them say the admission has changed how they go about their daily lives. They also highlighted social and psychological impacts of the admission;

Hmm. There are so many impacts that I simply cannot list them all. Sleeping is difficult since you're unsure about your infant's wellbeing. the best way to sleep Most of the time, you are always worried about your infant. You're unsure of his prognosis for survival (P6).

3.7 Admission's impact on family

All participants described the event as being traumatic for the family. They also mentioned how admittance affected their family's dynamics negatively. It was difficult for family members to interrupt their schedules in order to go to the hospital. Again, as a result of the admittance of the premature babies, funds that were utilised to pay for medicines and medical services instead of other equally important activities.

It's challenging for the family, too, my brother, because we spend a lot of money on drugs and lab tests while we're in school. When you contact the house and the money isn't there sometimes, they'll also lament the lack of funds. The most difficult situation is also when you are still unsure of when you will be released and family members at home don't call or repeatedly ask for you (P6).

Participants also mentioned how difficult it was to involve the family in the child's hospital stay, particularly when trying to contact them to clear some medical fees. They bemoaned the fact that they still hold out hope and confidence that things will turn around eventually.

4. DISCUSSION

4.1 Activating the Support Network

The participants in the current study found it upsetting to be responsible for a helpless infant in an unfamiliar setting. To help them cope, the participants required some sort of support. According to the study's findings, the personnel helped the participants in a variety of ways, including by explaining the baby's condition. Additionally, the staff encouraged participants to connect with their preterm infant, which aided in fostering a bond between participants and their preterm child. The assistance parents receive from the staff is beneficial in fostering competence and strong attachments with the child.

According to Schenk and Kelley [1], mothers reported needing individualised support to help them form relationships with their children. In order to determine what is known about the requirements of parents giving birth in the paediatric department and which behaviours support them, Cleveland [22] did a systematic review of both qualitative and quantitative studies. According to the review, moms wanted to be involved in decisions about the care of their infants and needed accurate information that was simple for them to understand. Mothers also said that they experienced stress if they didn't have accurate information regarding their baby's condition.

4.2 Nurses' Assistance to Mothers

According to research conducted by Mok and Leung [23], mothers felt they required information about how to care for their babies. They anticipated receiving the information at the right time and in a straightforward and honest manner. The parents claimed that knowing what was planned for their infants thanks to the information they received. According to mothers, they required emotional support since they were

disappointed, guilty, and anxious. When nurses listened to them and expressed concern for them, they felt like they were being kind. According to the study, when staff members encouraged women to help with their infants' care, they felt empowered and more like mothers. Additionally, they said that in order to improve their bond with their child, they required encouragement [23].

The study's participants valued the assistance they got from other mothers and thought it was very beneficial. The results showed that other mothers encouraged the participants to hold and touch their premature baby. The participants were helped to overcome challenges in providing care and developing a relationship with their preterm infant by the support and encouragement that the moms offered to one another. For mothers of sick preterm infants, support from other mothers is beneficial because it helps them get through their challenges.

Preyde and Ardal [24] observed that moms in the intervention group who got telephonic assistance from trained mothers who had previously delivered a preterm infant reported decreased stress at four weeks in a research that compared a supportive telephonic intervention with routine care. Mothers in the intervention group reported less anxiety, less depression, and more support perception at 16 weeks compared to the control group [25,12].

4.3 Mothers' Social Support

The results of this study showed that although women helped each other, they mostly helped the mothers of babies who were in the same cubicle as their own and did not interact much with moms of babies who were in other cubicles in the neonatal unit. It should thus be thought about creating a support group at the SCBU under the direction of a professional who can inform mothers and oversee group operations. If there is a recognised support group for mothers, they may successfully support one another by sharing their experiences, which will help other mothers cope with their conditions. Another choice is to hire a parent support coordinator, who is paid and largely in charge of helping parents in the neonatal unit.

The study recognises the importance of parent support groups for newborns referred to neonatal units. Moms supported the programme because they thought it would improve the calibre of the services provided, according to Jarrett [25]. They also thought that putting in place a support programme would increase the facility's ability to attract more patients in a competitive market [25,12,26]. Hurst [27] asserts that parent support programmes help women whose preterm children are admitted to neonatal units feel less stressed, which benefits both the moms and the physicians who work in those facilities.

