LIVED EXPERIENCES OF MOTHERS LODGING AT A PUBLIC HOSPITAL IN SOUTH AFRICA

by

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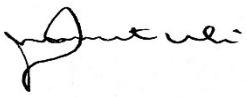
DECLARATION

I, Matshediso Julia Ntuli, declare that the Master's Degree research dissertation that I herewith submit for the Master's Degree qualification Master of Nursing at the University of the Free State is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.



Signature

30/11/2022

Date

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TABLE OF CONTENTS

LIST OF TABLES

CLARIFICATION AND APPLICATION OF CONCEPTS

Below are listed relevant concepts referred to in this study. The concepts are clarified per definition, and where necessary, an operational definition is provided to show its meaning and application in this study.

Baby

A baby is a child under 28 days old (World Health Organization [WHO], 2018). Only a small portion of the average person's predicted lifespan is spent in infancy, but this period is marked by significant physiological, physical and psychological changes, many of which are visible to the untrained eye (Bornstein, 2013). A baby is also referred to as a neonate and is regarded as such from birth to 28 days (South Africa. DoH, 2012a:2). An infant is referred to as a child aged one month to approximately twelve months of age (South Africa. DoH, 2012a:2). A baby in this study is a newborn or someone who was just born, from day one of life to more than one month, and was either born prematurely or sick and therefore required admission to the neonatal care unit (NCU). A neonate or an infant will be regarded as a baby in the study, because the participants who reflected on their lived experiences referred to their newborns as "baby".

Lived experiences

The process of learning a skill or information via seeing and doing something is referred to as experience (Roth & Jornet, 2013:107). The concept of lived experiences relates to people's choices and feelings in their everyday lives. These feelings include how individuals remember and feel about situations they come across daily (Botma *et al.*, 2010:190). Brink *et al.* (2018:105) describe lived experiences as ways through which people are involved in the world, with the focus thus being on what is happening in that individual's life, what aspects of the experience are most important, and what changes are required. For this study, lived experiences reflect those day-to-day experiences of mothers lodging at a public hospital, with their babies having been admitted to the NCU.

Lodging mothers

In this study, the term lodging mothers refers to mothers who are accommodated at the hospital premises while their ill babies are taken care of in the NCU. Lodging

mothers are women in the post-delivery period and who would, in normal circumstances, be at home with their newborn babies. However, due to their babies' illness and hospitalisation, they are "lodging" to be near them. These lodging facilities are usually within walking distance of the NCU.

Lodging residence

A typical definition of a lodging house/residence is that it is a place where people can rent rooms to live in or stay in (Collins English Dictionary, 2023: online). In this study, the lodging residence (also referred to as the lodging ward) is the facility that was designed to accommodate mothers who must stay near the Unit or Ward where their sick baby(s) was admitted to at a public hospital. This residence is supervised by a dedicated person who ensures cleanliness. Residents are expected to make their own beds and wash their own clothes as the institution does not offer these services.

Neonatal care unit

An NCU is a specially equipped unit typically consisting of an intensive care unit (ICU) and a high care unit. The ICU caters for the specialised care of seriously ill patients and where medical and specially trained professional nursing staff are available at all times (South Africa. DoH, 2015:24). The high care unit caters for babies who are small but stable enough to be carried by their mothers for kangaroo care. District hospitals transfer neonates who need assisted life support to regional or tertiary hospitals where they are cared for by paediatricians in an NCU (South Africa, DoH. 2014a:23). For this study's purposes, the NCU is referred to as a ward that caters for both specialised care and high care cases at a specific public hospital that admits premature or sick neonates who are too ill for the general hospital ward. Babies in the NCU are usually in the neonatal period (the first 28 days after birth).

Public hospital

A public hospital, often known as a government hospital, is a facility that has the staff and resources necessary to diagnose illnesses, treat patients medically and surgically, and provide for their housing while receiving care. It often also serves as a centre for research and teaching (Piercey *et al.*, 2020:1). According to the DoH (South Africa, 2012a:50), a public hospital provides secondary and tertiary care services and central referral services. In addition, it may provide national referral services, train healthcare

providers, perform research, receive patients from other provinces who are sent there, and serve as the primary teaching platform for a medical school. For this study, a public hospital is a hospital such as described by the DoH above.

ACRONYMS

DoH	Department of Health
FSDoH	Free State Department of Health
HSREC	Health Sciences Research Ethics Committee
KMC	Kangaroo mother care
NCU	Neonatal care unit

ABSTRACT

The lived experiences of mothers who must make use of lodging residences while their sick babies have been admitted to a neonatal care unit (NCU) is understudied. The challenges that these mothers face daily is not well documented. To explore and understand the phenomenon of lodging at a public hospital in South Africa, this study focused on mothers and their experiences while waiting for the recovery of their babies. The research question to be answered was: What are the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU?

Since little is understood about lodging and its challenges, the researcher selected a qualitative approach through which data could be obtained from participants who had first-hand experience of lodging. A sample of 13 mothers participated in the study. The research phenomenon was investigated using data obtained from in-depth individual interviews. The findings of the study included five categories with relevant subcategories. The five major categories were: lodging environment, emotional experiences, nursing care of babies, interaction with staff, and participant perspectives.

From the data, it was inferred that participants experienced many challenges and multiple causes of stress during the lodging period and that they were not well supported by the service providers.

In terms of recommendations, the institution providing the lodging should commit to developing support programmes and policies for mothers who must endure being away from family and social support structures. Extended research into the phenomenon of lodging mothers might lead to the development of a unique institutional approach that will ensure a stay as pleasant and supportive as possible. In turn, satisfied mothers and supportive staff relations may reflect positively on the well-being and health outcomes of the babies.

Key concepts: lodging mothers, lived experiences, lodging residence, neonatal care unit, public hospital.

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction and Background

The admission of a newborn baby to a neonatal care unit (NCU) is often unexpected. There are several reasons for admitting neonates to an NCU. For example, preterm babies are admitted immediately after birth to support their immature organs. Other reasons include babies with a birthweight of 1 to 1.99 kg, full-term babies who are unwell, or babies that have significant gastrointestinal abnormalities, such as omphalocele and gastroschisis (South Africa. Department of Health [DoH], 2014b:47). The unforeseen birth and admission of a sick or premature baby may lead to anxiety, stress and intense emotions in family members, especially the mother (Abuidhail *et al.*, 2017:156; Davim *et al.*, 2010:713–714,866). Parents, especially mothers, whose newborns are in the NCU can find it psychologically difficult to have a sick baby, to worry about losing their baby, and to not fulfil the expectations of traditional parenting (Mizrak *et al.*, 2015:1).

Studies have shown that mothers and babies should stay together after birth (Crenshaw, 2007:1; De Araujo & Rodrigues, 2010:866). The early separation of mother and baby can have a substantial negative impact on mother-baby bonding and may lead to long-term difficulties for the mother in adapting to the parenting role (Chellani *et al.*, 2018:103; Cleveland & Horner, 2012:164). Identified sources of stress for the mothers include having limited access to their babies, especially when they are premature and critically ill. In addition, inadequate spousal support, lactation difficulties, insufficient health information, financial constraints and loneliness add to the daily worries of these mothers (Abeasi & Emelife, 2020:4; Cleveland & Horner, 2012:164; Lomotey *et al.*, 2019:1).

Admission of their babies to an NCU challenges mothers to undertake the duty of raising children with unidentified professionals at an unplanned location (Shimizu & Mori, 2017:4). These mothers often require individual support to ensure mother-baby bonding and maternal role development. Although mothers may perceive their babies' hospitalisation as stressful, they can help in a variety of ways with newborn care. These

include ensuring routine baby hygiene, feeding the baby and practising kangaroo mother care (KMC).

KMC is referred to as “a package of interventions”, which includes holding the baby, maternal skin-to-skin contact after the baby has been stabilised, and close observation of the baby (Lomotey *et al.*, 2020:9). Through KMC, normal body temperature is maintained. Numerous benefits of the KMC technique have been scientifically validated. A few of these are better mother-child interactions, increased milk production, ideal baby growth and development, improved physiological stability in babies, decreased pain, increased mother confidence, and improved care-taking of the baby by the mother (South Africa, DoH, 2012b:3, 2014b:58). Apart from promoting bonding between mother and baby and helping the baby to feel secure (Bamford, 2012:49), KMC may lead to early discharge from the NCU (Fonseca *et al.*, 2013:261). At the public hospital where the research was conducted, the hospital policy allows all mothers whose babies are admitted to the NCU to lodge in a unit specifically designed for this purpose.

Apart from the benefits of KMC, maternal presence alone may improve the baby’s weight gain and possibly neurodevelopmental outcomes (Kritzinger & Van Rooyen, 2014:2). However, in order to have the mothers nearby, most of them will have to find a place to stay while their babies are being hospitalised – especially those mothers who are from other towns or provinces. Providing for mothers to have daily access to the NCU has the potential to achieve the positive outcomes mentioned (Lomotey *et al.*, 2020:2). According to Chellani *et al.* (2018:103), there is sufficient evidence from six developed countries that neonatal outcomes improve because of increased parent-baby interaction in an NCU. Mother-baby contact not only encourages frequent personal contact with the baby, it also offers an opportunity for health professionals to support the mother and family members (De Araujo & Rodrigues, 2010:866).

The practice of providing lodging for mothers, especially for mothers whose babies are admitted to an NCU, complies with the Statute of the Child and Adolescent (SCA) (Fonseca *et al.*, 2013:261). The SCA also applies to South Africa and states that the mother’s accommodation is a space that permits the mother’s full-time stay during the baby’s hospitalisation. The SCA caters for pregnant and nursing mothers and stipulates that even during pregnancy, mothers have the right to life and health, and

assures care at different levels of public health services. In this regard, the government of South Africa must also provide food to nursing mothers. Watts and Wilton (2015:2) state that in public hospitals, healthy mothers who are discharged from inpatient midwifery care are liable for lodging.

A typical lodging residence has a maximum of three rooms, accommodating twelve patients per cubicle where mothers stay (South Africa. DoH, 2015:60). This residence is supervised to ensure cleanliness and security, but nursing care for the mother is not needed (Bettercare Learning Programme, 2019:24). The mothers are provided with a bed, a place to sit and relax, and a locker to stow their clothes and personal belongings. According to the DoH (South Africa, 2015:7), it is not expensive to accommodate mothers at a lodging residence.

The mothers of this study who reside at the lodging residence do not pay any fees to stay there - therefore, lodging is an option for those whose babies are in an NCU. Otherwise, mothers from other towns or provinces (refer to study context here below) may incur travelling costs after being discharged if they want to see their babies regularly. In such case, to keep mother and baby together, the mother must travel daily, which is not feasible if she stays out of town and cannot afford transportation to visit her baby regularly. This situation may result in mothers having less contact with their babies and not being able to provide KMC or breastmilk as required for the health of the baby.

Study context: The research site was selected based on the researcher's access to the population. The lodging residence in this study refers to the living space established near the NCU to allow mothers easy access to their sick babies. The mothers walk approximately 120 meters outside the hospital building before reaching the NCU. Mothers visit the NCU to express breastmilk and to assist with routine tasks such as feeding and changing nappies. The residence is at a public hospital in the Free State province (one of the nine provinces in South Africa). The hospital is situated in the Motheo District (one of five districts in the Free State). Since the hospital accepts referrals from the surrounding districts in the Free State, a neighboring province (Northern Cape) and a neighboring country (Lesotho), some mothers live out of town and need a place to reside while their babies are admitted to the NCU. All the mothers who participated in this study were from out of town at the time of the interviews.

The researcher of this study has been working at the public hospital at the NCU and with lodging mothers for the last 11 years. The NCU can accommodate 24 babies. Five beds are for babies with surgical conditions, five for babies with medical conditions, and two for babies with infections and that require nursing in an isolated cubicle. Another 12 beds are specifically for low-weight babies who do not need specialised care and those who have recovered and are stable enough to receive KMC by their mothers. Mothers are allowed to visit their babies regularly on a three-hourly basis. Even though there are determined visiting hours, they can visit at any time if no procedures are done on their babies. When the babies' condition improves and they no longer need specialised care, they are transferred to a unit that caters for stable babies who are nearly well enough to go home but are waiting to gain weight or to be weaned from oxygen.

Throughout the years, the researcher has observed that, as the literature states, maternal presence seems to contribute to a faster recovery of premature and sick babies (De Araujo & Rodrigues, 2010:866; Davim *et al.*, 2010:714). The researcher has also noted that not all personnel treat mothers who are lodging alike. Some older personnel seem impatient when mothers ask questions or hold their babies, and sometimes even deny them access to touch their babies, change their diapers or practise KMC. On the other hand, the younger staff seemingly like to involve lodging mothers by providing health education and allowing mothers to touch their babies, change baby diapers and practise KMC. Nurses who work with newborn babies need to be aware of both stress and sources of support for parents (Davim *et al.*, 2010:715).

The researcher has also observed a lack of support from families for mothers who are from other provinces. Often, the mothers do not have enough clothes to change into because they did not know that their babies would have some complications after birth. They often bring only pyjamas to the hospital, thinking that they may be discharged the following day, but due to unforeseen complications, the babies had to be referred to a tertiary institution for further management.

From observation, mothers do not seem to be prepared emotionally for a sudden change in their babies' condition or sudden transfer to another institution. The researcher has noticed that mothers lodging at the hospital appear sad and demotivated. Some mothers have expressed worry about losing their babies,

especially when babies get an infection. Some mothers have even said they did not want to go home to visit their family members because they worried they might receive bad news about their babies while at home. These observations interested the researcher in gaining a deeper understanding of what mothers are experiencing while lodging at the hospital so that appropriate support can be provided where necessary.

1.2 Problem Statement

Babies are usually admitted to an NCU when they are critically unwell or prematurely born. Patients receive intense care in this highly advanced setting from specialised medical teams and highly technical equipment, prioritising preservation of life (O'Brien *et al.*, 2013:1). Emergency and surgical treatments, resuscitation, intubation and ventilation, drug administration, and other standard procedures are all included in care. These activities often result in mothers being separated from their babies (O'Brien *et al.*, 2013:1). Mother-baby separation can stress the baby unnecessarily, impede attachment and bonding, and result in poor motor and neurological development (Sullivan *et al*., 2012:3). Lack of attachment and bonding may have lifelong adverse effects on the baby, such as poor relationship building, poor psychosocial skills development, and feelings of abandonment and neglect. Bonding and attachment play a role in the growth of emotional intelligence as well as in the development of the brain. Decreased stress, easier bonding, and possibilities for attachment between the mother, family, and newborn are therefore essential (Kuo *et al.,* 2011:298), all of which may be improved by allowing the mother to lodge at the hospital.

Providing mothers whose newborns are admitted to hospital with lodging residences emerged as a gradual, structured process of KMC and to inspire these mothers as caregivers in an NCU. Motherly presence and caregiving are supervised by the NCU staff (Bracht *et al.*, 2013:115; O'Brien *et al.*, 2013:1). Ideally, mothers receive training, assistance, and participation in non-invasive tasks like feeding, basic healthcare, changing diapers and reporting care given. In so doing, the mothers become active members of the healthcare team, of their babies, by contributing in decision-making and their physical care (Galarza-Winton *et al.*, 2013:335; O'Brien *et al.*, 2013:1).

Since the hospitalisation of a newborn is often unexpected, mothers may feel separated from their babies and may experience difficulty with mother-baby bonding

during this time (Ncube *et al.*, 2016:2). For reasons mentioned in the introduction, it would be preferable for mothers whose babies are admitted to an NCU to stay as close as possible to their sick babies in a lodging residence (South Africa. DoH, 2015:39).

Literature on how mothers experience having to lodge for unknown periods is scarce. Most literature focuses on the mothers' lived experiences with rooming-in babies and not those of mothers who are separated from their sick babies (Crenshaw, 2007:2; Lomotey *et al.*, 2020:1). It is therefore necessary to explore how mothers experience lodging while their babies are admitted to the hospital. Although the lived experiences of mothers whose babies were admitted to the NCU have been explored before (Lomotey *et al.*, 2020:1; Steyn *et al.*, 2017:1), there is still a research gap on the lived experiences of mothers lodging at or nearby the hospital while their babies have been admitted to the NCU. As the topic has not been studied in depth, it is difficult to know what kind of challenges these mothers are facing and how they could be supported to make their stay as pleasant as possible.

1.3 Research Question

What are the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU?

1.4 Purpose

The purpose of the study was to explore and describe the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU.

1.5 Paradigmatic Perspective

An interpretivist paradigmatic perspective guided this descriptive phenomenological research about the lived experiences of lodging mothers. Phenomenology flows from interpretive philosophy (Savin-Baden & Howell-Major, 2013:26). The philosophical assumptions, ontology, epistemology, methodology and axiology of interpretivism are summarised in Table 1.1.

Table 1.1: Philosophical assumptions of interpretivism

Paradigmatic perspective	Application in this study
Ontology The nature of reality: assumptions about the nature of being, and reality.	The subjective reality of how lodging affects mothers while their babies are very sick and have been admitted to an NCU.
Epistemology The nature of knowledge: the relationship between the researcher and participants; assumptions about the nature of knowledge and knowing; the relation between the knower and the would-be known.	Individual meaning-making through the lived experiences of lodging mothers and the researcher's understanding of lodging mothers' lived experiences.
Methodology How evidence is best obtained: assumptions about "how things are done"; systematic inquiry.	In-depth individual interviews to discover the essence and meaning of the participant's lived experiences of being a lodging mother at a specific public hospital.
Axiology Values and ethics: the role of values and ethics; assumptions about the nature of ethics and values.	Values are essential and are stated clearly and in detail in section 2.2.4. Principles will be followed to ensure ethical research practice.

Compiled from Botma *et al*. (2010:42–43), Mertens (2015:11) and Polit and Beck (2017:10)

The application of the paradigmatic perspective is presented in more detail in Chapter 2, section 2.2. The following section offers a summary of the research methodology, the population and units of analysis, and data collection and analysis. A detailed description of the research method is provided in Chapter 2.

1.6 Research Design and Method

The researcher selected a qualitative approach to guide the design of the study. Descriptive phenomenology was employed as a tradition of inquiry to answer the research question relating to the lived experiences of lodging mothers. Participants' lived experiences were not only interpreted or understood but also explored (Polit & Beck, 2017:472). The study was exploratory to offer a deeper understanding of the lived experiences of participants.

Descriptive phenomenology was applied in this study to understand the meaning of participants' lived experiences. The inquiry process included lodging mothers' experiences in the same hospital setting (Brink *et al.*, 2018:105; Creswell, 2007:57−58; Polgar & Thomas, 2013:78). The inquiry included gathering information from participants to understand lodging through the researcher's observation and

introspective reflection (Polit & Beck, 2017:471). A descriptive design entails the methodical gathering of data about the phenomenon of interest, which is a crucial step in the development of nursing knowledge about the problem (Botma *et al.*, 2010:194). Four steps of descriptive phenomenology were adopted, as mentioned by Polit and Beck (2017:471), and are presented in detail in Chapter 2 (see Table 2.1).

1.6.1 Population and unit of analysis

The population of this study includes all individuals or sum of cases that meet certain criteria for inclusion and who are available for research (Botma *et al.*, 2010:200). Brink *et al.* (2018:116) describe population as the total group of people or subjects who are of interest to the researcher and who meet the requirements for the research and have access to relevant and adequate information. The individual or entity from which the researcher collects data, including groups of people, is the unit of analysis (Kumar, 2018:70−71).

The accessible population in this study were all lodging mothers whose babies had been admitted to an NCU at a specific public hospital from December 2020 to April 2021. Approximately 27 mothers lodge at the lodging residence of the hospital per month. Mothers who had lodged for at least two weeks at the time of data collection were asked to participate, because those who lodged less than that might not have provided the rich data that the researcher sought. Interviews were conducted for data collection from 31 March to 4 April 2021. Lodging mothers who appeared emotionally unstable and depressed during the postpartum period, or who were confirmed to have postpartum psychosis, were not asked for interviews to protect their emotional vulnerability. Additionally, mothers who were physically unwell during the postpartum period (e.g., high blood pressure, extreme pain) were not asked for an interview unless they were comfortable enough to consent to an interview. Since the researcher was directly involved in caring for some of the prospective participants' babies, an independent person with good interviewing skills was requested to conduct as many interviews as were required to attain data saturation (Polgar & Thomas, 2013:35). This arrangement excluded possible coercion of participants.