Because they are separated from their preterm children and family members, they experience loneliness. The support group can provide a vital connection and a chance to communicate with other moms going through a similar circumstance [28]. Because they were admitted to a different unit from their preterm baby, the study participants experienced separation from their families and their preterm children, which increased their need for support. For the individuals, help was needed on an emotional and social level. They received support from their family in a number of ways, such as phone calls and visits, which helped them overcome their challenges and establish a bond with their preterm child.

4.4 Assistance from Family

According to studies, in order to manage their stress and problems, Family members essential to provide parents of preterm babies with emotional and social support. Reassurance was how moms communicated their need to be supported by their family, according to Bialoskurski, Cox, and Wiggins [29], because it helped the mothers realise that the other person cared about their comfort and well-being. The study was titled "The relationship between maternal needs and priorities in a neonatal intensive care environment." For mothers to develop a link with their infants, assistance and encouragement are necessary [29]. In their study on dads' support to mothers of medically fragile infants during hospitalisation, Lee, Miles, and Holditch-Davis [30] enrolled 64 mothers.

Mothers were questioned at enrollment, one month after the infant was discharged, and 12 months after the baby was born. According to the survey, moms believed that fathers offered them more assistance while their children were in the hospital than they did once they were released. Since the father cared for the baby's needs while also supporting the mother, mothers reported that the father's support during the baby's hospital stay was quite high.

5. CONCLUSION

The social support systems of mothers of preterm infants who participated in the care of their preterm infants in the Pediatric department at the Northern Regional Hospital were the main subject of this qualitative study. Interactions with medical and nursing personnel, overcoming fear through emotional attachments, and having a supportive network were the three themes that emerged from the data and provided a full assessment of the experiences. The parents also stated that they were interested in learning what transpired when their infant became ill and was brought to the intensive care unit. They wanted to comprehend what was occurring and believed it was crucial for them to be fully aware of their babies' health. Parents felt like a part of the team when the doctors and nurses explained what was happening. Last but not least, neonatal units promote family-centered care. Even if the results of the current study do not take into account the requirement for other family members to be involved, the unit where this study was done does not sufficiently practice family-centered care. Healthcare practitioners, especially those who offer neonatal care, should pay attention to a few key elements of caregiving that are crucial to raising the standard of care. Meeting specific maternal requirements through counselling and welcoming moms to the newborn unit should be a part of the planning of neonatal care. To encourage early contact between mothers and their preterm children when they are admitted to the NICU in order to foster bonding.

CONSENT

As per international standard or university standard, Participants' written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

The ethical clearance and administrative approval were obtained from the Ethics Review Committee of the Ghana Health Service.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Schenk LK, Kelley JH. Mothering an extremely low birth-weight infant: A phenomenological study. Advances in Neonatal Care. 2010;10:88-97.
2. Ionio C, Lista G, Mascheroni E, Olivari MG, Confalonieri E, Mastrangelo M, et al. Premature birth: complexities and difficulties in building the mother–child relationship. J Reprod Infant Psychol. 2017;35(5):509–23.
3. Kynø NM, Ravn IH, Lindemann R, Smeby NA, Torgersen AM. Parents of preterm-born children ; sources of stress and worry and experiences with an early intervention programme – a qualitative study. BMC Nursing. 2013;12(28):1–11.
4. Flacking R, Lehtonen L, Thomson G, Axelin A, Ahlqvist S, Moran VH, Dykes F. Closeness and separation in neonatal intensive care. Acts Peadiatrica. 2012; (101):1032–1037.
   Available:https://doi.org/10.1111/j.1651-2227.2012.02787.x
5. Kildea S, Stapleton H, Murphy R, Kosiak M, Gibbons K. The maternal and neonatal outcomes for an urban Indigenous population compared with their non-Indigenous counterparts and a trend analysis over four triennia. BMC Pregnancy and Childbirth. 2013;13(1):1.
   Available:https://doi.org/10.1186/1471-2393-13-167
6. Aliabadi T., Bastani F., Haghani H. Effect of mothers' participation in preterm infants' care in NICU on readmission rates. Journal of Hayat. 2011;17:71-77.
7. Steyn E, Poggenpoel M, Myburgh C, Africa S. Lived experiences of parents of premature babies in the intensive care unit in a private hospital in Johannesburg, South Africa. Curationis. 2017;40(1): 1–8.
8. Misund AR. Mothers' trauma reactions following preterm birth Department of Clinical Medicine; 2016.
9. Jarrett MA, Ollendick TH. A conceptual review of the comorbidity of attention-deficit/hyperactivity disorder and anxiety: Implications for future research and practice. Clinical Psychology Review. 2008;28:1266-1280.
10. Russell G, Sawyer A, Rabe H, Abbott J, Gyte G, Duley L, Ayers S. Parents ' views on care of their very premature babies in neonatal intensive care units : a qualitative study. BMC Pediatrics. 2014;14(230): 1–10.
11. Arnold L, Sawyer A, Rabe H, Abbott J, Gyte G. Parents ' fi rst moments with their very

preterm babies : A qualitative study. BMJ Open. 2013;10(1136):1–7. Available:https://doi.org/10.1136/bmjopen-2012-002487

12. Marley J, Tully MA, Porter-Armstrong A, Bunting B, O'Hanlon J, Atkins L, Howes S, Mc Donough SM. The effectiveness of interventions aimed at increasing physical activity in adults with persistent musculoskeletal pain: a systematic review and meta-analysis. BMC Musculoskelet Disord. 2017;18(1):482.
13. Misund AR, Nerdrum P, Diseth TH. Mental health in women experiencing preterm birth. BMC Pregnancy and Child Birth. 2014; 14(263):1–8.
14. Ahn Y, Kim N. Parental perception of neonates, parental stress and education for NICU parents. Asian Nursing Research. 2007;1(3):199–210. Available:https://doi.org/10.1016/S1976-1317(08)60022-5
15. Polit DF, Beck CT. Essentials of Nursing Research: Appraising Evidence for Nursing Practice. 7th Edition, Wolters Kluwer Health/Lippincott Williams & Wilkins, Philadelphia; 2010.
16. Grove SK, Burns N, Gray J. The practice of nursing research. Appraisal, Synthesis and Generation of Evidence. Elsevier, Saunders; 2012.
17. Basavanthappa BT. Essentials of medical surgical nursing. Mosby: Jaypee Brothers Medical Publication; 2011.
18. Burns N, Grove SK. The practice of nursing research: Appraisal, synthesis and generation of evidence (6th ed.). St. Louis: Saunders; 2010.
19. Raslova H, Komura E, Le Couédic JP, Larbret F, Debili N, Feunteun J, Danos O, Albagli O, Vainchenker W, Favier R. FLI1 monoallelic expression combined with its hemizygous loss underlies Paris-Trousseau/Jacobsen thrombopenia. The Journal of Clinical Investigation. 2017;114: 77– 84.
20. Lincoln YS, Guba EG. Naturalistic Inquiry. Beverly Hills, CA: Sage Publications, Inc; 1985.
21. Prion SK, Adamson KA. Making Sense of Methods and Measurement: Rigor in Qualitative Research. Clinical Simulation in Nursing. 2014;10.
22. Cleveland LM. Parenting in the neonatal intensive care unit. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2008;37:666–91. DOI:10.1111/j.1552-6909.2008.00288
23. Mok E, Leung SF. Nurses as providers of support for mothers of premature infants. Journal of Clinical Nursing 15, 726-734. J Clin Nurs. 2007;16(8):1584-6; discussion 1586-7.
24. Preyde M, Ardal F. Effectiveness of a parent "buddy" program for mothers of very preterm infants in a neonatal intensive care unit. Canadian Medical Association Journal. 2003;168(8): 969–973.
25. Jarrett MH. Parent Partners: a parent-to-parent support program in the NICU. Part 1: Program development. Pediatric Nursing. 1996;22(1):60-3.
26. Kynø NM, Ravn IH, Lindemann R, Smeby NA, Torgersen AM. Parents of preterm-born children ; sources of stress and worry and experiences with an early intervention programme – a qualitative study. BMC N. 2013;12(28):1–11.
27. Hurst J, Kelley E. Health care quality indicators project: conceptual framework paper. OECD Health Working Papers, No. 23, OECD Publishing, Paris; 2006.
28. Enke C, Oliva Y, Hausmann A, Miedaner F, Roth B, Woopen C. Communicating with parents in neonatal intensive care units: The impact on parental stress. Patient Educ Couns. 2017;100(4):710-719.
29. Bialoskurski MM, Cox CL, Wiggins RD. The relationship between maternal needs and priorities in a neonatal intensive care environment. J Adv Nurs. 2002;37(1):62-9. DOI: 10.1046/j.1365-2648.2002.02057. PMID: 11784399.
30. Lee T-Y, Miles MS, Holditch-Davis D. Fathers' support to mothers of medically fragile infants. Journal of Obstetric Gynecologic and Neonatal Nursing. 2006;35:46–55.

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