1.6.2 Recruitment

Access to the participating lodging mothers was obtained by the researcher, who handed out information leaflets to them in their language of choice (Addenda A – C). The researcher briefed the prospective participants about the study and informed them that their participation was voluntary and that they could withdraw at any time. Subsequently, the independent interviewer made appointments with mothers who had agreed to participate and obtained informed consent on the day of the interview. Interviews were conducted at a time that was most suitable for the participants and when it was not required of them to nurse their babies.

The participants were chosen through purposeful sampling. In this kind of non-probability sampling, the researcher used her discretion to select participants from the population (Merriam & Tisdell, 2016:96). Prospective participants were included due to their lodging experience, their willingness to participate in an individual interview, and their ability to reflect on and communicate effectively about the feelings they experienced (Botma *et al.*, 2010:200). Maximum variation was used by including a variety of participants with different ages, gravidity, parity, background and cultural heritage to explore the diversity of individual experiences (Polit & Beck, 2017:499). Participants were interviewed in the language of their choice, which were Sesotho, Afrikaans or English.

1.6.3 Explorative interview

An explorative interview was conducted to test the interview question(s) and practise the interview process (Botma *et al.*, 2010:291). Simultaneously, the research question was tested. The interviewer conducted an individual explorative interview with a mother whose baby had been admitted to the NCU at the same public hospital where all the other interviews were conducted. Privacy was ensured by using a quiet seminar room near the NCU without interference from other staff (Brink *et al.*, 2018:115). According to the interviewer, the question(s) seemed clear to the participant, and she stayed within the allocated timeframe of 30 to 45 minutes for the interview. As Botma *et al.* (2010:291) suggest, the explorative interview would be repeated were amendments made to the research question or interview process, but in this case, the explorative interview was used as part of the data analysed because of the rich information obtained.

1.6.4 Data collection

The interviewer's abilities and experience as a qualitative researcher and an advanced midwife made her a suitable interviewer. An independent interviewer was asked to conduct the interviews to mitigate bias and to allow the participants the opportunity to express themselves freely, as the interviewer was not directly responsible for their babies' nursing care. In this way, in-depth interviewing allowed participants to respond freely to questions and to describe and explain situations that provided rich descriptive data (Abeasi & Emelife, 2020:3).

The interviews with a small number of lodging mothers aimed to explore and understand the participants' experiences from their point of view (Botma *et al.*, 2010:207). A guiding, open-ended question was asked during the interviews: Please tell me in detail the feelings you had as a lodging mother while your baby was admitted to the NCU? Based on the responses, comments and reactions of participants, the interviewer asked additional questions (Savin-Baden & Howell-Major, 2013:359). The interviews were audio-recorded with permission by the participants. The researcher ensured that the audio recorder was in good working order to ensure reliable recorded data. The interviewer used an interview guide as explained by Boyce and Neale (2006:5). An in-depth discussion of the interview process is presented in Chapter 2.

Only the researcher, the transcriber and the study supervisor had access to the raw data, which were kept in a locked cabinet. Data will be destroyed five years after the publication of this research. Audio recordings of interviews were downloaded onto an electronic storing device and placed in the locked cupboard for safe-keeping. Recordings were erased from the original device as soon as they were downloaded on a secure device.

1.6.5 Data analysis

When analysing qualitative data, researchers organise the information they have gathered and consider the significance of the participants' words and actions (Polgar & Thomas, 2013:181). Understanding participants' lived experiences included listening to their thoughts and observing what they said. Coding entails line-by-line reading through the transcribed data to separate it into meaningful analytical units (Maguire & Delahunt, 2017:3353). The preferred way to analyse qualitative data is to read the transcribed data throughout the data collection process, as the researcher does not

know what would be discovered or what the final analysis would be like (Merriam & Tisdell, 2016:197).

An experienced, independent transcriber transcribed the audio-recorded interviews as soon as possible after the interviews. Sesotho transcripts were translated into English and provided a permanent record of what was said during the interviews. Verbatim transcribing meant recording word for word what was said by the participants (Maguire & Delahunt, 2017:3353). The data analysis process was done according to Tesch's eight steps in the coding process (Creswell, 2014:198), and is described in more detail in Chapter 2.

1.7 Role of the Researcher

The researcher formulated the research question, selected the research design and method, and obtained the necessary approval to conduct the research. It was the researcher's duty to gain entry to the research site and address all the ethical issues concerned with this research (refer to section 2.8). Another task for the researcher was to choose the population and recruit the participants (see sections 2.4.2 and 2.4.5). Since the researcher was employed as a registered nurse at the NCU of the research site, she requested an independent, experienced interviewer for data collection to minimise bias. Prior to the interviews, the researcher and the interviewer agreed that the interviewer will make notes of the process that she followed during the interviews. This was necessary because the researcher had to ensure that the interviews were conducted in a standard relevant to rigorous research. Since the researcher was not directly involved in data collection, it was necessary to verify the content of the interviews and the transcriptions with the interviewer (see section 2.5.2).

1.8 Ethical Considerations

The actual process of conducting interviews only commenced after the necessary permission had been granted and the Health Sciences Research Ethics Committee (HSREC) of the University of Free State had granted approval for the study (refer to Addendum D). The researcher sought approval from the Free State Department of Health (FSDoH) to access the research site (refer to Addendum F). The researcher

took a letter requesting permission to conduct the study to the hospital management (Addendum G), and approval was granted verbally by the CEO of the hospital.

Ethics refers to how people and animals are treated when participating in research and how they gain from their participation, even if only indirectly. These are crucial issues that need to be maintained at the forefront of all considerations (Van Zyl, 2014:85). If an ethics committee approves a research project after reviewing the research question, study design, and implementation strategies, it is deemed approved (Polgar & Thomas, 2013:43).

Ethical principles assist an ethics committee in identifying and protecting research participants' interests in various research contexts and promoting the development of high-quality knowledge that may benefit future generations. The rights to self-determination, privacy, anonymity, and confidentiality, as well as those to fair selection and treatment and protection from discomfort and injury, all need to be upheld in research. These principles are articulated in national and international research ethics guidelines (Gray *et al.*, 2017:273–274).

The researcher was responsible for her work and had to advance South African moral and ethical values (Brink *et al.*, 2018:27). Ethical principles of beneficence and non-maleficence, justice, and respect for persons were adhered to throughout the study and are summarised in Chapter 2 (see Table 2.3). The ethical considerations must be adhered to because they guide the researcher and protect the participants (Polit & Beck, 2017:138; South Africa. DoH, 2015:36). A thorough description of the ethical considerations related and applied to this study is presented in Chapter 2.

1.9 Methodological Rigor of the Study

The study could clarify how mothers of newborn babies experienced lodging and what assistance can be made available to support them while their babies are in the NCU. Based on the results, new standard operating procedures could be developed and implemented at the institution under research. The self-esteem of some lodging mothers might improve when seeing that their feelings have been heard and issues have been addressed by the hospital management and nursing personnel.

The researcher intends to share the research results with the healthcare staff of the NCU and collaborate on ways to provide lodging mothers with the support they need. The institution under study will benefit from increased research capacity, and the researcher may benefit by being recognised as a valued researcher in her field of work.

1.10 Study Limitations

A perceived study limitation may be that only one public hospital was explored in the study, and the findings may not be exhaustive to other public and private healthcare systems. The findings were systemic in nature and may not be transferable to other situations. In addition, this study was conducted in Motheo district, Free State province in one hospital only. Furthermore, during the literature search, not many articles were found related to the study topic or specifically the phenomenon of “lodger mother”, hence making it difficult to support the results with recent literature. The researcher did not compare the experiences of participants based on their length of stay at the lodging residence. In retrospection, such an analysis and comparison could have added depth to the findings and the represented the “voice” of the participants more distinctly.

1.11 Layout of the Dissertation

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Results and literature control

Chapter 4: Conclusions and recommendations

1.12 Summary

This chapter provided an overview of the study. The introduction and background to the study, the problem statement, research question and purpose of the study were discussed. The research design and method, population and unit of analysis, data collection and analysis, and structure of the dissertation were outlined. In the following chapter, the researcher will provide an overview of the method and design selected.

Since it was a challenge to locate sufficient literature about the phenomenon of mothers lodging at a public hospital – even with the assistance of an experienced and qualified librarian – the researcher and her supervisor selected not to include a literature chapter but to incorporate literature control together with data interpretation in Chapter 3. This decision was also based on guidance (and debate) from other texts and researchers who prefer not to include a literature chapter in phenomenological studies:

- **Inductive approach**: *"The researcher begins by gathering detailed information from participants and then forms this information into categories or themes. These themes are developed into broad patterns, theories, or generalization's that are then compared with personal experiences or with existing literature on the topic"* (Creswell & Creswell, 2018:109).

- **Debate surrounding literature reviews in research**: *"It could be argued that a literature review constitutes an integral part of the research process in both the qualitative and the quantitative paradigm, given that it serves to inform the researcher of the present state of knowledge on the topic to be investigated*" (Fry *et al.*, 2017:12).

- **The literature review within the qualitative paradigm:** *"…that a literature review should be avoided in an attempt to elude being 'contaminated' by previous research knowledge…"; "…a literature review can condition your thinking about your study and the methodology you might use, resulting in a less innovative choice of research problem and methodology…"* "*For this reason, a systematic literature review involving an in-depth critical examination of the existing literature is often not undertaken at an early stage in the research*" (Fry *et al.*, 2017:12).

- **The use of literature:** *"One of the chief reasons for conducting a qualitative study is that the study is exploratory. This usually means that not much has been written about a topic, and the researcher seeks to listen to participants and build an understanding based on what is heard" "In some of the qualitative research strategies the literature is reviewed after data collection and analysis so that the literature does not influence the researcher's objectivity"* (Botma *et al.,* 2010:197).

- **Literature reviews in qualitative research:** *"Quantitative researchers almost always do an upfront literature review, but qualitative researchers have varying opinions about reviewing the literature before doing a new study"* (Polit & Beck, 2021:83).

CHAPTER 2: RESEARCH METHODOLOGY

2.1 Introduction

In the introductory chapter, the researcher provided a summary and an outline of processes followed to gather data on the lived experiences of mothers lodging at a public hospital during their babies' admission to an NCU. The mother's presence has many benefits to the baby, the family, the institution and the nursing staff. The study was undertaken to understand the lodging experiences of these mothers. The researcher viewed the experiences of lodging mothers as vital to the future implementation of support structures. In this chapter, the researcher describes the research methodology selected to answer the research question: What are the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU? The chapter further elaborates on and motivates the paradigmatic perspective that guided the study, the research design, the research population and steps taken to collect and analyse the data. The chapter concludes with a detailed description of ethical considerations and methodological rigor that were applied in this research.

2.2 Paradigmatic Perspective

An individual's place and range in the world and their many interactions with it are defined by a set of beliefs called a paradigm (Žukauskas *et al.*, 2018:127). According to Kamal (2019:1388), all research has a paradigm, which is defined as "systems of beliefs that guide action". To gain a deeper understanding of the lived experiences of lodging mothers, an interpretivist paradigm was selected (Savin-Badin & Howell-Major, 2013:220). In so doing, the phenomenon under study could be explored in its unique context instead of trying to generalise what all lodging mothers might experience. An advantage of working within the interpretivist paradigm is that the researcher can gather valuable data about the participant's perceptions, views, feelings and thoughts (Savin-Badin & Howell-Major, 2013:220). To this end, researchers often use in-depth interviews to interact with participants and to provide participants the opportunity to express their experiences (Creswell, 2009:181).

Within the interpretivist paradigm, the researcher selected descriptive phenomenology as the strategy of enquiry, as it could best answer the research question about how the participants experienced the phenomenon of lodging. Application of the research paradigm included the norms of how reality was observed (ontology), the nature of the methods (methodology), the nature of knowledge (epistemology), and how value-laden the study is (axiology) (Savin-Baden & Howell-Major, 2013:63). Each of these norms is briefly discussed below.

2.2.1 Ontology

Ontology is defined as "the study of being". It is concerned with "what kind of world we are investigating, with the nature of existence, with the structure of reality as such" (Scotland, 2012:10). Furthermore, the ontological assumptions are those that respond to the question "What is there that can be known?" or "What is the nature of reality?" (Scotland, 2012:10). Ontology, which is essentially a social universe of meanings, was used by the researcher. In this world, the researcher had to assume that the world she investigated was a world populated by lodging mothers who had their own thoughts, interpretations and meanings. The usage of the in-depth interview effectively demonstrated the researcher's investigation into this world, which helped to focus on the participants' lived experiences, opinions, feelings and inner thoughts.

In this study, the researcher explored the participants' reality from their point of view and not her own (Holmes, 2020:1). A discoverable reality existed independently of the researcher and the participants. The subjective reality on how lodging affected mothers while their babies were very sick and admitted to an NCU was different from the researcher's understanding. The interaction between the researcher and the participants allowed for the creation of mutually beneficial discoveries within the context of the situation that necessitates the investigation (Goundar, 2012:19). In this study, the researcher assumed that the participants revealed their own understanding and meaning of their experience of lodging at a public hospital.

2.2.2 Epistemology

Epistemology focuses on the nature and forms of knowledge (Gringeri *et al.*, 2013:55; Hussain *et al.*, 2013:2376). More specifically, epistemology emphasises that humans create reality by interpreting and interacting with their environment. According to this

epistemology, although things have a nature that exists independently of people, they do not have a meaning; instead, individuals create their own reality by assigning meaning to things (Wener & Woodgate, 2013:3). It focuses on the types of knowledge and understanding that a person, as a researcher or knower, may be able to acquire in order to be able to extend, broaden, and deepen understanding in their field of research (Kivunja & Kuyini, 2017:26).

To uncover new knowledge, the researcher positioned herself within the context based on what was known. Individual meaning-making through the lived experiences of participants and the researcher's understanding of the participants' experiences were explored. The interaction between the researcher and the data gathered about lodging mothers' experiences developed a kind of knowledge that led her to construct an interpretation and meaning of these experiences (Botma *et al.*, 2010:288).

2.2.3 Methodology

This study was based on the assumption that mothers of newborn babies would create meaning and understanding based on their experiences of lodging and that they would be willing to share these experiences with the interviewer. In-depth individual interviews were used to gather meaningful data on the participants' lived experiences. It was believed that useful information about the participant's experiences may be obtained, by conducting a qualitative descriptive study using in-depth individual interviews (Creswell, 2009:181; Guest *et al.*, 2013:113). In order to comprehend the phenomenon of lodging, the researcher employed inductive reasoning, and while entering the participants' environment, "reduction" was applied. Reduction entails giving significance to some parts of the data before categorising it (Namey *et al.*, 2008:139).

2.2.4 Axiology

The axiological assumption upholds that the study has biases and that it is value-laden (Kivunja & Kuyini, 2017:28). As seen by the steps she took to ensure credibility, the researcher used the axiological assumption by acknowledging the interpretivistic nature of the study and by seeking to minimise biases in it (described in section 2.9.1). Axiology focuses on the ethical issues that should be considered when conducting research. These include privacy, accuracy, property and accessibility (Kivunja & Kuyini

2017:2829). Axiology emphasises two realms closely related to philosophy, namely ethics and values. We possess values that guide our thoughts, behaviours and actions in everyday life, whether personal or social. Axiological thinking is involved in every moment, intentionally and unintentionally (Tufail, 2012:1). Norms are also important in research; they promote truth and knowledge. The researcher took care to respect the participants' points of view as it related to their experiences as lodging mothers.

2.3 Research Design and Method

The approach the researcher plans to take when conducting the research is known as the research design (Creswell, 2013:49; Kamal, 2019:1388; Rehman & Alharthi, 2016:51). After identifying the need to conduct research on the lived experiences of mothers lodging at a public hospital, the researcher selected a design that would yield answers concomitant to understanding the challenges experienced by lodging mothers. Therefore, the researcher selected a qualitative, descriptive phenomenological design to generate an in-depth understanding of the lived experiences of mothers lodging at a public hospital.

2.3.1 Qualitative research approach

In line with phenomenological research, qualitative research refers to a comprehensive and in-depth investigation of a phenomenon in order to acquire insights through the identification of meaning (Creswell, 2007:48; Jameel *et al.*, 2018:1; Mohajan, 2018:1). This kind of research can help researchers gain access to the ideas and feelings of research participants, which can help researchers better comprehend the significance that people attribute to their experiences. Researchers can better understand how and why certain behaviors occur by using qualitative research methods (Sutton & Austin, 2015:226). Qualitative research aims to methodically explain and analyse problems or occurrences from the perspective of the person or group being researched in order to generate new ideas and theories (Mohajan, 2018:24).

A qualitative approach with a descriptive phenomenological design was selected as a tradition of inquiry to explore and answer the research question relating to the lived experiences of lodging mothers. Through exploration, a deeper understanding of the participating lodging mothers' lived experiences was gained (De Araujo & Rodrigues, 2010:867; Polit & Beck, 2017:15). The lodging experiences of mothers at a public

hospital is a phenomenon which is not well established. Therefore, it was necessary to make use of an explorative design to investigate the nature of lodging. When little is known about the topic of interest, the explorative component of the qualitative research design is appropriate (Bradshaw *et al.,* 2017:1; Polit & Beck, 2012:18).

2.3.2 Descriptive phenomenology

Phenomenology is an approach to research that draws on both philosophy and psychology, and it involves outlining what people actually experience when they talk about a topic. The essence of the experiences of various people who have all encountered the phenomenon under inquiry are captured in this description. In this research, the researcher analysed the words of the participating lodging mothers, found meaning in the words and described the experiences that promoted a deeper understanding of participants' experiences (Grove & Gray, 2019:89). This design was used because it aimed at gaining more information about the phenomenon within the particular field as well as to obtain information about real-life situations of lodging for mothers of newborn babies (Goundar, 2012:15). Individual experiences are taken into account in phenomenology. It focuses on what all individuals (in this case, lodging mothers) have in common while they experience social occurrences (Elshafie, 2013:7). The inquiry included gathering information from lodging mothers and efforts to experience lodging through the observation and introspective reflection of an experienced independent interviewer (Polit & Beck, 2017:471).

Research that is descriptive investigates new areas of inquiry and presents things as they actually occur in the real world (Grove & Gray, 2019:35). A descriptive design entails the methodical gathering of data regarding the phenomenon of interest, which constitutes a crucial stage in the development of knowledge (nursing) about the issue (Botma *et al.*, 2010:194; Goundar, 2012:29). Little is known about the lived experiences of mothers lodging, particularly at a public hospital. The researcher had the purpose to understand the standpoints of concerned mothers with the aim of implementing an acceptable and efficient intervention from the perspectives of those concerned. Based on the exploratory and descriptive objective, a phenomenological descriptive design was a suitable option to actualise the purpose of this study.

The researcher adopted the four steps of descriptive phenomenology, as mentioned by Polit and Beck (2017:471), which are presented in Table 2.1 and explained further below the table.

Table 2.1: The four steps of descriptive phenomenology

Step	Application
Bracketing	The researcher held back her opinions about lodging and focused on analysing participants' feelings using a reflexive journal
Intuiting	The researcher tried to understand the lived experiences of participants
Analysing	The researcher reviewed the data frequently until an understanding was reached
Describing	The researcher paid detailed attention and provided a full description of the findings

Compiled from Brink *et al*. (2018:105–106), Botma *et al*. (2010:190) and Polit and Beck (2017:471–472)

Bracketing: Researchers must deliberately set aside their own ideas about the subject of the study or what they already know about it before beginning with and throughout the phenomenological investigation. This facet of research is called bracketing (Chan *et al.*, 2013:2). The researcher made efforts to put aside her personal opinions, biases, preconceived notions of the research topic to describe participants' lived experiences accurately through knowledge of previous research findings and theories (Polgar & Thomas, 2013:79). The personal values of the researcher were clarified, and areas in which the researcher was biased were identified (Polit & Beck, 2017:471). The researcher made use of a personal reflexive journal by noting interesting events or ideas while listening to the interview audios and describing new or surprising discoveries when analysing the data (Polgar & Thomas, 2013:78).

Intuiting: The researcher tried to understand the meanings of the lived experiences described by the participants. Throughout the research process, the researcher remained open to the meaning provided by the participants regarding their lodging experiences (Polit & Beck, 2017:472). The researcher was immersed in the participants' descriptions of their lived experiences.

Analysing: The researcher reviewed the data frequently until reaching a deeper understanding. Analysing entailed contrasting and comparing the final data to discover

if any new information was emerging. The knowledge should be understandable and clear to make it useful for other researchers (Botma *et al.*, 2010:191).

Describing: The researcher paid detailed attention and provided a complete description of the findings in Chapter 3.

2.4 Population and Unit of Analysis

All the lodging mothers that met specific criteria about lodging which the researcher was interested in were regarded as the population (Botma *et al.*, 2010:200; Brink *et al.*, 2018:116). Participants are those individuals or subjects who are notified about the research project and voluntarily consent to participate when contacted (Botma *et al.*, 2010:52). The unit of analysis is the person or object from which the researcher gathers data, and it includes groups of individuals who were the aim of the investigation (Kumar, 2018:70–71) as well as the portion of data content that would be the basis for decisions made during the development of codes.

2.4.1 Accessible population and sampling

In this study, the accessible population was lodging mothers whose babies had been admitted to an NCU while waiting for the recovery of their babies in a selected public hospital. Approximately 27 mothers lodge at the lodging ward of the public hospital per month. The total population who met the inclusion criteria at the time of the study was invited to participate. There were 20 mothers who were lodging at the time when the researcher collected the data. In line with the contextual nature of the study, the researcher decided to access only mothers whose babies were admitted in the mentioned unit and no other lodging mothers whose babies were admitted in other departments. This decision was taken to rule out possible challenges of the mothers' daily routines.

As mentioned in Chapter 1 (section 1.1), mothers are encouraged to interact with their baby(s) as often as possible to promote KMC and breastfeeding. Mothers who do not reside near the hospital stay in the lodging residence where they are provided with a room that is equipped with a bed and a locker for personal belongings. The institution provides three routine meals per day at 08h00, 12h00 and 16h00. The dining room is not part of the lodging residence but is situated in the hospital building about 350m

walking distance from the lodging residence. Apart from staying in the lodging area and visiting their babies as often as necessary, there are no planned activities for the residents.

2.4.2 Selection of participants

Participants were selected through purposive sampling based on the inclusion criteria described below. In purposive sampling, the researcher selects the instances or case types that will be most helpful to the study's informative goals (Etikan *et al.*, 2016:1; Palinkas *et al.*, 2013:2). For this form of sampling, the researcher of this study relied on her own judgement when choosing members of the population (Merriam & Tisdell, 2016:96). Members of the accessible population were not interchangeable, and data saturation, not statistical power analysis, was used to establish sample size (Palinkas *et al.*, 2013:1). The number of participants required in a qualitative study is adequate when saturation of data is achieved (Malterud *et al.*, 2018:abstr; Weller *et al.*, 2018:1). Data saturation takes place when more sampling yields no new insights except repetition of previously gathered data. In this study, 13 participants were interviewed until data saturation was evident.

2.4.3 Inclusion criteria

Specific inclusion criteria were determined for the selection of participants. First, participants had to have lodged at the research site for at least two weeks, with their babies having been admitted to the NCU. Second, participants had to be able to communicate in Sesotho, English and/or Afrikaans and be above 18 years of age.

2.4.4 Exclusion criteria

Exclusion criteria are characteristics not desirable in, or applicable to, the research population (Meline, 2022:21; Polit & Beck, 2017:499). Exclusion criteria are important to avert distortion of the study data, which could nullify credibility of the findings. For this study, participants were excluded based on appearing emotionally unstable and depressed during the postpartum period, or if they were a confirmed case of postpartum psychosis. The aim with excluding these mothers from participating was to protect their emotional vulnerability during this period. Those who were physically unwell during the postpartum period (e.g., high blood pressure, extreme pain) were not asked for an interview, unless they were comfortable enough to consent to an

interview. In addition, those who were on medication due to postpartum complications and would possibly not be able to provide credible data on their experiences of lodging were also excluded from participation.

2.4.5 Recruitment of participants

After permission was obtained from the HSREC of the University of Free State (Addendum D) and the FSDoH (Addendum F), the researcher informed all lodging mothers present at the time of data gathering and they were invited to participate voluntarily. Information leaflets were handed to them a week prior to the interviews (refer to Addenda A, B and C). The researcher briefed only those mothers who had been lodging for two weeks and more. Participants varied in terms of ethnicity, race, age, culture and background, which contributed to exploring diverse individual experiences (Polit & Beck, 2017:499). Suitable dates and times for interviews were discussed and participants were allowed to ask questions about the research topic and intended procedures. Arrangements were made to schedule individual interviews at suitable times to minimise interruptions in the care and feeding of babies. Participants were made fully aware of the voluntary nature of the participation and their right to discontinue at any moment without penalty. They were informed of their right to anonymity, the purpose of the research, how the findings would be utilised, and how it would be documented after the research was completed. From there, the interviewer made appointments with mothers who had agreed to participate and obtained informed consent at the day of the interview.

2.5 Data Collection

The researcher used in-depth interviews as a data gathering method. Interviews are commonly used to obtain data in qualitative research (Showkat & Parveen, 2017:4). This technique was useful because the responses were recorded in the “own words” of the participants to avoid bias through the interpretation of data, allowing for participant input in the research data. However, according to Polgar and Thomas (2013:92), interviews are not objective and are susceptible to biases, because the interviewer is the person who controls the interview process. A disadvantage of using this technique is that it was time-consuming. Despite this, individual in-depth interviews

were seen to be the best way for learning about the participants' genuine experiences because it allowed them to talk freely (Boswell & Cannon, 2017:315).

2.5.1 Explorative interview

As mentioned in Chapter 1, an explorative interview was conducted with one of the lodging mothers (see section 1.6.3). Since no alterations to the interview question or process were necessary, the interviewer managed all other interviews in the same manner. This first interview was so rich in information that it was used as part of the interviews and data analysis.

As mentioned in Section 1.7, the interviewer agreed to inform the researcher about the process that she followed during every interview. This arrangement was necessary because the researcher was not present at the interviews. In the following section, the researcher describes the process followed by the interviewer.

2.5.2 Process of data collection

Interviews were conducted at a time that was most suitable for the participants. The in-depth individual interviews were conducted in Sesotho or English, which were the languages of choice. Eleven of the participants stated that they were comfortable using Sesotho or English or a combination during the interviews. There were also two Afrikaans-speaking participants, but they preferred to have their interviews conducted in English. The interviewer was fluent in both interview languages (Sesotho and Afrikaans) and was able to read and understand the transcribed interviews. The in-depth interviews were conducted until data saturation was reached. Saturation is a methodological principle in qualitative research indicating the point at which further data collection is not necessary (Hennink *et al.*, 2017:1; Saunders *et al.*, 2018:1). The interviewer reported that from the ninth interview onwards she could sense the beginning of data saturation, but she continued with four more interviews to confirm saturation. The total number of interviews conducted were 13.

All the interviews had a guiding, open-ended first question: Please tell me, in detail, the feelings that you had as a lodging mother while your baby was admitted to the neonatal care unit? The participants were familiar with the hospital, and it was assumed that they would be comfortable and relaxed in describing and discussing their experiences. Prior to the interviews, the researcher assisted the interviewer to prepare

the venue where interviews were held. Chairs were arranged in a manner that allowed the participant to face the interviewer. The lighting and ventilation were adequate, and the room was clean and comfortable.

On arrival at the interview setting, the interviewer introduced herself to the participant. She thanked each participant for her time and interest to take part in the research project. After the interview purpose was explained, the participant willingly signed the consent form and gave permission to be audio-recorded. The participants were ensured of confidentiality. This afforded participants an idea of what to expect from the interview, increased the likelihood of honesty, and was also a fundamental aspect of the informed consent process (Gill *et al.*, 2008:292–293). Participants were informed that the interview may last between 30 to 45 minutes.

Following the initial interview question, probing questions were asked for clarification, and the interviewer felt confident that the information she had obtained would offer the researcher a clear comprehension of the participants' experiences. The probing questions were:

- How did you experience lodging as an individual?
- What worked well regarding your lodging experience?
- What were the challenges that you experienced while lodging?
- What were the opportunities that could improve this lodging area?
- Did you have any other comments regarding your lodging experience?

Six participants took part in the first interview session, three in the second and four in the third. The interviewer used open and emotionally neutral body language, such as nodding, smiling, looking interested and making encouraging expressions and utterances (e.g., "Mmmm"). Probing remarks such as "What do you mean when you say you were afraid in the lodging ward?" allowed for more details to be disclosed. Silence was used appropriately by the interviewer and was highly effective at getting participants to contemplate their responses, talk more, elaborate or clarify particular experiences (Gill *et al.*, 2008:292–293; Merriam & Tisdell, 2016:122).

2.6 Data Analysis

The process of describing, categorising, and connecting phenomena with the researcher's concepts is known as qualitative data analysis (Palic, 2015:8). Polgar and Thomas (2013:181) refer to qualitative data analysis as the way in which researchers arrange the data they have gathered and interpret what the participants have stated. According to Raskind *et al*. (2019:3), qualitative data analysis requires coding and finding patterns/themes in narrative data. Furthermore, Mohajan (2018:24) defines data analysis as the process of labelling data segments with characters, descriptive words or unique identifying names. Coding is compared to "cutting and pasting" similar components together. Coding is used to organise data collected in interviews and other types of documents and involves inventing and applying a category system (Brink *et al.*, 2018:181; Maguire & Delahunt, 2017:3353).

The true significance of the participants' experiences were analyzed using qualitative content analysis, which also helped the researcher understand the participants' mixed responses to their lodging experiences. The process of data analysis was done according to Tesch's eight steps in the coding process (Creswell, 2014:198), as summarised in Table 2.2.

Table 2.2: Tesch's eight steps in coding qualitative data

Step of data analysis	Motivation
1. Read through all the transcriptions carefully.	Acquire a sense of the whole.
2. Pick one interview and go through it.	Try to find the underlying meaning of the information. Ask yourself what this interview is about.
3. Read through all the other interviews.	Make a list of all the topics; cluster similar topics together; form these topics into columns that will reflect the major topics, unique topics and leftovers.
4. Assign codes to the topics to organise them.	Observe whether new categories and codes emerge.
5. Find the most descriptive wording for the topics.	Turn them into categories; group related topics together to reduce the total list of categories.
6. Attach final codes to each category.	Alphabetise the codes.
7. Assemble the data material belonging to each category in one place.	Start on the preliminary analysis.
8. If necessary, re-code the existing information.	Ensure consistency throughout.

Compiled from Tesch's eight steps in the coding process (Creswell, 2014:198)

The eight steps according to Tesch's coding process that the researcher followed during data analysis are described in more detail below. These eight steps engaged the researcher in the systematic process of analysing textual data (Creswell, 2014:198).

Step 1: Read through all the transcriptions carefully. According to Botma *et al.* (2010:224), organising the data for analysis and acquiring a sense of the whole require the transcribing of interviews and gaining of information, typing of the information and placement of the different forms of data into categories. The initial step in data analysis is to translate spoken and visual data into written form, which is an interpretive process. Written materials (such as field notes or documents) as well as audio and visual data (e.g., recordings of interviews, focus groups or consultations) are all acceptable sources of information for qualitative studies.

The audio recordings of interviews were converted into written transcripts so that they could be carefully examined, analysed and/or coded (Bailey, 2008:127). After an independent transcriber transcribed all the recordings verbatim and all the participants' identities were removed, the researcher read the entire transcript carefully to obtain a sense of the whole and jot down some ideas. The researcher started from the shortest to the longest transcript by continually rereading the transcripts and making use of reflective notes to familiarise herself with the content.

Step 2: Pick one interview and go through it. The researcher carefully reviewed one of the transcriptions and took notes on the main conclusions and initial thoughts generated by the participants. The researcher chose one instance, thought about the underlying meaning of the information, and asked herself, "What is this about?"

Step 3: Read through all the other interviews. The researcher read the data from all interviews and took note of any categories or patterns that stood out to her from the participants' responses to the research questions. As she continued reading, she made a list of all the categories or topics. Similar topics were clustered together and placed in columns for easy reference. Later, these were organized into a single category based on their shared traits. The researcher read the transcripts, analysed the data, came up with a list of subjects and then went back to the data.

Step 4: Assign codes to the topics to organise them. The researcher returned to the data sets and classified the relevant segments for each category using the codes for each category. Since she employed open coding, several segments had multiple categories. The data were used by the researcher to apply the list of topics. Corresponding sections of the transcripts were given the abbreviated codes of the topic, which were written next to them. The researcher tested this initial organisational structure to see if any new categories and codes would emerge. In this study, she used categorisation to refer to noting the categories and patterns in the interview data. As she developed the categories, she constantly asked herself whether the information was relevant to the research question or not. The data from each case were displayed on a chart where these categories were organised. Using the study questions as a guide, codes for these categories were then created. Coding is used to create a description of the setting or particulars, as well as subcategories from the categories. The coding process made it possible to separate data into components or categories. To generate headings for subsequent sorting, it involved utilising specified or repeated words, phrases, sentences, paragraphs or images (Botma *et al.*, 2010:224). The codes were based on what the participants shared during the interviews. The researcher categorised the transcripts into different codes.

Step 5: Find the most descriptive wording for the topics. Categories and subcategories were developed from the descriptive notes (Sutton & Austin, 2015:229). The researcher determined the most descriptive wording for the topics and sorted them into categories and subcategories. The researcher noted only categories that were common in all cases and those that appeared only in some cases but not in others. She considered the information from each participant vital even if the category did not appear in each data set. Special care was taken not to lose the richness in the narrative data from the interviews by relating the category to the context. The categories generally represent five major findings of the research and were used to create the subheadings of topics that were identified in the data. The categories portrayed different experiences and perspectives from the different participants and were "supported" by "diverse quotations and specific evidence" (Botma *et al.*, 2010:225). The researcher then connected codes with similar meanings to make up subcategories, as these serve as building blocks for creating a category.

Step 6: Attach final codes to each category. In this step, the categories that had been identified were thoroughly addressed utilising subheadings and subcategories, specific illustrations, the participants' direct words, and different perspectives. A colourful table was created to illustrate the findings and the headings and subheadings for discussion. The researcher and supervisor tried to reduce the number of categories by grouping topics that relate to each other. In this study, the researcher made the final decision on the abbreviations for each category and alphabetised the codes.

Step 7: Assemble the data material belonging to each category in one place. The researcher went back to the data sets and tagged the pertinent portions in each category using the codes for each category. Since she employed open coding, several portions had multiple categories. This step involves the researcher interpreting and making meaning of the data. As per Botma *et al.* (2010:225), the researcher was guided by the question: What were the lessons learned? The answer would be a combination of the researcher's personal interpretation and literature or theories. The researcher interpreted the true meaning of the data and true meaning of the experiences of the participants at the research site. The researcher presented the categories and subcategories in a tabular form to offer the reader a snapshot of the major findings from data collection. The researcher described each category first before discussing its subcategories.

Step 8: If necessary, re-code the existing information in order to ensure consistency throughout. After confirming the initial categories and subcategories with the supervisor, the researcher realised that it was not necessary to re-code, and the analysis process was stopped at this stage.

2.7 Role of the Researcher

The role that the researcher played in the study has been discussed in detail Chapter 1, section 1.7. In the case of nurses conducting qualitative research, when the nurse-patient contact in the research field results in some degree of therapeutic communication for the participants, ethical concerns are addressed. Nurse researchers must consider how participants may be affected by their questions, and the "reflexive method" is advised to reduce such detrimental impacts on human subjects (Sanjari *et al.*, 2014:4).

2.8 Ethical Considerations

Permission to conduct the study was granted by the HSREC, Faculty of Health Science (University of Free State), and the FSDoH. The hospital management where the study was conducted gave permission based on approval by the HSREC and FSDoH (refer to Addenda D and F). Table 2.3 is a summary of the ethical principles applied in this study.

Table 2.3: Ethical principles applied in the study

Principle	Application
Beneficence • Right to freedom from discomfort • Right to protection from exploitation	• The researcher protected the participants from any emotional harm • Names of the participants were omitted from transcripts • The interviewer avoided exhausting the participants during interviews • Participants were allowed to answer as far as they were comfortable • The researcher reassured the participants that information provided would not be used against them
Respect for dignity and autonomy • Right to self-determination • Right to full disclosure	• Participation in the interviews was voluntary • Participants were invited to ask questions, and permitted refusal to provide information or withdraw • Participants gave informed consent to participate • The purpose of the study was explained fully to participants
Justice • Right to fair treatment • Right to privacy	• Participants were treated fairly • Beliefs, lifestyle, background and culture were respected • Privacy was maintained by keeping data of the participants confidential

Compiled from Polit and Beck (2017:138) and DoH (South Africa, 2015:36)

2.8.1 Beneficence and non-maleficence

The obligation of professionals to advance their patients' well-being is referred to as benevolence and the obligation of physicians to not intentionally hurt patients or expose them to harm is known as beneficence (Singh & Ivory, 2015:2). The research did not directly benefit the participants in this study, except perhaps by being a means

through which they could voice their experiences. The researcher aimed to better understand and assist mothers at a public hospital in South Africa. The study was not anticipated to have any unfavourable effects on any of the participants, but it was anticipated that once the results were known, the personnel at NCUs as well as the mothers staying there would benefit from the ensuing modifications.

2.8.1.1 *Right to freedom from discomfort*

As the participants were sharing their personal information, the researcher asked the interviewer to make sure that they were protected from any emotional harm by structuring questions carefully and monitoring them for signs of distress or discomfort (Brink *et al.*, 2018:30). According to the interviewer, no signs of distress were experienced by the participants during any of the interviews. The social worker on duty at the research site was aware of the interviews and on standby should participants be distressed to facilitate debriefing sessions with the participants. It is not easy to prevent intrusion in qualitative research as the in-depth interview tends to intrude into participants' lives, and therefore probing and personal information may disturb some participants emotionally (Peter, 2015:2626).

2.8.1.2 *Right to protection from exploitation*

Names of the participants were omitted. The interviewer avoided exhausting the participants during interviews. The allocated time for interviews was adhered to and participants could answer as far as they were comfortable. The researcher reassured the participants that information provided would not be used against them (Surmiak, 2018:3–4).

2.8.2 Respect for dignity and autonomy

The "respect for persons" principle relates to making choices that uphold a person's autonomy and dignity. Confidentiality serves to defend dignity. A participant's ability to choose whom they share information with and what they keep to themselves is referred to as confidentiality. Respecting someone's autonomy involves giving them the freedom to decide whether to participate in the study once they have been properly informed (Botma *et al.*, 2010:3). Respect for human dignity was adhered to by not using participants' real names on any documents or reports (Barrow *et al.*, 2022:1). In this study, participants were all treated with respect and not judged based on different

beliefs, views, culture, gender, background, economic status, race or any other characteristic, whether they participated or not. The same question was asked in the same manner to all participants.

2.8.2.1 *Right to self-determination*

According to the self-determination principle, potential participants are free to choose whether or not to willingly participate in a study without running the danger of suffering negative repercussions. Additionally, it implies that participants have the freedom to ask questions, withhold information, or to withdraw from the study at any time. The freedom from all forms of compulsion is part of a person's right to self-determination. Threats of penalties for declining to participate in a study or excessive rewards for participating constitute coercion (Barrow *et al.,* 2002:1). Participants were allowed to participate voluntarily and to ask questions. They were also informed that they could stop participating in the study at any time and that the research might be published in an academic journal but that their names or identity will remain anonymous. Participants were also notified that interviews would be conducted in a private room where neither staff nor other participants would notice who enters and exits the room during the times of the scheduled interviews and that information will be kept confidential. The interviews were held in private, participant data were kept confidential, and the data were reported without revealing any participant's identity or personal information.

2.8.2.2 *Right to full disclosure*

Full disclosure was maintained by describing the purpose of the study in detail to the participants and informing participants that they had the right to refuse participation. In this study, the researcher obtained written, informed consent from the participants to participate voluntarily (refer to Addenda A, B and C). The researcher used easily comprehensible and short words and sentences to improve the participants' grasp of the research topic as well as the voluntary nature of their involvement, among other things (Beckmann, 2017:15).

2.8.3 Justice

Justice, according to Botma *et al.* (2010:3), means that participants must experience fair treatment.

2.8.3.1 *Right to fair treatment*

The right to fair treatment pertains to researchers treating study-participation decliners impartially and without bias (Barrow *et al.*, 2022:1). Participants in this study were all treated with respect, and no one was singled out for negative treatment because of their colour, gender, ethnic background or any other attribute.

2.8.3.2 *Right to privacy*

Any information supplied by participants must be held in the highest secrecy. In order to protect the right to privacy, measures for secrecy or anonymity are frequently used (Barrow *et al.*, 2022:1). Both inside and outside of academia, the right of study participants to keep their privacy and withhold some information has been more commonly understood, and it is now protected by a variety of laws (Bos, 2020:154). The aim or purpose of the study, the methods of investigation, and names of those who would have access to the data were all explained to the participants. Participants provided informed consent, were not coerced to participate and had the freedom to end their participation at any time.

2.9 Methodological Rigor

Methodological rigor in qualitative research signals truthfulness, appropriateness, epistemological and methodological congruence, and thoroughness in data collection and data analysis processes (Brink *et al.*, 2018:110; Merriam & Tisdell, 2016:239). Gray *et al.* (cited in Brink *et al.*, 2018:82) describe rigor as striving for high-quality research, which implies discipline, attention to detail and diligent accuracy. Trustworthiness refers to how confident the researcher is that the research is an accurate portrayal of the study process and outcome (Polit & Beck, 2017:559). In this study, the principles of credibility, dependability, confirmability, transferability and authenticity were adhered to as far as possible to enhance trustworthiness. The researcher aimed to disseminate the real significance of the participants' experiences and data by abiding by these principles. The application of trustworthiness is summarised in Table 2.4 and further described below.

Table 2.4: Trustworthiness criteria applied in the study

Criterion	Application of criterion to ensure trustworthiness
Credibility Confidence in the truthfulness of data and interpretations	• Using an experienced interviewer • Ensuring data saturation • Verifying the accuracy of transcriptions and interpretation of the data with the supervisor • Verifying the findings with the supervisor
Dependability The findings are consistent	• Providing a comprehensive account of the research process, namely data collection, analysis and reporting the findings • Doing a thick or dense description of the process • Creating an audit trail
Confirmability The data are a true representation of the information supplied by the participants	• Using an impartial interviewer • Not influencing the responses by the participants • Confirming interpretation of data with the supervisor
Transferability The extent to which the findings of this study can be applied to other situations	• Providing a thick description of the processes followed during the study • Providing in-depth descriptions in reporting the findings • Describing the limitations of the study
Authenticity The research reflects the participants' lives as they are lived	• Providing a true reflection of the participants' views and experiences

Compiled from Polgar and Thomas (2013:187), Polit and Beck (2017:559) and Maree (2019:144)

2.9.1 Credibility

Credibility is the level of trust that the researcher has established in the accuracy of the findings that are being examined (Botma *et al.*, 2010:233). Early familiarity with the individuals and the participating organisations helps establish credibility, as does well-defined purposive sampling, detailed data collection methods and triangulation (Cope, 2014a:89). The technique of "intuiting" also ensures credibility. This means that the researcher focuses all their awareness and energy on the narrated experiences of the participants through the transcriptions, thus gaining more insight. The interviewer of this study asked the same question(s) in the same manner to all the participants. The participants were not interrupted when feeding their babies or when they needed to rest. Certain criteria were followed to ensure credibility of the findings.

Using an experienced interviewer: In this study, the researcher enhanced credibility by requesting an experienced independent interviewer to conduct the interviews. This person was experienced in phenomenological interviews and understood the process of qualitative data collection (Polgar & Thomas, 2013:187). The prolonged engagement of the experienced interviewer, who was familiar with the context as well as the discipline, also contributed to the credibility of the study.

Ensuring data saturation: Saturation is the stage of continuous data collection in qualitative research at which there is little need to proceed because further data will just serve to corroborate an emerging understanding (Saunders *et al*., 2018:1895). In this study, the interviewer met this criterion by conducting individual in-depth interviews with participants until data saturation was reached, that is until no more new information was elicited. The interviewer asked the same question(s) in the same manner to all the participants.

Verifying the accuracy of transcriptions and interpretation of the data with the supervisor: After the researcher interpreted the data, she sent it to the supervisor for verification and also to avoid the intrusion of her own views.

Verifying the findings with the supervisor: The researcher analysed the data with the assistance of the supervisor. The importance of triangulation must be underlined once more in this context to ensure reliability and lessen the impact of researcher bias. Triangulation is a technique used in qualitative research to assess how closely all available information converges by cross-checking various data sources and data collection techniques (Cope, 2014b:545).

2.9.2 Dependability

Dependability refers to consistency and requires that the findings be similar should the study be repeated (Botma *et al.*, 2010:233). Polit and Beck (2017:559) define dependability as the extent to which repeated administration of a measure will yield the same data. The steps taken to ensure dependability are discussed below.

Providing a comprehensive account of the research process, namely data collection, analysis and reporting the findings: Participants were given an opportunity to describe their experiences in full. The researcher expected the results to be consistent were the study to be repeated by another researcher under the same

circumstances (Brink *et al.*, 2018:111). In order to be thoroughly investigated and connected with analytic coding, recordings are transcribed into written form. What data are evaluated and to what extent it may be trusted depend largely on the transcriptionist's ability to hear and interpret the material as well as the style and correctness of the transcription (Stuckey, 2014:6). The researcher documented the analysis process so that another person can see the decisions that she made, how she went about the analysis, and how she arrived at the interpretation with the confirmation of the supervisor.

Doing a thick or dense description of the process: A thorough description goes beyond merely capturing and describing something. In order to comprehend the significance, meanings and intents that underlie social interactions, background knowledge must be provided (Drew, 2022:1). As it helps to portray the real circumstances that have been researched and, to some extent, the surroundings that surround them, detailed description was provided of the study process as a crucial element for increasing dependability. In this regard, detailed information about the participants' backgrounds was provided.

Creating an audit trail: A research audit trail should be created. Carcary (2009:14) suggests that a study's dependability can be determined if a reader can audit the researcher's efforts, influences and actions. In addition, De Kleinjn and Van Leeuwen, 2018:3) suggest that audit trails are a way to ensure quality in qualitative studies.

The results of a study are "auditable", in the words of Carcary (2009:15), when another researcher can clearly follow the decision trail utilised by the investigator in the study. Additionally, given the facts, perspective, and circumstances, another researcher could reach the same or similar but non-contradictory results. For this study, the researcher kept an audit trail. For others to be able to follow and confirm the findings, this involved the detailed recording of the research interview transcripts and raw data field notes (including the date and time of the interview, how consent was obtained and the interview process).

2.9.3 Confirmability

Confirmability refers to appropriateness and relates to the extent that the results of a study can be applied to different populations and the same conclusion still be reached (Botma *et al.*, 2010:233). Furthermore, Connelly (2016:1) defines confirmability as the

degree to which findings may be reproduced and are neutral. Moon *et al.* (2016:2) state that confirmability is the extent to which the study's findings are shaped by the participants and not the researcher's bias, motivation or likes. The following steps were taken to ensure confirmability.

Using an impartial interviewer: As the researcher was involved with the research participants and the study, there was a greater risk of bias that may have had an influence on the study, freedom from bias in the research process and the outcome (Polit & Beck, 2017:559). The researcher asked an impartial interviewer to conduct interviews on her behalf. The interviewer maintained neutrality using "bracketing", which means disregarding previous knowledge about lodging experiences of the participants under study and only concentrating on the information provided by the participants.

Not influencing the responses by the participants: The researcher ensured confirmability by making sure that the data reflected the participants' voices and not interpretations fuelled by her own imagination (Brink *et al.*, 2018:159).

Confirming interpretation of data with the supervisor: The decisions made by the researcher and the supervisor and the developments in their analysis were all carefully documented. Deliberation in this sense guards against the prejudices that come from including merely one person's viewpoint in the study (Connelly, 2016:1). The confirmability of this study in other contexts has not been determined.

2.9.3 Transferability

Transferability relates to ensuring how representative the participants are to the context being studied (Anney, 2014:272). One would think that the results would not be drastically different if identical research were carried out with great care (Carcary, 2009:14). Transferability also refers to the degree to which the study can be applied to other contexts or the ability to generalise the findings to the larger population (Botma *et al.*, 2010:2340; Polit & Beck, 2017:560). The relevant steps taken are described next.

Providing a thick description of the processes followed during the study: Thick description entails giving the reader a full and purposeful account of the context, participants, and research design so they may decide for themselves whether or not

the findings are transferable (Drew, 2022:1). Should there be a desire to repeat the study, the researcher gave a thick or dense description of the process taken to enable replication.

Providing in-depth descriptions in reporting the findings: The researcher compiled detailed information in depth, so that the reader can deepen their understanding of the situation and be able to relate to the lodging experiences of participants. Words of participants were used to convey what the researcher has learned about their lodging experiences. The quotes and excerpts contributed to the descriptive nature of qualitative research (Merriam & Tisdell, 2016:18). Direct quotes from the participants were used to substantiate the findings of the in-depth interviews (Mertler, 2017:140–141). Thick descriptions of the research site, participants, sampling, data collection, and data analysis were provided to make it possible for the reader to decide what the possibility would be of transferring the findings to another setting.

Describing the limitations of the study: Qualitative studies cannot be generalised to larger populations. The study was conducted in a naturalistic setting and the situation was unique. It is the researcher's responsibility to paint a full picture of the context and to then allow the reader to determine if the research is transferable to a different context (Anney, 2014:272).

2.9.4 Authenticity

Authenticity refers to the degree to which the researcher fairly and faithfully shows a range of different realities in a report by portraying participants' experiences as they lived it. When a textual description welcomes the reader into a virtual experience of the lives being portrayed and enables the reader to have a deeper understanding of the topics being presented, it is considered authentic (Botma *et al.*, 2010:234; Polit & Beck, 2017:560). The term "authenticity" describes something that is "real", "genuine", or "true". One step was followed to ensure authenticity.

Providing a true reflection of the participants' views and experiences: The researcher ensured that the quality of data or information was as true and genuine as disclosed by the participants.

2.10 Summary

In this chapter, the research methods used in this study were highlighted. It described the study's research paradigm and design. The study was based on a phenomenological, qualitative approach. The chapter also outlined the various sampling methods employed in the research as well as the sample selected in the study. Data collection and data analysis were described in detail. Measures to ensure trustworthiness, ethical considerations and methodological rigor were explained. Chapter 3 presents the results supported by a literature control.

CHAPTER 3: RESULTS AND LITERATURE CONTROL

3.1 Introduction

Chapter 2 presented the research methodology, paradigmatic perspective, research design and method adopted in this study. The research population and unit of analysis and data collection and data analysis methods were discussed in detail. The chapter ended with a brief discussion on ethical considerations and methodological rigor.

This chapter includes a narrative description of the major categories and subcategories derived from interviewing the 13 participating mothers lodging at a public hospital. Before the researcher embarked on her journey to investigate the lived experiences of lodging mothers, her perceptions of these mothers were based only upon informal conversations with them and from noticing their distressed emotional appearance. The results provided in this chapter convey convincing evidence that some lodging mothers face unnecessary challenges while waiting for their very ill babies to recover. According to Henning (2005:27) and Snyder (2019:333), literature control is important to show the relevance of the researcher's findings in relation to the existing body of knowledge. Where necessary, findings of this research are supported, or contradicted, by current literature from South Africa and from research settings outside of South Africa.

3.2 Description of the Participants

This section presents the demographic profile of the participants (see Table 3.1). Participants were given pseudonyms and were labelled as "P" with a number to indicate interview number. For example, the first participant was labelled P1, the second P2 and so forth. To ensure that confidentiality is maintained, these pseudonyms are used consistently when describing the participants' experiences of lodging.

Table 3.1 depicts the participants' age dynamics and time spent as lodgers at the time of the interviews. The sample comprised thirteen participants, aged between 23 and 37 years. Eleven participants were Sesotho speaking and two were Afrikaans speaking (P2 and P11). Three of the thirteen participants were married, while the remaining ten were single. The duration of their stay ranged between six weeks to four months, which

meant that all the participants had more than two weeks of lodging experience and could therefore provide relevant information about their experiences. These participants were included in the empirical research process on account of their daily experiences and feelings regarding lodging.

Table 3.1: Participants' ages and lodging duration

Participant	Age	Lodging duration	Spoken language
P1	24	3 months	Sesotho
P2	26	6 weeks	Afrikaans
P3	23	8 weeks	Sesotho
P4	25	7 weeks	Sesotho
P5	36	7 weeks	Sesotho
P6	33	4 weeks	Sesotho
P7	27	5 weeks	Sesotho
P8	33	7 weeks	Sesotho
P9	37	4 weeks	Sesotho
P10	31	7 weeks	Sesotho
P11	29	3 months	Afrikaans
P12	32	4 months	Sesotho
P13	28	2 months	Sesotho

3.3 The Process of Data Analysis

In Chapter 2, section 2.6, the researcher gave a detailed description of how the data were analysed by following the eight steps as recommended by Tesch (Creswell, 2014:198). As directed by Bevan (2014:138) the researcher applied personal bracketing and tried to set aside her opinions about the phenomenon of lodging mothers so that the focus could be directed at the participants in the study. The next step was to develop and classify significant statements about how the participants experienced lodging into categories. The "essence" of the experience of lodging was then described and represented the culminating aspect of this phenomenological study. The researcher was able to correlate the analysis procedures with the methodological position of the study and consistently managed the analysis process according to the principles of the study design. To ensure the credibility of her interpretation of the data, she verified her interpretations with her supervisor, who is

experienced in qualitative research. After the supervisor had verified the data, the researcher and her supervisor discussed the categorising of the findings.

Verbatim quotes of participants are reflected in italic font and serve as evidence of the participants' experiences of lodging as described by them. The experiences of the participants are written as a narrative, reflecting the essence of the experience of lodging. The verbatim quotes were carefully selected to accurately portray the participants' voices regarding their experiences of lodging. Table 3.2 portrays a schematic condensation of the data analysis of the participants' lodging experiences. From the analysis, the researcher developed five main categories each with its own subcategories.

Table 3.2: Categories and subcategories of the participants' lodging experiences

Category	Subcategories
1. Lodging environment	a) Comfort b) Security c) Serving of meals d) Length of stay e) Communication barrier
2. Emotional experiences	a) Distress b) Frustration c) Loneliness d) Boredom e) Satisfaction
3. Nursing care of babies	a) General nursing practices b) Kangaroo mother care
4. Interaction with staff	a) Staff support b) Communication between mothers and staff c) Staff attitude
5. Participant perspectives	a) Arrange counselling sessions (group and individual) b) Provide sufficient and nutritious meals c) Improve living arrangements (security, boredom, rooms, hygiene) d) Improve communication by healthcare staff

3.4 Discussion of the Findings

The findings are discussed in relation to the categories and relevant subcategories. Where necessary, and to highlight the essence of the participants' experiences,

verbatim quotes are provided. As advised by Noble and Heale (2019:67), the researcher triangulated findings with existing literature to support her interpretations.

3.4.1 Lodging environment

In every interview, the participants alluded to the living arrangements and the lodging setting where they spent most of their time during their babies' hospitalisation. As described in Chapter 1, section 1.1, a lodging ward has three rooms accommodating 36 mothers at a time. The ward is under supervision of a caretaker to ensure that mothers are well catered for. The lodging mothers are responsible for cleaning the ward. Each mother is provided with a bed, a locker to put clothes in and a place to sit and relax. The mothers are not in need of nursing care, as they are not sick but are waiting for their babies to recover.

Subcategories were developed as the analysis proceeded. The discussion is highlighted by direct quotations from the participants and accompanying literature control.

a) Comfort

When an individual says they are comfortable, this means that they experience physiological, psychological and physical harmony with their environment. The individual is comfortable when they feel subjectively good about themselves in response to their surroundings or circumstances (Ahmed-Kristensen & Stavrakos, 2012:2). Being relieved from pain and getting continuous care or support from others means that the person can still experience comfort, despite the negative environmental factors that the person experiences (Olausson *et al*., 2019:329).

The participants verbalised that they experienced much discomfort at the lodging area. The findings revealed that this discomfort resulted in emotional challenges, seemingly negatively influencing their stay at the lodging area. Participants stated that they were assured that the place where they were going to sleep would be pleasant. However, most participants described that mattresses were not comfortable at all, that they felt like they were living in a prison, and that their sleeping arrangements were uncomfortable. In addition, they did not have enough blankets and were cold at night, the place was noisy and was not a proper lodging facility, and it was not conducive at all. Participants mentioned that there was no washing line on which to hang their

clothes. The place was unfamiliar, the television did not work, and the best thing for them to do there was to sleep. Furthermore, space between the beds was too small and did not adhere to Covid-19 regulations for social distancing. The participants expressed these challenges as such:

> *I am not in any way saying that our rooms and beds where we are sleeping should be comfortable to our satisfaction. The mattresses are not comfortable at all. There are not enough blankets and it is very cold.* (P6)

> *You know, mam, it is only ladies who are staying here. We must make turns to clean our rooms, but some of them refuse to clean or even to wash toilets or bathrooms. This area is so dirty.* (P13)

Another participant felt like they were in prison and seemed unhappy with the cleanliness.

> *The environment is just not conducive at all. The place is dirty, they give us little food, and the nurses don't change our babies. We live like we are in prison. This is not the way to live.* (P4)

Stremler *et al*. (2008:292) state that an inconducive environment for parents with sick babies will cause sleep deprivation and fragmentation. This situation might impair cognitive performance and make it harder for parents to make decisions and control their emotions. A recent study by Carrega *et al.* (2020:289), confirm that sleep disturbances during the early postpartum period may have a negative effect on breastmilk production. It is therefore preferable that lodging mothers stay in a conducive environment that will not contribute negatively to their emotional well-being.

To successfully guarantee the rights of lodging mothers, in KwaZulu-Natal, a policy for lodging mothers has been approved by Dr S.T. Mtshali and mandated for NCUs to comply. The policy makes provision for mothers to have easy access to their newborn babies in the hospital and ensures that these mothers are safe with adequate accommodation (KwaZulu-Natal DoH, 2017). The DoH of KwaZulu-Natal has implemented a tool that audits lodging facilities on a monthly basis to ensure cleanliness (KwaZulu-Natal DoH, 2017). Bevan (2014:137) emphasises that it is important for hospitals that offer neonatal services to have the necessary infrastructure in place to enable mothers to care for their babies. Insufficient facilities, such as a lack

of overnight accommodation or kitchen space, and an absence of practical support to help manage costs are significant barriers to mothers to be able to participate fully in their babies' care (Anderson, 2013:9). To the current knowledge of the researcher, there is no policy at the hospital where the research was conducted that directs the condition of the environment where a lodger mothers reside, and she thus offered a recommendation in this regard (Chapter 4).

b) Security

Several participants mentioned that the area where they lived and the footpath to the NCU was dark at night and that they did not feel safe. According to them, there was no security guard available for protection, and they felt vulnerable as women who had no choice other than to make use of the pathway to the NCU. One security guard was allocated to the area during the day but not at night.

> *The week before last week, there was a man stalking me. He would come and stand here staring at me at night when everyone has left. We were five girls in here and someone would come knock at the door around 12 o'clock midnight and at 1:00 am again. That is why I am requesting that we get a security in here, because I feel unsafe.* (P2)

> *It would also be nice if they could put a light outside. It gets too dark at night and we tend to be afraid.* (P6)

One of the participants emphasised the importance of having a security guard in the lodging area.

> *You go alone. They had said that we can come in groups, but that doesn't work, because our children sleep at different times. Recently, we heard rumours that there were thieves stealing cars in the parking lot. The nurses had to leave us like that to go and guard their cars, because there is no security at all here. So, it is not safe for us to be going to the baby room at midnight, and we are also afraid.* (P7)

> *Another critical issue is that when we go to the baby room, our room is not locked, and we have important things in the room, such as our chargers, clothes and other personal belongings. What will happen if we lose our belongings, because there will be no one to answer?* (P9)

Providing a secure environment for staff, patients and visitors is typically a problem for hospital security departments and personnel (Ma *et al.,* 2022:5). This is because hospitals are intentionally made public spaces, making it more likely that criminals and other threats may enter the hospital premises if they are not adequately guarded (Bigira & Katongole, 2015:173). If the hospital is not properly secured and does not have enough security guards, lives might be in danger from perpetrators, including lodging mothers at a hospital. Therefore, having a secure environment with security guards is vital to hospitals (Ma *et al.*, 2022:8). A secure environment includes safeguarding vulnerable patients, including as babies and young children, as well as reviewing and analysing event and accident reports for patients and employees to spot any incidents or patterns of incidents that do not promote a safe environment (Scaglione, 2019:12). The participants' perception of feeling unsafe in the hospital environment might relate to a security problem at the institution of which hospital management might not be aware of. Based on the importance of securing safety for patients and visitors, the researcher offered recommendations to this effect in Chapter 4.

c) Serving of meals

Several participants indicated that the food that was served from the kitchen was too little and was like a toddler's meal.

> *Another issue is food. The food they provide for us is not satisfactory at all.* (P1)

> *The other problem that we are experiencing is that we do not get enough food in the kitchen and that causes a lot of stress in us.* (P13)

> *We get a small portion of macaroni, which even a toddler cannot eat, with a mixture of tomato and lettuce; that is it for the whole night.* (P3)

Awkward mealtimes seemed to have had a tremendous effect on the participants' experiences of lodging. Some participants stated that the time intervals in between meals was uncomfortable and that they went too long in between meals. Other participants added that some of them did not have extra money to buy food, as they were not all the same and came from different backgrounds.

We eat our supper at 4:00 pm, which is too early, and some of us do not have money and are less privileged, so we find ourselves in a desperate situation to eat the very same food they provide for us. (P1)

I mean, when we eat at 4:00 pm, by 6:00 pm we are hungry again; and it is not everyone who has something to eat afterwards, especially those who are breastfeeding. (P2)

Yes, after eating at 12 o'clock, we become stressed of hunger. We only get three slices of bread from the kitchen and four sugars, two for oats and another two for tea. (P13)

Then you will only eat again at 4:00 pm. We are breastfeeding and in between we go to feed our babies. I mean, we breastfeed from 8:00 am until 9:00 am and come back around 9:00 am. We wait for three hours before we get our lunch, at 12:00 pm, and another four hours, from 12:00 pm until 4:00 pm. (P4)

Some of the participants stated that the nursing staff expected them to provide enough breastmilk for their babies, yet the meals that were served to them were not nutritional. Participants verbalised that their milk production was very poor due to insufficient nutrient intake. The perceived pressure that nurses placed on participants to provide enough milk seemingly had a negative impact on their milk production.

Sometimes, we don't have enough milk to express because we don't get enough nutrients; and the nurses also put immense pressure on us to give our children food. (P6)

For example, my child is a premature baby … I do not have enough milk and have requested that they provide pills for me to boost my milk supply. However, the response I would get would be something like, "No, you must drink water." My question would then be: "How do you drink water when you are hungry?" You are stressed that your child needs milk, but you also didn't eat to ensure that there is milk for your child. Do you understand how frustrating that is? (P7)

There is no way you can express enough milk without having enough nutrients in your body. It cannot happen. I mean, to keep constant supply of breastmilk,

you need to consume enough food, otherwise the milk will dry up. When you express your feelings, you are wrong. (P4)

Human milk gets its energy, proteins and nutrients from the mother's meals and her body reserves. Women who do not consume enough nutrients may be at danger of lacking in certain vitamins and minerals that are necessary for critical bodily processes (Ares Segura *et al*., 2016:4). For lodging mothers to produce enough milk, it is important that they have a balanced diet with good nutrition. Such a diet might alleviate some of the stress that the participants link to the expectation of providing enough breastmilk and not being able to do so. This finding made the researcher realise that her observation about lodger mothers who seem to be unhappy at times may be linked to their concern about inadequate milk production.

Babies' health and nutritional statuses, in particular, are important indicators of development, social advancement, and resource availability in larger societies. According to the World Health Organization (WHO) and the Constitution of South Africa (108 of 1996), continuous access to healthcare and satisfactory food for a healthy and active life is a human right (Shisana *et al.*, 2013:1). There is growing evidence that sustaining maternal energy balance requires sufficient nutritional intake and proper nutrient homeostasis (Selimoğlu, 2013:186). Furthermore, extreme caloric restriction has a harmful impact on the composition, secretion and production of milk (Cousins, 2020:16). Therefore, it is the right of lodging mothers to have a balanced meal so that they can provide enough milk for their babies to avoid unnecessary developmental problems in these babies.

A study by Neu and Walker (2011:1) revealed that one of the reasons behind lodging for mothers in hospitals is to make sure that there is enough milk for their babies, with mothers being required to express milk regularly. Furthermore, he reveals that because these babies are so small and fragile, they tend to develop necrotising enterocolitis (NEC), which results in surgical intervention. These babies become malnourished and have to stay in hospital for longer periods. It has therefore become necessary for the mothers of these babies to lodge at the hospital setting to provide sufficient milk for their babies and to avoid complications that may arise in the nutritional development of the babies. As has been noted by Afaghi *et al*. (2021:1) and

Rosales (2021:2), breastmilk is a known protective factor in the prevention of NEC when compared with commercial formula.

d) Length of stay

Participants stated that they did not have any choice but to stay at the lodging area until their babies recovered. Although the participants had accepted that they had to stay, it was difficult for some to stay for longer durations.

> *I have been here for too long and I feel like going home; but I do not have a choice, because my child is still here; it has been six weeks now staying at the hospital.* (P2)

> *I got here on the 10th of January. So, I will be completing my third month on the 10th of April.* (P11)

> *I have been here for two months now. I am from [small town in the Free State]. I stayed in [hospital] for a month. My baby was transferred here for operation.* (P13)

> *It has been three months and a week now staying at the hospital. I arrived last year on the 29th of December 2020, and gave birth in January, but I am still waiting for my child.* (P1)

It might be concluded that the length of stay was cumbersome to some of the participants due to the discomfort and challenges surrounding their living arrangements. Additionally, it is believed that the length of the babies' stay in the NCU has an impact on the level of parental stress. It has been shown that the longer the baby is in the hospital, the more stressed mothers are when it comes to communicating with the staff (Musabirema *et al*., 2015:1). Perhaps if the environment were more conducive and "mother-friendly", it would become more bearable, especially where mothers have to stay for extended periods.

e) Communication barrier

As mentioned in Chapter 1, section 1.1, the lodging area caters for mothers of different ethnic groups and from different places and provinces. The language also plays a pivotal role in the mothers' experiences. Some participants experienced

communication barriers, as not all of them could speak Sesotho and Afrikaans. One participant felt like they were gossiping about her.

> *However, there was a communication barrier in that I could not hear what they were saying because they were talking in their home language (South Sotho). As a result, I felt like they were gossiping about me. However, I managed to talk to them regarding that communication barrier I had with them; and I am pleased to say that the matter has been resolved and we are now in good terms.* (P2)

Effective communication is frequently hampered by communication hurdles. The problems encountered by two people who do not speak the same language and attempt to communicate with one another are the most frequent communication barriers that lead to misunderstandings and misinterpretations between people. It may also apply to a situation in which two speakers of different languages are completely unable to communicate with one another (Buarqoub, 2019:68). The researcher did not explore how cultural differences may have influenced communication. However, findings from this study warrants a deeper look into discovering the reasons for the communication difficulties expressed by participants. It might be interesting to explore communication from the healthcare workers' viewpoint also.

This section relating to the lodging environment at the research site revealed that the surroundings and living circumstances at the research site did impact the participants emotionally. Staying for longer periods in an inconducive environment was not good for the emotional state of these participants. Little food and the awkward mealtimes made them feel unsatisfied as they cannot produce enough milk for their babies, and the food provided lacked nutrition and contributed to less milk production. The next section elaborates on the perceived emotional experiences of the participants.

3.4.2 Emotional experiences

Depending on the circumstances they encountered, the participants showed a variety of emotions. During their stay at the research site, they displayed both positive and negative emotions that were impacted by their views. Abuidhail *et al.* (2017:156) agree with other studies that mothers do not expect to give birth to a sick or premature baby who would need to be admitted to an NCU immediately after birth. This leads to

anxiety, stress and intense emotions among family members, especially the mother (Abuidhail *et al.*, 2017:156; Davim *et al.*, 2010:713,866, Lomotey *et al.,* 2019:152).

a) Distress

Several participants had a general feeling of unhappiness when seeing other mothers being discharged with their babies.

> *It does hurt when I see people being discharged; my emotional state is completely out of balance.* (P1)

Other participants were not distressed for staying at the research site per se, but by the report that they received from the doctors about the condition of their babies.

> *No, I am not stressed about me being here, but about the baby. The doctors' reports are constantly changing. Sometimes, they give you a positive report, and other days a negative report. Other times, they don't give you a detailed report. They would just say, "The baby is fine." However, as a mother, you can sense when things are not fine with your baby.* (P2)

> *In addition, the state of our children also adds more stress on us. One moment they are fine, the next their health is deteriorating. Sometimes, other women lose their children and that affects us all because we are in the same place. This is overwhelming and heavy on us, because you end up wondering if your child will make it.* (P6)

> *Umm, mam, I really do not feel well sleeping here at the hospital, because the baby is not well.* (P10)

> *We are always sleeping and you start thinking so hard and stressing about the condition of the baby. Today … right now, I found my child not doing well. I am wondering that at 2 o'clock when I get to that side, how will she be. So, those are the things we are always thinking hard about. You also lose weight; you are not able to eat well. You hear it, my sister? It is not nice at all.* (P11)

The feeling of distress followed as the participants struggled to produce enough milk for their babies, as was evident in their narratives.

Very sad! It's not a nice feeling at all for you as a mother to be sleeping while your baby does not have milk. What is more heart-breaking is that, if your child does not have milk, the nurses won't even make a plan to give them formula milk, even if the baby is crying. (P7)

So, you are stressed that your child needs milk, but you also didn't eat to ensure that there is milk for your child. Do you understand how frustrating that is? (P6)

Nurses require breastmilk from lodging mothers, which may have contributed to the stress experienced by some of the participants.

On the other hand, the nurses are demanding milk, and that also contribute to our stress. It is a known fact that stress can also stop milk supply. (P7)

Some participants seemed distressed because of the time they spent moving to and from the kitchen and indicated that it took away from their time to express milk and stay with their babies. As mentioned earlier, participants stated that their eating times were too close to the feeding times of their babies. Some felt rushed to finish feeding their babies so that they could go and eat.

Here at the wards where we sleep so that we can have enough time so that … there is enough time for us to milk out, because we are mostly in a hurry … when we get there in a hurry, hurrying to see the babies, the milk does not come out well, because we now have depression that time is about to run out, so when we get that side, time is up. (P10)

The under-five mortality rate (U5MR) and infant mortality rate (IMR) are among the most sensitive measures of a nation's socioeconomic position and standard of living. Infant mortality represents both the unique issues that young babies under the age of five face and the systemic issues that have an impact on the health of entire populations (WHO, 2013:2). According to estimates, globally, 7000 newborns passed away per day in 2016, accounting for 46% of all deaths in children under the age of five (Horwood *et al*., 2019:2a). Therefore, it is a global concern for all mothers, not only for the participants of the study, who were worried about losing their babies. According to Obeidat *et al*. (2009:26), mothers with babies in NCUs are worried that their babies might not live, which will result in them having to go through grief. Therefore, it may be

that some mothers, not only the participants in this study, with sick babies will feel sad and anxious about their babies' condition and to fear losing them (Lomotey *et al.*, 2019:152).

b) Frustration

Some of the participants were not frustrated by the lodging environment but by the different instructions between nursing staff and doctors:

> *When the doctor instructs you to bond with your baby, they (the nurses) say you must put the baby down. When you tell them that the doctor gave you the instruction, they say, "But we are in charge in here; you put that baby down." When the doctor comes back, he would be asking, "Why didn't you take your baby?" Do you understand the frustration they cause us? No, this is not acceptable.* (P7)

Since all participants who were interviewed were from another town or province, some described a situation of running out of money to buy toiletries, travel home to visit, or even call their family members as frustrating.

> *This will enable my parents to visit me often, and also bring me clothes, because I don't have enough clothes, toiletry, etc. I constantly have to call them to send me money; then I have to take a taxi to go to Shoprite to withdraw it and buy what I need. This process is really frustrating. I mean, I don't have any support from loved ones here in Bloemfontein, I am all alone.* (P9)

> *Because here, you have to take a taxi multiple times, they (parents) take a taxi multiple times and sometimes there is no money. At least that side, one is able to borrow a tag and then get to [hospital]. So here, one takes transport twice, comes, goes back and take a taxi, and then that is when they will take a bus that takes them back.* (P10)

> *Being far from home is not the same as being at home, because people that will support you are there. Especially when we live far like this, we need a lot of support. There is no one coming to see you; you are always stressed when you encounter some challenges. You are always confused, wondering that this pain today, when I am in pain like this, and I do not have airtime and I know how home is like.* (P11)

The transfer of a newborn between hospitals while they are recovering is not uncommon. Ensuring that babies receive the appropriate level of care in the ideal environment for their needs is a typical and crucial component of neonatal care. However, a transfer from a hospital that provides a lot of assistance to one that provides very little help can be unsettling, unpleasant and stressful for the families (Miorin, 2020:4; Price *et al*., 2016:2). In this study, participants who were coming from other provinces to the research site were more frustrated than the local ones. The distance from home seemingly played a major role in their stay.

As mentioned earlier, not having enough food contributed to the frustration experienced by some of the participants.

> *You are stressed that your child needs milk, but you also didn't eat to ensure that there is milk for your child. Do you understand how frustrating that is?* (P7)

Participants were also frustrated by the living environment.

> *What is most frustrating here at the lodge is that there are not enough blankets and it is very cold.* (P7)

> *It's not all of us. We also can't afford some of the things. You may find that you were given a certain amount to buy toiletry, but you still feel like, okay, let me buy myself food and sacrifice other things.* (P12)

The perceived unfriendly attitude of the nursing staff appeared to add to some of the participants' frustration regarding not having enough milk.

> *What is frustrating is that the nurses would be shouting, saying that we must express milk; and it is highly impossible to express milk when you are not full and don't have enough nutrients.* (P7)

> *Secondly, they shout at us that we must express enough milk, but this is impossible, because we don't get enough food. Moreover, we also need to give our breasts some rest, because they get sore at times.* (P9)

Relevant to the above-mentioned findings, Cousins (2020:15) describes inadequate milk supply as one of the most frequent causes of frustration to mothers, based on the painful breasts that some mothers experience after birth, breasts that are engorged or

overfull. This leads to mothers not having enough milk, resulting in babies not gaining weight as required.

The participants' sense of frustration seemed to be linked to communication difficulties between them and the healthcare staff (section 2.4.1), lack of money or support from family members, not having enough to eat and general uncomfortable living conditions. Participants also experienced feelings of loneliness, which added to a general state of "unhappy" lodging for some of the participants, as seen in the next section.

c) Loneliness

Participants felt alone at the unfamiliar place where they were to live with people they did not know and who were from different places.

> *At first, I felt like people did not care and I was lonely. However, as time went on, I started communicating with others, and it really helped to calm my emotions and reduce my stress. This made me feel better; even though I still feel that it's not home, I feel like being alone most of the time and don't feel like talking.* (P8)

Several participants expressed their sense of loneliness because of staying in the same area for a long time.

> *In these four months I have been here, I could say it is very lonely, because I'm the type of person that loves writing.* (P12)

Some participants felt lonely because their family members were unable to visit them due to the distance and travelling costs as they were staying too far to travel to the hospital. Participants were unable to call family members because of the financial constraints and that contributed to the feeling of loneliness and desertedness as their family was far.

> *Yes, they are trying, I do not want to lie, they try very hard. Even the child's father really tries, a lot. But at times things get a bit shaky. Sometimes, especially since Covid started, they go to work at some times, and other times they do not work. They get too many offs. So, the money is not enough for them to visit me now.* (P10)

Uhm, it's lonely. I don't feel well, but I do not have a choice but to be here, but the problem is loneliness. The more I am sitting in the room, I just sleep, sometimes during the day. (P11)

I am just sitting depressed because you are always just sitting; it gets lonely. (P12)

As the data were collected at the peak of the Covid-19 pandemic, family members were not given access to the research site to support the participants. In addition, the rules that were implemented by the government during that time left some of the participants miserable and lonely. Results of the study by Kynø *et al*. (2021:2) indicated that admission to hospital during the first wave of the pandemic was difficult, and that caused some mothers to look for support from other mothers in the same situation. Additionally, the regulations also contributed a sense of quietness and loneliness among some parents, especially mothers, as most visitors were kept away. The participants of this study found themselves being alone for longer periods without seeing their loved ones.

All participants were at risk of contracting Covid-19, as the disease was at its peak.

I contracted Covid-19 here in the hospital from someone who comes from Ghana but stays in Sasolburg. When she first arrived here, we heard rumours that she had Covid-19, and she was sleeping with us in our room. A week later, she was sick and I referred her to the nurses even though she refused. That same day on Monday, she went for tests and discovered that she was positive. At that time, I was already showing the symptoms and decided to go for tests as well; and they came out positive. (P1)

These beds are also squashed together. Yes, we are unable to adhere to Covid-19 rules. (P11)

Participants were not allowed to express their feelings about the rules that had been stipulated during the pandemic at a unit when they visited their babies.

Well, I do agree with the Covid-19 rule that says we must sanitise our hands, but the sanitiser that they are using is burning my hands. One of the nurses made it very clear to me that I must sanitise my hands whether I like it or not.

I am not disputing, but I told them that I have a skin problem. However, they did not do anything about it. (P2)

In their Canadian study, Lim *et al*. (2022:2) state that travelling mothers experience social separation and loneliness for various reasons. Crucial aspects that may contribute to or aggravate social separation and loneliness include family separation, language barriers and unfamiliarity with the values of other demographic groups. Therefore, due to lack of support from close family members, it was not easy for participants coming from other provinces to cope at the research site. A study conducted by Shimizu and Mori (2017:4) showed that admission of babies to an NCU challenges mothers to face the task of childrearing with unknown nursing professionals in an unfamiliar place. The study showed that baby hospitalisation affects not only the baby but the whole family. This implies the need for support, attention, guidance and permanent care for the companion, mainly the mother. This is because she is closely related to the baby and is usually the one who most longs for healing and discharge and suffers the emotional effects of the hospital stay. If the communication between mothers and staff is not good, this may have a negative impact on the mothers' experiences of lodging.

d) Boredom

Several participants stated that due to them not doing anything except visiting their babies led to stress and boredom during their lodging period.

This is our daily routine, and it is frustrating that we have nothing to keep our minds busy with, and possibly shift our thoughts from negative experiences we had in the babies' room. (P3)

Furthermore, I think it would be nice to have some activities in place for us, because we are always sitting and doing nothing; and this contributes to stress. All we do is to sleep when we come back to our rooms. (P4)

It is overcrowded, it is. I feel like when- I feel every person in here has got nothing to do. We just sit here on the beds, have a chat while we are on our beds. (P12)

The participants were bored mainly because they had nothing else to do than to take care of their babies at feeding times, and also because they had to stay for long periods of time without any alternative stimulating activities.

e) Satisfaction

A few participants felt satisfied staying in the lodging area, stating that they were only there for their babies' sake.

> *However, we are well taken care of in terms of sleep, and our stay here has been pleasant.* (P1)

> *I feel okay, because I am still waiting for my child to recover. I do not have a choice but to stay, as I cannot afford to leave my child at the hospital and go home.* (P3)

The relationship between the physical environment and the health and comfort of residents may differ among hospital departments, since hospitals are complex organisations with differing purposes (Eijkelenboom & Bluyssen, 2019:2). Therefore, if patients are comfortable with the environment that they are staying in, this will have a positive influence on their state of mind. In the current study, the emotional well-being of the participants was affected by different stressors experienced while staying in the lodging area.

3.4.3 Nursing care of babies

The third category revealed through data analysis relates to the nursing care of babies. Small and sick babies need recurrent supportive care and observation, with constant and often multiple interventions delivered 24 hours a day, their condition easily fluctuating (Murphy *et al.,* 2018:1). Babies need to be carefully monitored to prevent an unnecessary increase in mortality.

At the NCU where the researcher worked, mothers are allowed to visit their babies on a three-hourly interval for changing nappies, expressing breastmilk, feeding and providing KMC. Visiting may last from 30 minutes to an hour. Mothers are thus available and engage in some of the care required for their babies. Participants expressed how they experienced these visiting times.

a) General nursing practices

In addition to the participants' stay at the lodging area having an effect on their emotional experiences, the nursing care that was provided by the nursing staff to their babies also affected them.

> *Sometimes, the nurses are too busy to look after him, and they end up leaving him crying nonstop.* (P1)

> *Furthermore, I do not like the fact that they would be busy with their phones while the baby is crying.* (P2)

> *They don't change their nappies regularly. The child would be crying nonstop, and when I check my child, I would find that the nappy is now yellow due to urine. This means that the child is crying due to the burning sensation of urine.* (P4)

The presence of nursing and medical students in the NCU unsettled some participants.

> *The only thing that bothers me are the students. Students are always waking my baby and fiddling with her … Like now she is not in a good state because they always bother our babies. Every now and then we find them in the babies' section, fiddling with the babies, even when they are sleeping. Babies cannot even rest when the student doctors are around. They do their doctor's practical.* (P11)

> *However, the only problem I am experiencing is the nursing students. They tend to wake the babies while sleeping. For example, I was told that my baby is going for a CT scan today, they were busy changing nappies, I understand. Just before the baby left, they were still busy again and my baby was crying so much. Babies cannot rest when students are around.* (P13)

> *When it is time to rest, I want the child to rest. So, they do not want the child to rest. After seeing that she is resting well again, they come and inconvenience her, undress her; my child is then left naked.* (P12)

Preterm babies may also be more vulnerable to sleep disturbances from noise or frequent interruptions due to stress. For optimum development, sleep – a periodic physiological state marked by altered consciousness – is crucial. For premature

neonates, sleep is a crucial concern in the current NCU model (Firmino *et al.,* 2022:2). Therefore, it is crucial not only for the babies of the participants of this study to rest but for all babies, as this affects all developmental growth.

b) Kangaroo mother care

One of the important advantages of lodging is that it allows the mother to provide KMC. As described in Chapter 1, section 1.1, KMC is defined as "a package of interventions", which includes maternal skin-to-skin contact after stabilising the newborn, breastfeeding and close monitoring of the baby (Lomotey *et al*., 2020:9). KMC keeps the babies warm and helps to maintain their normal body temperature from contact with their mothers. Apart from promoting bonding between mother and newborn baby, KMC helps the baby to feel secure (South Africa. DoH, 2012:31b). This approach includes routines such as baby hygiene and feeding. Practising KMC may lead to early discharge of the baby from the NCU.

In addition, KMC increases oxytocin levels in the mother and her newborn baby, which results in enhanced lactation and bonding with the baby and reduced stress, anxiety and postnatal depression (South Africa. DoH, 2014b:57). According to Lee *et al*. (2010:635), KMC was implemented in Colombia in 1978. It was divided into three categories: early discharge (kangaroo discharge policy), exclusive or virtually exclusive breastfeeding (kangaroo nutrition) and direct skin-to-skin contact (kangaroo position). According to several studies, benefits of KMC include the babies' mental stability, increased successful breastfeeding, and reduced neonatal morbidity (Boundy *et al*., 2016:2; Kritzinger & Van Rooyen, 2014:2). The WHO (2018a:17) advises that immediate skin-to-skin contact keeps newborns warm and help to populate their microbiomes.

Several participants expressed that nursing staff did not always allow them to hold their babies or to even wipe saliva from the babies' mouths.

> *We are not even allowed to touch our babies. When we touch them, the nurses say we'll wake them up. Whenever we try to bond with them, the nurses shout at us as if we are children.* (P4)

> *Firstly, we long to hold our babies as mothers, but they prohibit us from doing so, saying that we will infect our babies with infection.* (P9)

As much as participants wanted to spend time with their babies, only two participants said they were given enough time to bond with their babies, but were not given time to rest.

> *Yes. So, all we do is to change their nappies. Well, we also hold our babies (bonding session) so that they can feel our touch. Other than this, there's nothing else to do. So, when do we rest?* (P7)

According to Kurth *et al*. (2010:2), mothers usually adore the unlimited interaction with their babies, whereas some find it hard to consolidate their own recovery with baby care. A recent study by Coşkun & Günay (2020:e30) underscore the correlation between KMC applied by the mother and (a) increasing breastmilk production and (b) decreasing stress. It is thus not ideal that nursing staff – as perceived by the participants – do not always promote KMC at the NCU.

According to Lomotey *et al*. (2019:153), when mothers stay at a hospital, it is vital that they participate in the care of their babies and receive emotional support with adequate information. In their study, Lomotey *et al.* (2019:154) revealed that some participants enjoyed the opportunity to perform KMC while some others were afraid that the baby would be hurt. The participants of this study seemingly wished for more contact with their babies and did not agree with the current state of affairs.

The researcher appreciated the participants' willingness to provide KMC. The benefits of this practice were mentioned earlier (section 1.1). The notion of no separation is underscored by O'Brien *et al.* (2015:2) who mentioned that early parent-baby separation could be detrimental to the health of the baby (O'Brien *et al*., 2015:2). The authors elaborate on how parent-baby interaction actually led to the development of programmes related to family-centred care, kangaroo care and skin-to-skin care.

The researcher of this study, who practises at a public hospital, has realised that without a lodging ward, many mothers would be discharged and go home, leaving them without daily contact with their babies. Hence, these mothers will have less contact with their babies and would not be able to provide the KMC or breastmilk as required for the health of the baby. However, the participants' perceived lack of contact with their babies are a concern and warrants revision of KMC policy and implementation at the NCU.

Although some participants disapproved of the nursing care and opportunities to provide KMC, a few participants expressed that the babies are well taken care off by the nursing staff.

> *I found my child doing great, and they were taking good care of him. There were no complaints at all; instead, my child had grown.* (P1)

> *Yes, he is fine, sister said they are checking him regularly, but he seems to be doing well without oxygen. I am so glad to see him improving.* (P13)

The strain of the physical setting of an NCU on babies' physical appearance and behaviour, staff and parent interaction and adjustments in the parents' role have specifically been noted to be potentially demanding for mothers with babies in an NCU. Additionally, it has been noted that the stress these parents experience influences their parenting behaviour, which in turn can have an impact on their long-term relationship with their babies and their ability to care for them (Musabirema *et al.*, 2015:1).

Chellani *et al*. (2018:103) add that there is sufficient evidence from several developed countries that neonatal outcome improves because of increased parent-baby interaction in an NCU. De Araujo and Rodrigues (2010:866) and Davim *et al.* (2010:714) posit that mother-baby contact during the lodging period not only encourages frequent personal contact with the baby, it also offers an opportunity for health professionals to support the mother and family members while waiting for their babies to recover. Bonding during lodging for mothers involves a sense of feeling in control and being comfortable with its process. Bracht *et al*. (2013:115) suggest that providing mothers with education and empowering them to be the primary caregivers of their own newborn babies strengthen the bonding process while they wait for their babies to recover. Although some mothers perceive their babies' hospitalisation as stressful, lodging can contribute to neonatal care and assist them during their difficult circumstances.

3.4.4 Interaction with staff

As stated by Buckley (2016:2), it is vital that people should express their feelings in terms of how they are being treated. In this study, interaction between the staff and the participants played the most important role in the feelings that the participants expressed.

a) *Staff support*

Some participants said the staff did not support them at all.

> *Sometimes, one (a nurse) will shout at you, and if I can talk and shout back, my worry is that this person has my baby's life in her hands. And obviously she is the one that gives medication to my baby; what if she gives my baby the wrong one just to spite me and say, "This one shouted at me."* (P12)

Participants indicated that they did not experience support from nursing staff about issues surrounding sad news or day-to-day updates.

> *We do not get any support at all. They do not even send a counsellor the following day to come and support this woman who had just been informed that her baby is no more.* (P3)

> *Mm. There is no support; besides, they will only support you while they are in there with you. As soon as you leave the ward and come in here to lodging area, you just go back to feeling the same way.* (P12)

Another participant described the treatment as follows:

> *It makes me feel sad, because we came here for our babies to recover and heal, not to be shouted and treated like kids. … The treatment we get from the nurses is not good at all. The food they give us is too little and our last meal is at 4:00 pm. The only person who helps us here is the caretaker.* (P9)

On a positive note, some participants indicated that some support was provided and that not everything was bad.

> *Sometimes, we get assistance from the caretaker. She would prepare something extra for us. She is doing all of this for us because we always show her what they give us as food – the kind of food that she is also not happy with as a parent.* (P3)

> *The nurses also encouraged me to be strong, and to also acknowledge that this is my first child; I must be kind to myself.* (P8)

Again, even when we get to the wards, there are … I swear, I do not want to lie, the sisters (nurses) are nice, extremely nice. Especially me, it was my first time coming across something like that. They held me well, I was crying. (P12)

I swear, I do not want to tell lies, I do not want to gossip. They are good people. Yes, even when we ask them questions, they respond well. (P10)

I did not intend and did not think that I would find myself sleeping here at some point, but since … sometimes, the sisters (nurses) are able to support, so one is able to feel free sometimes. (P11)

Since parents cannot physically or verbally communicate with their family members at home while their babies are in the NCU, only nurses can offer them emotional and practical support throughout their time there. Therefore, it is crucial to build a relationship of trust between nurses and mothers during this time (Aitugulova, 2020:4). Findings in this study revealed that some nurses were good and able to provide support to the participants, thus decreasing the negative experiences they may have encountered. Perceptions of not being supported could be related to the next section that deals with communication between mothers and staff.

b) Communication between mothers and staff

According to the participants, the doctors and nursing staff did not provide them detailed information about the condition of their babies.

No. They do not tell us anything. It is only the doctor who can give us feedback regarding our babies' health conditions. The nurses would just say, "The baby is fine." … The doctors' reports are constantly changing. Sometimes, they give you a positive report, and other days a negative report. Other times, they don't give you a detailed report. They would just say, "The baby is fine." However, as a mother, you can sense when things are not fine with your baby. (P2)

Yes, because you get nurses who are very rude. Sometimes, you get false information about your baby's health condition, because they don't have our best interests at heart. Today I get a promising report, tomorrow I get a contradicting report; so, I am currently confused. I just go to see my baby without knowing about his current condition. (P9)

> *The doctors do not know how to communicate with people well. So, the doctors here are not able to encourage a person at all.* (P11)

One participant elaborated that doctors used difficult words that she did not understand.

> *When you ask him/her, "Doctor, how is my child doing today?" he/she will say to you, "You know, I explained to you." So, they are not able to advise a person at all. They will tell you something huge that you do not understand and expect you to understand the condition of your baby.* (P11)

Another participant stated that the doctors did communicate.

> *The doctors do communicate; yesterday, they were telling me that my boy, actually, there is nothing they can do for him, because almost every medication is fighting his body. So, for now, they are going to observe him, and in any case, if something happens, they have already prepared me emotionally and made me understand that "you've been here for so long and you've seen how we done everything to help your baby".* (P12)

Due to inadequate health vocabularies, little previous knowledge and issues with responding to new information, participants frequently struggled to communicate with physicians. Patients with insufficient health literacy frequently state that they do not comprehend their diagnosis or treatment regimens. Additionally, lower treatment adherence is brought on by insufficient communication and miscommunication between the clinician and patients (Murugesu *et al*., 2022:2). Therefore, it is important that doctors not speak to patients in such way that the information is unclear and understandable. In this instance, doctors need to come down to the level of the lodging mothers when explaining the conditions of their babies so that they will be able to understand exactly what is going on with their babies. The mother may feel more at ease and less anxious during any necessary medical procedures if doctors and nursing staff explain what will happen to their babies beforehand (Tan, 2019:8). Since these findings rest on the perceptions from the participants' it might be wise to also explore the perceptions of healthcare staff in relation to communication behaviours.

c) Staff attitude

According to most participants, nurses' attitudes towards them were very unpleasant. Some experienced the nurses as being either rude or very nice. According to the participants, some of the nursing staff did not want the babies to feel their mothers' touch, only that of the nurses. Being harsh with mothers for not having enough milk caused some participants anxiety. Some of the nurses were perceived to be busy on their phones, not involving mothers in the care of their babies. Participants also stated that nurses put pressure on them to provide milk, while other participants mentioned that nurses seemed to be generally overburdened. Some of the participants indicated that the nurses disliked being asked questions. The nurses would say that the participants talked too much and would make participants' lives miserable while staying at the lodging area. According to participants, nurses seldomly updated them on the condition of their babies and they did not always show compassion.

> *Well, most of the nurses are gentle, but there are still those who are not as kind as we would like them to be.* (P2)

> *However, nurses are not the same. You would be resting, but the next nurse would be shouting and asking why we didn't go to the baby room.* (P5)

> *Nurses are nurses. One moment they are nice, the next they are shouting at you. We have made peace with the situation … and their response really affect us emotionally.* (P6)

> *Others are kind, and some are very rude. Sometimes, you are even afraid to ask for a sheet or say something, because they would say, "You have too many questions!" And some would say, "You talk too much." The environment here is really not nice at all. The majority of the nurses here are very rude and simply don't care about us.* (P7)

The nurses' attitude towards lodging mothers should be addressed to alleviate the negative pressure experienced. The researcher wanted to know the lived experiences of mothers during lodging to unveil their fears, anguishes and challenges in their involvement with nursing staff during their babies' recovery and care. The difficulties in this regard include having limited access to their babies, especially when they are premature and critically ill; inadequate spousal support; lactation difficulties; insufficient

information; struggling to get money to buy toiletries; being unable to contact their family members; and loneliness (Abeasi & Emelife, 2020:4; Cleveland & Horner, 2012:164).

3.4.5 Participant perspectives

As the researcher explored the lived experiences of mothers who often have no choice but to reside close to the hospital, it was important to understand the challenges they encounter and pay attention to their perspectives about improving their living arrangements. In the section above, the physical and emotional challenges experienced by the participants were described. In the following section, the researcher elaborates on the participants' perspectives on how to ensure a more pleasant stay at the lodging residence. Inclusion of participants' perspectives is important, according to Tong and Dew (2016:710). When people have the opportunity to express their ideas, what is important to them can be revealed. The exposed issues may redirect services promoted by local institutions to develop, or revise, current policies to ensure that services rendered to those in need of care are of high standard.

a) Arrange counselling sessions (individual and group)

As was noted, many of the participants had negative emotional experiences, including being distressed, frustrated and lonely (section 3.4.2a, b and c). The reasons mentioned were issues such as a general feeling of unhappiness when seeing other mothers being discharged and being concerned about their babies' condition, and not necessarily the lodging itself. Those who were not local felt more frustrated by not having money to buy toiletries or call their family members and not receiving enough food. Participants seemed dissatisfied with the living environment. They felt alone at the unfamiliar place where they were to live with people they did not know and who were from different places. Several participants expressed their feelings of loneliness because of staying in the same area for a long time. As evidenced by the following quotations, the participants expressed an eagerness for counselling or at least some kind of support that would alleviate their fluctuating emotions.

> *During the time when I was infected with Covid-19, there was a social worker who would call every now and then to check up on me; and it really helped to stabilise my emotions.* (P1)

I feel that we need someone to talk to, even if it is just once or twice a week, just to give us emotional support …. So, it would be great to have that someone who can just sit with each of us, and allow us to express our emotions and thoughts. (P3)

Seemingly, any kind of support was welcomed, even if it were to be in the form of group meetings.

A group session will also be fine… At least we will be able to express our feelings. (P4)

I think we need counselling… Group counselling. I think it is better this way, because you get encouragement from other people's challenges. (P6)

I would suggest that they conduct therapy classes for us, because it is not everyone who feels comfortable to talk about their issues. This platform or class will make us feel that we are supported, and will enable us all to communicate about our challenges. (P8)

The emotional distress that NCU mothers experience is related to complex relationships with nursing staff, uncertainty about how or when to care for their babies and the need for support from professionals on how to manage the distress (Turner *et al.*, 2015:165). Without any form of support, whether from the healthcare staff or a dedicated counsellor, the mothers may find it difficult to deal with the grief and anxiety so often experienced in NCU settings. Therefore, an intervention programme such as a support group or counselling sessions can decrease symptoms of stress (Turner *et al.*, 2015:175). If lodging mothers were to be given a platform where they can express themselves and be counselled about the condition of their babies, it might also have a positive impact on their long stay in the lodging environment.

b) Provide sufficient and nutritious meals

It was evident from the participants' responses that the provision of meals and mealtimes was a great concern to them (section 3.4.1c). Participants mentioned that they were served too little food and that the food was not nutritious enough for them to produce enough breastmilk. It is therefore not surprising that the participants felt strongly about this issue by suggesting the following adjustments.

They should consider changing dinner time from 4:00 pm to 6:00 pm, and also increase the food they provide for us. We really need enough food. (P1)

They should really make an effort to improve their services, not only for us, but also for those who will be coming in the future. I mean, if we get enough food, then we won't struggle to express milk for our young ones. (P7)

The food is so little. You know, even if they can say we should cook for ourselves, it would be better, knowing that we cook right in here and eat our mealie pap. And mealie pap will make us produce more milk for our babies. (P10)

The timing of meals was also an issue, and the participants suggested the following.

Maybe when we got food at 4:00 pm, maybe at around 7:00 pm or 8:00 pm at night we get food again, and then we will get it again tomorrow. (P11)

As stated earlier, a restricted diet could lower a breastfeeding mother's quality of life and decreases her ability to continue exclusively breastfeeding. According to Jeong *et al*. (2017:71) survey, some mothers made the decision to stop breastfeeding, and many women hold the belief that what they eat has a direct impact on the amount of breastmilk they produce. Furthermore, according to scientific research, mother's milk is the best food source to ensure a newborn baby's optimum health. For the first six months of a baby's life, mother's milk alone supplies all the nutrients required for their physical and mental development, with the added bonus of providing natural immunity against many diseases (Ogunba *et al.*, 2019:30).

c) Improve living arrangements (security, boredom, rooms, hygiene)

It was distressing that some of the participants expressed feeling unsafe because of an apparent lack of security at the lodging residence. They offered the following solutions.

There is a woman who comes to check up on us, but I want someone to come and stay here with us 24/7 to ensure that we are all safe. That is why I am requesting that we get a security in here, because I feel unsafe. (P2)

It would also be nice if they could put a light outside. It gets too dark at night and we tend to be afraid. (P6)

To alleviate the boredom experienced by some lodging mothers, participants suggested some creative activities.

So, perhaps they could prepare the soil and supply some seeds for us to plant. I also love to water the plants. I think this is what will make me feel better, because I feel so rejuvenated every time I plant. I like being active to avoid stressing about my child. (P8)

We will appreciate if they can give us some activities to do with our hands, such as to knit clothes with wool. (P9)

Again, I am saying this because there are people who stay here for a very long time, so as they have stayed for a long time, for them not to stress, it is as if there could be taught how to sew, something that can be done by hands, you see? At least some activities. (P10)

The unpleasant feeling of wanting to do something enjoyable but being unable to, is known as boredom. The emotional state of boredom will push people to explore alternative goals and experiences, especially ones that are likely to trigger unpleasant emotions (Bench & Lench, 2013:460). It is therefore important for lodging mothers to have something to do to keep them busy while at the lodging residence.

As evident by the long periods of time that mothers have to spend at the lodging residence, it is not unexpected that participants commented about improving their immediate surroundings.

Additionally, the outside area where we are sitting could also be improved to make us feel at home. We also need a washing line to hang our washing. (P6)

They should improve the rooms where we are currently sleeping. The beds are also very old. (P7)

I think there should be extra blankets, where they are being kept, you see, so that when a mother arrives without blankets, she can be able to go get blankets and go to her bed …. We also ask for a watch, a watch please, mam. To look

at time, because sometimes you find that our phones are off, but we wake each other up, we do not leave one another behind. (P10)

At least if they can make it look more welcoming. (P12)

As noted in section 3.4.1a, a few participants also perceived the lodging environment as being unhygienic. They made a few suggestions to improve this situation.

At times, we would have cleaned up the area without any mess. Ants are sometimes there, so we ask that the place be plastered a little bit. I believe the bedroom will look better then. Ants really like a lot in there, even when we have cleaned and cleared up. (P11)

El-Houfey and Areeshi (2014:1) assert that it is easy to take action to maintain a clean environment. The environment will significantly change if all stakeholders implement a few minor modifications. The creation of a clean environment requires collective attention.

d) Improve communication by healthcare staff

In the medical field, the whole practice of medicine relies heavily on communication. It is used for exchanging ideas, delivering messages and exchanging information through signals, speech or text. The healthcare knowledge acquired by physicians is a powerful medium that requires competence in communication to effectively be wielded in addressing and solving patient problems (Alnaser, 2020:3).

Without proper communication, the whole health system, which involves patients, medical professionals and the health of the nation, will suffer and not be able to function accurately. Hence, efficient communication is significant for medical professionals, enabling them to appropriately perform essential patient care (Alnaser, 2020:4). Literature on lodging mothers in hospitals reveals that due to challenges such as lack of communication and information exchange from nurses and doctors, mothers are feeling alone and helpless during their babies' illness. The study of Yam and Au (2004:119) indicated that mothers feel inadequate to contribute to the care of their babies. The study further indicated that mothers that were referred from other provinces had a concern that doctors and nurses do not give them more information for the reasons of their babies being transferred to other hospital and that leave them clueless about the transfer.

The suggestions raised by participants regarding improved communication included updates about their babies' condition and the healthcare that are provided to their babies.

> *Actually, right there, mam, another thing that I am requesting … sometimes, the sisters (nurses) do not explain to us. It feels like when we get in, we should be told about the conditions of our babies. They do not explain anything to us. We are the ones that have to ask, "Sister, how is my child doing today?"* (P10)

> *So, I want them to speak to us about everything that they do, the medication they give to our babies and the proper diagnosis. I want them to communicate more with us as mothers so that we can know exactly what is wrong with our children. In addition, I would like to suggest that the nurses also be updated with our babies' health reports, so that they can communicate it to us even when the doctor is not on duty. I want them to communicate more with us.* (P2)

One of the participants mentioned that she would appreciate information during times when she had to go home to attend to other family members.

> *You know, maybe to give me a call when I am at home to tell me the condition of my baby. I want things like that. I would have like to maybe take a week at home. They should still call and tell me how the baby is doing so that I can be well, instead of being told when the baby has changed the condition …* (P11)

As mentioned in section 3.4.4a, the participants did not always perceive the nursing staff as being supportive and displaying a comforting attitude towards them. Suggestions to alleviate their dissatisfaction with the treatment that they receive include:

> *My suggestion is that they should focus on their work during working hours and stop using their phones. I think that is a solution for now. They really need to pay attention on the children.* (P2)

> *I also feel that the nurses should be addressed in terms of how they treat us. I mean, we should enjoy going to the baby room, right? We should be comfortable and not scared to ask the nurses for advice and help, and enjoy holding our babies.* (P7)

Some participants indicated that they were longing to hold their babies and suggested that that be granted to them.

> *I think the best solution would be for them to give us our babies to care for them. I do not mean that they must bring the kids to us while they are still sick. What I am trying to say is that they should allow us to change them so that our babies can be clean.* (P4)

Indeed, it was also noted that not all the personnel treated participants alike. Participants mentioned that the younger staff liked to involve them by providing health education, asking them about their well-being, and allowing them to touch their babies, change their diapers and practise KMC. On the contrary, some of the older personnel seemed impatient when participants asked questions and held their babies, and sometimes even denied them access to touch their babies, change their diapers or practise KMC. For this reason, symptoms such as depression and anxiety are prevalent among mothers of babies hospitalised in the NCU.

Surprisingly, emotional distress is often not identified among lodging mothers, and even when it is detected, they are not always able to access support (Davila & Segre, 2018:114). This study also identified other challenges for lodging mothers. These include lack of support from families, as they are from other provinces, and that they do not have enough clothes, because they did not know that their babies would have some complications after birth. In many cases, mothers would only bring to the hospital pyjamas or the clothes that they wore when they left home, having had the intention of going back home after delivery. They might have thought that they may be discharged the following day, but due to unforeseen complications, their babies had to be referred to a tertiary institution for further management.

3.5 Summary

This study sought to answer the research question: What are the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU? In this chapter, the findings that were generated in this regard are presented. The findings reflect the perceptions of 13 mothers lodging at a public hospital while their sick babies had been admitted to the NCU. Five categories and related subcategories

emerged, which were discussed in triangulation with relevant literature. The following and final chapter presents the concluding thoughts and remarks of the study.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

The purpose of the study was to explore and describe the lived experiences of mothers lodging at a public hospital with their babies having been admitted to an NCU. In this final chapter, the researcher presents deductions from the in-depth interviews with participants and discusses proposed recommendations and summative thoughts. In conclusion, the researcher presents her final reflections and lessons learnt from exploring the experiences of lodging mothers.

4.2 Response to the Research Problem

The study sought to answer the following question: What are the lived experiences of mothers lodging at a public hospital while their babies have been admitted to an NCU? As far as the researcher is aware, no studies exist that address this phenomenon, and there is a paucity of literature on the lodging phenomenon as it is described in this study. Most literature accessed addresses the lived experiences of mothers with sick babies in an NCU, mothers' experiences of caring for very low birthweight premature infants in one public hospital (Ntswane-Lebang & Khoza, 2010:69), and the mother-baby-friendly-initiative (MBFI) that was implemented in Kwazulu-Natal to ensure that mothers and babies are always together. This study was necessary to gain a deeper understanding of how mothers experience having to stay near their sick babies and the challenges they were experiencing. The researcher responded by using in-depth individual interviews with a group of mothers lodging at a public hospital while their babies have been admitted to an NCU.

4.3 Deductions from the In-Depth Interviews

The researcher has been working at the NCU for 11 years. During this time, she noticed particular behaviour by healthcare personnel and lodger mothers (section 1,1). Her observations sparked an interest in exploring how these mothers experience having to stay at a residence developed for the purpose of allowing them easy access

to their sick babies. She realized that her assumptions were not empirical and therefor opted to study the phenomenon by way of rigorous research.

The lived experiences of lodging mothers were grouped into five categories with related subcategories. The categories were discussed in Chapter 3 and supported by relevant literature. The findings revealed issues with the lodging environment, the participants' emotional experiences while lodging, and concerns about the nursing care of their babies and interaction with staff. In the fifth category, the participants shared their perspectives regarding creating conducive living arrangements, the provision of sufficient and nutritious meals and the need for support and counselling.

The researcher realized that much of her observations about the behavior of personnel and lodger mothers could be explained by the findings. For example, her observation about mothers appearing worried, stressed, or frustrated could now be explained by what the mothers revealed during the interviews about day-to-day aspects such as mealtimes, security, boredom and living arrangements. Apparently, it was also not the researcher imagination that some healthcare personnel seem to display unfriendly behavior towards mothers at times – especially surrounding the issue of providing breastmilk and handling their babies.

The overall perception of how the mothers experience lodging is that of them having to endure an environment and circumstances that are not always conducive – not to them nor to their desire to be included in the care of their baby. The researcher realized that a sustained effort would have to be made to bring about the necessary changes that will provide the mothers with supportive living arrangements.

However, the researcher acknowledges that the findings reveal the perceptions of the lodger mothers and not those of the healthcare staff. To gain better insight into the phenomenon of lodging at a hospital setting it might be worthwhile to explore the perceptions of the healthcare workers so that effective care can be planned to meet the needs of nursing staff, the mothers, and babies.

The findings of the study are summarized in the sections below.

4.3.1 Lodging environment

The participants stated that the environment they were staying in was not conducive and they expressed having a range of discomforts at the lodging area. These

discomforts led to emotional difficulties, which in turn seemed to have left a negative impression of lodging. Data revealed that participants found the beds and mattresses to be uncomfortable with not enough blankets to protect against the cold. The area was noisy and boring, with nothing much to do other than sleep and visit their babies. In addition, there was no laundry line on which to hang clothes and the television did not work. Other concerns raised included a lack of security and that the distance between beds was insufficient for social distancing, thus disregarding Covid-19 guidelines in place at the time. Another issue that seemed to concern most of the participants was the lack of nutritious food and awkward mealtimes. Since most lodging mothers have to stay at the lodging residence for long periods of time – even months in some cases – it is not difficult to see how all of these discomforts may have led to the emotional challenges experienced by many of the participants.

4.3.2 Emotional experiences

Most participants were more concerned about their babies' health than the actual accommodation at the research site. They feared that their babies would not survive, which forced them to deal with grief, anguish and anxiety. Due to the long distance from home and associated expenditures, several participants felt abandoned and upset because their families were not able to visit them. Due to financial limitations, they were unable to phone family members, which caused them to feel sad. Additionally, the distance between their family members and them added to their sense of abandonment and loneliness. Other than being challenged by not being close to home or family, some participants voiced the frustration of not receiving clear messages about their babies' condition from the healthcare staff. Nevertheless, there were those who did not complain about lodging and were quite satisfied with their living circumstances.

4.3.3 Nursing care of babies

Most participants were affected by the nursing care provided to their babies by the nursing personnel. Some mentioned that some members of the nursing staff would not let them hold their babies, which did not foster KMC practices. Others complained that they were not provided any time to rest. The researcher was somewhat surprised by participants' perception of not having time to rest because many of them mentioned being bored at times. As mentioned in the section above, not all participants were

negative and some were content that the nursing staff was taking good care of their babies.

4.3.4 Interaction with staff

The majority of participants claimed that the nursing staff did not support them at all. Few participants said that nursing personnel helped them when they visited their babies in the NCU, but that nurses did not assist them with living arrangements and the frustrations of lodging. On the positive side, several participants mentioned that some help was offered and that not all was negative. Other participants were concerned about the medical terms used by the doctors when explaining and informing them about the condition of their babies. Unfortunately, some of the participants experienced nursing staff as being rude and unengaged, thus seemingly not providing the kind of support that a worried mother might need.

4.3.5 Participant perspectives

The findings of this category relate to the participants' suggestions that will make their and future residents' stay more comfortable. Most of the participants expressed a need for counselling or at the very least some form of support to help them manage their stay at the hospital. Since the participants understood the necessity of producing enough breastmilk for their babies, they made suggestions about meals and meal timing. Besides suggestions about meals, participants mentioned that their living arrangements could be improved. Some of the participants reported feeling bored and suggested engaging in creative pursuits such as sewing or manual labour such as gardening to break the monotony and despair brought on by constantly thinking about the situation of their babies. Rightfully, participants requested better security and safety by having extra lights outside during the night.

4.4 Recommendations

This research that explored the lived experiences of lodging mothers would have been a waste of time if no actions were to be taken to address the research findings. Although further research about the phenomenon of lodging mothers may provide more in-depth and broader evidence into how lodging is experienced in various

contexts, results from this study point to inadequate service delivery. The researcher therefore proposes recommendations in this section.

4.4.1 Hospital management and staff

In response to the findings of this study, it is recommended that hospital management be made aware of the issues raised by the users of the services provided. This can be accomplished by compiling a report and presenting the findings at a formal meeting between the researcher and relative executive officers. The researcher has gained much insight about the daily challenges of lodging mothers. She is therefore better equipped than before to represent the lodging mothers and help finding solutions that will profit them, their babies and the healthcare staff.

Short-term solutions might include dedicating a security officer to the lodging area and ensuring adequate light on the path leading to the NCU. A visit to the lodging rooms to take inventory of sleeping arrangements and daily cleaning routines can raise awareness about the mothers' needs. The long periods of stay for some of these mothers should be brought under the attention of service providers, because mothers have to endure whatever the environment offers them. The researcher can again stress the importance of sufficient and nutritious meals for the sake of adequate breastmilk production. A hospital dietician can be consulted to address the feasibility of well-balanced meals.

The researcher undertakes to inform the operational manager of the NCU about the findings of her study and about the recent feelings of the mothers lodging. During doctors' rounds, the researcher could address the issues raised by the mothers relevant to them. The researcher could arrange a unit meeting where she could make nursing staff aware about the outcome of the study and how the mothers can be supported while lodging. The sensitive issue about staff attitudes as expressed by the participants might be discussed with the unit manager first before the rest of the staff are included. The researcher and the manager can discuss an approach to be adopted at the NCU to make healthcare staff aware of the challenges that some of the mothers face during lodging.

4.4.2 Free State Department of Health

The approval letter from the FSDoH (see Addendum F) stated that the research results and a complete report should be made available to the department (a hardcopy plus a softcopy). Apart from providing the FSDoH with feedback, the researcher will also present the findings and recommendations of her study at the annual FSDoH provincial research day, which usually takes place at the end of the year. This will assist the researcher to make recommendations to the department based on the participants' perspectives.

At the moment, there is an emphasis from the DoH on translating research to policy. All reports need to be analysed to assess the merit and to investigate the possibility of formulating new policy or amendments. The institution should thus focus on implementing emotional wellness programmes that include advocacy for the utility of counselling and promoting use of mental health services among lodging mothers. The head of nursing of the institution will be informed by the researcher about the outcome of the study. They will also be informed about the concern that the participants had concerning mealtimes and whether any adjustments can be made to accommodate mothers in this regard or even if extra meals can be provided. It is imperative that there be collaboration between the multidisciplinary team and the nursing staff in terms of supporting these mothers during their stay at the hospital. Continuous communication regarding supporting these mothers will help. As the researcher works with other multidisciplinary teams and has good relations with them, she can organise a meeting with the dietician and discuss the needs of lodging mothers pertaining to meals. The institution provides researchers a platform to present their studies to the chief executive officer (CEO), head of nursing and other stakeholders. Apart from the recommendations in the section above, the researcher plans to write and publish an article and disseminate the results to a wider audience of scholars and healthcare workers.

4.4.3 Recommendations for further research

The study was confined to one public hospital focusing only on mothers whose babies have been admitted to the NCU and not on other departments in the hospital. Therefore, the study may be extended to other local public and private hospitals in the same as well as other South African provinces to gain a broader understanding of this

phenomenon. Empirical data can result in the development of guidelines that ensure a supportive and conducive lodging environment.

As noted, the researcher acknowledges that exploring the perspectives of the healthcare personnel might add even deeper insight into the relationship between lodger mother and nurse/doctor. Issues raised by participants such as perceived poor communication between themselves and nurses, unfriendly behaviour form the nurses and having limited access to their sick babies could be better understood if the healthcare personnel were given the opportunity to voice their experiences of lodger mothers. A follow-up qualitative enquiry in this regard may be useful.

4.5 Limitations of the Study

The fact that only one public hospital was examined in the study and that the conclusions might not apply to all public and private healthcare systems is one perceived study limitation. Being systematic in nature, the findings might not apply to different contexts. It was also challenging to support the findings with contemporary literature because the literature search yielded very little data relevant to the study problem. As mentioned in Chapter 1, the researcher did not compare the experiences of participants based on their length of stay at the lodging residence and acknowledge that such an analysis and comparison could have added depth to the findings and represented the “voice” of the participants more distinctly.

4.6 Contributions of the Study

The study contributes to both knowledge and policy in multiple ways. The contribution to knowledge is firstly empirical in that it provides new knowledge around an area that has limited research. The study provides unique insights of experiences from a diverse sample of lodging mothers. The study is also a first of its kind focusing on lodging mothers related to a single hospital in South Africa where they are waiting for the recovery of their sick babies. The study therefore provides a unique empirical reflection of the lived realities of these mothers. The study highlights the gaps in policy and practice that the government and key stakeholders can focus on to improve the emotional well-being of lodging mothers. The expectation is that the findings of the current study contribute in the following ways:

- The study findings provide information that may guide future programme improvements.
- The findings may also inform the public health discipline curriculum regarding the lived experiences of mothers who are lodging at a particular hospital, and the development of skills required to support them.
- The findings will assist with awareness of negative emotions seen in mothers who have been lodging for two weeks and longer and how to support them to deal with their emotions.
- The quality of services rendered to lodging mothers to promote the bond between them and their babies without feeling stressed by the surroundings.
- As lodging mothers are the ones experiencing the phenomenon of lodging, their experiences and attitudes play a crucial role in the successful execution of lodging.
- The study sheds some light on the grey area of the perceptions of lodging mothers as perceived from their experiences during their stay at a particular public hospital in South Africa. Nurses who work with newborn babies need to be aware of both stress and sources of support for parents. This study may help to provide an understanding of what factors health professionals should focus on in promoting appropriate emotional support for mothers.

4.7 Final Reflections

Before the researcher offers concluding remarks, she shares some of her inner thoughts and reflections on her own experiences while exploring an issue dear to her heart.

> I learnt that any research demands a lot of time, commitment and sleepless nights. I had to put so many things aside in order to focus on this study. My patience was tested for so many times that sometimes I felt like quitting, especially with the corrections. There were times when I felt I put all my efforts and energy in looking for literature, only to find that I was totally out of context. I thought I had perseverance, but it was increased more than before. I had face-to-face meetings with my supervisor and I came to the conclusion that these meetings, which included feedback on my progress,

were more positive and enlightening. I gained a better understanding of what was required of me in my development as a qualitative researcher from these contact sessions as opposed to the electronic communication we utilised before because of the Covid-19 situation. I used to assume about the feelings of lodging mothers from my own world, but hearing their experiences torn my heart that we as nursing staff are not doing any justice to these mothers by the treatment we give and how much pressure we placed on them, especially when looking for milk for babies. At that time, we are not even aware how they feel when they are alone in the lodging area. The research itself brought more insight into my perspective, as I used to wonder what is actually going on in their minds. Sometimes, seeing them looking sad and frustrated used to worry me so much, but I did not have a deeper understanding of their sadness. Some of the mothers would cry while still speaking to them. The research made me realise the frustration they went through by increasing my empathy for them regardless of where they come from, and made me realise that some of them seem to be happy at times, but deep down, they were hurt and unable to express their feelings. This also made me to be more concerned about the information given to them by the doctors and made me advocate more for these mothers, especially when it comes to the condition of the babies and the constant information given to the mothers about the progress of the babies on a daily basis.

4.8 Concluding Remarks

As mentioned, the research study let the researcher better grasp the difficulties that mothers had at the research site. Participants indicated that negative experiences could be contributed to the rudeness of and lack of support by the nursing staff, that the lodging environment was not conducive, and that they did not receive counselling. The research study also revealed several challenges faced by lodging mothers about the hospital security.

Protection of the mother-baby dyad is one of the WHO initiatives and seen as one of the key principles in ending preventable maternal mortality. This is the principle of

survival convergence (WHO, 2018:11). It's critical to recognize the unique importance of the mother-baby bond. When necessary, newborn health outcomes are improved, and treatment is given without separating the baby from his or her mother. This type of care integration increases the effectiveness of the healthcare system while also being more acceptable to women and families. Maternal and newborn health services should be delivered together wherever possible without compromising the quality of care for either.

Contextually, the study revealed that there is a correlation between social support and emotional experiences of mothers who are lodging. As social support strengthens, there might be a significant reduction in negative emotional behaviours among those who require lodging while their babies have been admitted to an NCU.

Finally, extended research into the phenomenon of lodging mothers might lead to the development of a unique institutional approach that will ensure a stay as pleasant and supportive as possible. In turn, satisfied mothers and supportive staff relations may reflect positively on the well-being and health outcomes of the babies.

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ADDENDUM A: Participant information leaflet and consent form

TITLE OF THE RESEARCH PROJECT: Lived experiences of mothers lodging at a public hospital in South Africa

STUDENT NUMBER: 1995633342

PRINCIPAL INVESTIGATOR: Mrs. Matshediso Julia Ntuli

ADDRESS: University of the Free State

: School of Nursing

CONTACT NUMBER: 081 499 3598

I am a student pursuing my Master's degree and will like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher or supervisor any questions about any part of this project that you do not fully understand.

It is very important that you are content that you clearly understand what this research entails and how you could be involved. Also, your participation is completely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. The interviews will be audio-recorded with permission from the mothers and the approximate time required for the interview will be one hour and the information gathered will be kept confidential.

This study has been approved by the Health Sciences Research Ethics Committee at the University of the Free State and will be conducted according to the set ethical guidelines and principles.

What is this research all about?

The study will be conducted at a public hospital, Universitas Academic Hospital in the Free State

The study aims to explore the lived experiences of mothers lodging at a public hospital while their babies are being admitted to a Neonatal Care Unit. Participants will be expected to be part of the study if agreed to and sign an informed consent provided in the next page

A question will be asked on which participants must provide relevant answers about their lodging experiences at a public hospital

There are no right or wrong answers

The session will be facilitated by an independent interviewer who is not working with the babies. No preparation is needed to participate

Why have you been invited to participate?

The researcher wishes to include participants who are lodging at a public hospital so that she can have a deeper understanding on what they are actually experiencing What will your responsibilities be?

No preparation is required. You will be expected to be available at a specific time and venue that will be communicated to you prior the interview

Will you benefit from taking part in this research?

There are no tangible benefits to participating in this study – the valuable information gathered from your participation will be utilized to help the organisations to improve care

There is no monetary funding offered for participants

Are there any risks involved in your taking part in this research?

Should you experience uneasiness at any stage, feel free to discuss it with the interviewer

If you do not agree to take part, what alternatives do you have?

The study is completely voluntary. Should you wish to not take part or withdraw, it will not influence you in any way.

Who will have access to your information?

All information obtained during this study will be treated as confidential and protected

The data obtained will be used for publication or thesis, confidentiality will be maintained

| The researcher, the supervisor of the study, the facilitator and assessors will have access to the data.

| Data obtained may be reported in scientific journal but will not include any information that identifies you as a participant in this study.

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

There are no known risks involved in this study.

Will you be paid to take part in this study and are there any costs involved? No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the study leader Doctor C. Spies at 051-401 9721 or the Health Sciences Research Committee (HSREC) on 051-401 7794 / 051-401 7795 if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……. agree to take part in a research study about the lived experiences of lodging mothers while their babies are being admitted to a neonatal care unit. I give permission that the interview may be audio-recorded.

I declare that:

• I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

• I have had a chance to ask questions and all my questions have been adequately answered.

• I understand that taking part in this study is voluntary and I have not been pressurised to take part.

• I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

• I may be asked to leave the study before it has finished, if the study leader or the researcher feels it is in my best interests, or if I do not follow the rules and regulations explained to me beforehand, as agreed to.

Signed at (place) .....on (date).....20...

Signature of participant:

Signature of witness:

Declaration by investigator

I, (name of the interviewer) declare that:

• I explained the information in this document to …….

• I encouraged her to ask questions and took adequate time to answer them.

• I am satisfied that she adequately understands all aspects of the research, as discussed above

• I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.

Signed at (place) .....on (date) .....20….

Signature of interviewer:

Signature of witness:

ADDENDUM B: Pampitshana ya tlhahiso-leseding ya banka- karolo le foromo ya tumello

SEHLOOHO SA MORERO WA PATLISISO: Diphihlelo tseo bomme ba fetileng ho tsona ha bane ba dula sepetlele nakong eo masea a bona a kenngweng lefapheng la bana ba kulang

NOMORO YA THUTO: 1995633342

MOTLATSI WA SEKGETHO: Mme Matshediso Julia Ntuli

ATERESE: Univesithi ya Free State

: Sekolo sa booki

NOMORO TSA MOHALA WA THEKENG: 081 499 3598

Ke e mong wa baithuti ba ballang tsa tsebo ya dipatlisiso mme o mengwa ho nka karolo morerong wa dipatlisiso. Ka kopo iphe nako ya ho bala tlhahiso-leseding e hlahisitsweng mona, e tla hlalosa dintlha tsa projeke ena ka botlalo. Ka kopo botsa mofuputsi kapa motsamaisi dipotso leha e le dife ka karolo efe kapa efe ya morero eo o sa e utlwisiseng ka botlalo. Ho bohlokwa haholo hore o kgotsofalle hore o utlwisise hantle hore na patlisiso ena e kenyelletsa eng le hore na o ka nka karolo jwang. Hape, ho nka karolo ha hao ke ha boithatelo mme o lokolohile ho hana ho nka karolo. Haeba o re tjhe, hona ho keke ha o ama hampe ka tsela efe kapa efe. Hape o lokolohile ho ikgula thutong neng kapa neng, leha o ne o dumetse ho nka karolo. Dipuisano di tla hatiswa ka theipi ka tumello ya bomme, mme nako e batlang e hlokahala bakeng sa dipotso e tla ba hora e le nngwe mme tlhaiso-leseding e bokelletsweng e tla bolokwa. Boithuto bona bo amohetswe ke Komiti ya Boitshwaro ba Patlisiso ya Saense ya Bophelo Univesithing ya Foreisetata mme e tla etswa ho latela melawana le dipehelo tse behilweng tsa boitshwaro.

Phuputso ena e bua ka eng?

Thuto e tla kgannelwa sepetleleng sa setjhaba sa mmuso, Universitas Academic Hospital, Foreisitata

Phuputso e ikemiseditse ho lekola boiphihlelo bo phetsweng ke bomme ba robetseng sepetleleng sa setjhaba ha masea a bona a ntse a alafshwa lefapheng la tlhokomelo ya bana ba kulang

Bomme ba batswetse ba tla lebellwa ho ba karolo ya boithuto haeba ho dumellanwa le ho saena tumello e nang le tsebo e fanweng leqepheng le latelang

Ho tla botswa potso ya hore na ke bomme bafe ba lokelang ho fana ka dikarabo tse nepahetseng ka boiphihlelo ba bona ba bodulo sepetleleng sa setjhaba

Ha ho na dikarabo tse nepahetseng kapa tse fosahetseng Lenaneo le tla nolofatswa ke mofuputsi ya ikemetseng a bile asa sebetse le bana ba lona. Ha ho hlokahale boitokiso ho nka karolo

Hobaneng o memetswe ho nka karolo?

Mofuputsi o lakatsa ho sebedisa banka-karolo ba robalang sepetleleng sa setjhaba hore a be le kutlwisiso ya pele ya seo ba leng ho sona le hore ba ikutlwa jwang

Boikarabello ba hao e tla ba bofe?

Ha ho hlokahale boitokiso. O tla lebellwa hore o thuse ka ho fumaneha ka nako le sebaka se itseng seo o tla tsebiswa sona pele ho seo.

Na o tla fumantshwa molemo o itseng ka ho nka karolo phuputsong ena?Ha ho na meriana ya letho ya ho nka karolo ya boithuto bona - tlhaiso-leseding e tlo fumanwa ho tswa patlisisong ena leho nka karolo ha hao ho tla thusa tshebetsong yaho ntlafatsa tlhokomelo

Ha ho na tjhelete e fanwang bakeng sa banka-karolo

Na ho na le dikotsi tse teng tsa ho nka karolo ha hao ho etsa dipatlisiso tsena?

Boithuto ba bohlokwa ha bo na dikotsi tse tsebahalang

Haeba o ka ba le pherekano ya maikutlo e itseng ka nako efe kapa efe, o lokolohile hoka tsebisa mofuputsi ya ikemetseng

Ha osa kgone ho nka karolo, ke metjha efe eo o lokelang ho e latela?

Boithuto ke ba boithatelo ka dihlahiswa. Haeba o lakatsa ho se be karolo kapa ho ikgula, o ke ke wa susumetswa kapa ho hatellwa ka tsela efe kapa efe

Ke mang ya tla fumana lesedi la hao?

Boitsebiso bohle bo fumanweng nakong ya boithuto bona bo tla nkuwa ele lekunutu

Haeba e phatlalatswa phatlalatsong kapa thesiseng, tsohle di tla bolokwa ele lekunutu

Mofuputsi, mookamedi wa thuto, morupelli le bahlahlobi ba tla fumana tlhaiso-leseding. Dintlha tse fumanweng di ka sebediswa ke koranta ya mahlale

Ho tla etsahala eng ketsahalong e sa lebellwang ya mofuta o itseng wa kotsi o ka bang teng ka lebaka la ho nka karolo ha hao thutong ena ya dipatlisiso?

Ha ho na dikotsi tse tsebahalang tse amehang thutong ena.

Na o tla lefuwa ho nka karolo thutong ena mme na ho na le ditshenyehelo tse itseng?

Tjhe, o ke ke wa lefuwa ho nka karolo phuputsong ena. Ho ke ke ha ba le ditshenyehelo tse o amang, haeba o nka karolo.

Na ho na le eng kapa eng eo o lokelang ho e tseba kapa ho e etsa?

O ka ikopanya le mookamedi wa phuputso, Ngaka C. Spies ho 051-401 9721 kapa setho sa komiti ya melao ya boitshwaro ya dipatlisiso (Health Sciences Research Committee) ho 051-401 7794 / 051 401 7795, haeba o na le ditletlebo kapa dingongoreho tse so kang di rarollwa ka ho phethahala ke mofuputsi.

O tla fumana khopi (pampiri) ya tlhahiso-leseding ena le foromo ya tumello bakeng sa ditlaleho tsa hao.

Phatlalatso ka monka-karolo

Ka ho saena ka tlase, nna ……ke dumela ho nka karolo phuputsong e mabapi le boiphihlelo bo phetseng ba bomme ha masea a bona a amohelwa lefapheng la tlhokomelo ya masea. Ke fana ka tumello ya hore puisano e ka rekota mantswe.

Ke phatlalatsa hore:

• Ke badile kapa ke balletswe tlhahiso-leseding ena le foromo ya tumello mme e ngotswe ka puo eo ke e utlwisisang ebile e phutholohileng.

• Ke bile le monyetla wa ho botsa dipotso mme dipotso tsohle tsa ka di arabilwe ka nepo.

• Ke utlwisisa hore ho nka karolo phuputsong ena ke ho ithaopa mme ha ke a ka hatellwa ho nka karolo.

• Nka kgetha ho tswa phuputsong ena neng kapa neng mme nke ke ka otlwa kapa ka kgethollwa ka tsela efe kapa efe.

• Nka kopa ho tlohela phuputso pele e qetwa, haeba moetapele wa thuto kapa mofuputsi a utlwa hore hae molemong wa ka, kapa haeba ke sa latele moralo wa phuputso, kamoo ho dumellanweng ka teng.

E saennwe (sebakeng) ..... ka (letsatsi) …… .... 20 ….

Signature ya monka-karolo:

Tshaeno ya paki:

Phatlalatso ka mofuputsi ya ikemetseng

Nna, (mofuputsi ya ikemetseng) ke phatlalatsa hore:

• Ke hlalositse lesedi lena la tokomane ena ho ……

• Ke ile ka mo kgothaletsa ho botsa dipotso mme ka nka nako e lekaneng ho di araba.

• Ke kgotsofetse hore o utlwisisa ka botlalo dintlha tsohle tsa dipatlisiso, jwaloka ha ho boletswe kahodimo.

• Ke sebedisitse / ha kea sebedisa toloko. (Haeba mofetoledi a sebedliswa, mofetoledi o lokela ho saena polelo e ka tlase).

Nna, (lebitso la motho ya botsang dipotso) ke phatlalatsa hore:

E saennwe (sebakeng) ..... ka (letsatsi) …… 20….

ADDENDUM C: Inligtingsblaadjie vir deelnemer en toestemmingsvorm

TITEL VAN DIE NAVORSING'S PROJEK: Lewende ervarings van moeders wat in 'n openbare hospitaal in Suid-Afrika tuisgaan

STUDENT NOMMER: 1995633342

HOOF ONDERSOEKER: mev. Matshediso Julia Ntuli

ADDRESS: University of the Free State

: School of Nursing

KONTAKNOMMER: 081 499 3598

Ek is 'n student wat my meestersgraad volg en wil u uitnooi om deel te neem aan 'n navorsingsprojek. Neem 'n bietjie tyd om die inligting wat hier aangebied word te lees, wat die besonderhede van hierdie projek sal verduidelik. Vra die navorser of onafhanklike nderhoudvoerder enige vrae oor enige deel van hierdie projek wat u nie heeltemal verstaan nie.

Dit is baie belangrik dat u tevrede is dat u duidelik verstaan wat hierdie navorsing behels en hoe u daarby betrokke kan wees. U deelname is ook heeltemal vrywillig en dit staan u vry om deel te neem. As u nee sê, sal dit u hoegenaamd nie negatief beïnvloed nie. Dit staan u ook vry om op enige stadium van die studie te onttrek, selfs al stem u in om deel te neem. Die onderhoude sal met die toestemming van die moeders op klank opgeneem word en die geskatte tydsduur vir die onderhoud sal een uur wees en die versamelde inligting word vertroulik gehou.

Hierdie studie is goedgekeur deur die Gesondheidswetenskaplike Navorsingsetiekkomitee aan die Universiteit van die Vrystaat en sal volgens die vasgestelde etiese riglyne en beginsels gedoen word.

Waaroor gaan hierdie navorsing?

Die studie sal in 'n openbare hospitaal (Universitas Akademiese Hospitaal in Vrystaat) gedoen word

Die studie het ten doel om die ervarings van moeders wat in 'n openbare hospitaal tuisgaan, te ondersoek terwyl hul babas in 'n neonatale versorgingseenheid opgeneem word.

Daar sal van deelnemers verwag word om deel te wees van die studie indien hulle daartoe instem en onderteken 'n ingeligte toestemming wat op die volgende bladsy verskaf word

'N Vraag word gestel oor watter deelnemers relevante antwoorde moet verskaf oor hul verblyfervarings in 'n openbare hospitaal

Daar is geen regte of verkeerde antwoorde nie

Die sessie sal gefasiliteer word deur 'n onafhanklike onderhoudvoerder wat nie met die babas werk nie. Geen voorbereiding is nodig om deel te neem nie

Waarom is u genooi om deel te neem?

Die navorser wil deelnemers insluit wat in 'n openbare hospitaal tuisgaan, sodat sy 'n beter begrip kan hê van wat hulle werklik ervaar

Wat sal u verantwoordelikhede wees?

Geen voorbereiding is nodig nie. Daar word van u verwag om beskikbaar te wees op 'n spesifieke tydstip en plek waarna u voor die onderhoud gekommunikeer sal word

Baat u daaraan om aan hierdie navorsing deel te neem?

Daar is geen tasbare voordele daaraan verbonde om aan hierdie studie deel te neem nie - die waardevolle inligting wat u tydens u deelname versamel het, sal gebruik word om organisasies te help om sorg te verbeter

Daar word geen geldelike befondsing vir deelnemers aangebied nie

Watter alternatiewe het u as u nie saamstem om deel te neem nie?

Die studie is heeltemal vrywillig.

As u nie wil deelneem of uittrek nie, sal dit u nie beïnvloed nie.

Die navorser, die studieleier van die studie, die fasiliteerder en assessore het toegang tot die data.

Data wat verkry word, kan in die wetenskaplike tydskrif gerapporteer word, maar bevat geen inligting wat u as deelnemer aan hierdie studie identifiseer nie.

Wat sal gebeur in die onwaarskynlike geval dat die een of ander vorm letsel sal plaasvind as gevolg van u deelname aan hierdie navorsingstudie?

Daar is geen bekende risiko's betrokke by hierdie studie nie.

Sal u betaal word om aan hierdie studie deel te neem en is daar enige koste daaraan verbonde?

Nee, u sal nie betaal word om aan die studie deel te neem nie. Daar is geen koste verbonde aan u as u wel daaraan deelneem nie.

Is daar nog iets wat u moet weet of doen?

U kan die studieleier, dokter C. Spies, kontak by 051-401 9721 of die Universiteit se navorsingsetiekkomitee (HSREC) by 051-401 7794 / 051-401 7795 indien u enige probleme of klagtes het wat die navorser nie voldoende behandel het nie.

U ontvang 'n afskrif van hierdie inligting en toestemmingsvorm vir u eie rekords.

Verklaring deur deelnemer

Deur hieronder te teken, het ek ……stem in om deel te neem aan 'n navorsingstudie oor die ervarings van moeders wat tuisgaan, terwyl hul babas in 'n neonatale versorgingseenheid opgeneem word. Ek gee toestemming dat die onderhoud op 'n klankopname kan plaasvind

Ek verklaar dat:

• Ek het hierdie inligtings- en toestemmingsvorm gelees of gelees, en dit is geskryf in 'n taal waarmee ek vlot en gemaklik is.

• Ek het die kans gehad om vrae te stel en al my vrae is voldoende beantwoord.

• Ek verstaan dat deelname aan hierdie studie vrywillig is en dat ek nie onder druk geplaas is om deel te neem nie.

• Ek kan kies om die studie te eniger tyd te verlaat en sal op geen enkele manier gepenaliseer of benadeel word nie.

• Ek kan gevra word om die studie te verlaat voordat dit voltooi is, as die studieleier of die navorser van mening is dat dit in my beste belang is, of as ek nie die voorgeskrewe reëls en voorskrifte nakom nie, soos ooreengekom.

Geteken by (plek) ..... op (datum) ..... 20 ...

Handtekening van deelnemer:

Handtekening van getuie:

Verklaring deur ondersoeker

Ek (naam van die onafhanklike onderhoudvoerder) verklaar dat:

• Ek het die inligting in hierdie dokument aan …… verduidelik.

• Ek het haar aangemoedig om vrae te stel en genoeg tyd geneem om dit te beantwoord.

• Ek is tevrede dat sy alle aspekte van die navorsing, soos hierbo bespreek, voldoende verstaan

• Ek het 'n tolk gebruik / nie gebruik nie. (As 'n tolk gebruik word, moet die tolk die onderstaande verklaring onderteken.

Geteken by (plek) .....op (datum) ..... 20….

Handtekening van onafhanklike onderhoudvoerder

Handtekening van getuie

ADDENDUM D: Approval letter from Health Science Research Ethics Committee, University of the Free State

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

24-Mar-2021

Dear **Mrs Matshediso Ntuli**

Ethics Clearance: **Lived experiences of mothers lodging at a public hospital in South Africa**

Principal Investigator: **Mrs Matshediso Ntuli**

Department: **School of Nursing Department (Bloemfontein Campus)**

Submission Page

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2020/2005/2004**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. A. Sheriff
Chairperson: Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947

ADDENDUM E: Letter to the Head of the Department of Health of the Free State

3 Kolkop Street

Fleurdal Bloemfontein 9300

28 September 2020

The Head of the Department of Health of the Free State

Bophelo House

BLOEMFONTEIN 9300

Dear Sir / Madam

Topic: Lived experiences of mothers lodging at a public hospital in South Africa

I am a Master's degree student in the school of Nursing, Faculty of Health Sciences, University of the Free State.

For my proposal, I am undertaking a study to explore the lived experiences of lodging mothers at a public hospital, focusing at mothers whose babies are being admitted in a neonatal care unit. Data will be gathered by interviewing the mothers who are willing to participate.

I hereby request permission to conduct a study in the premises of the Department of Health, Universitas Academic Hospital – Neonatal Intensive Care Unit and High Care Unit.

Yours sincerely MJ Ntuli

ADDENDUM F: Approval letter from the Free State Department of Health

Mrs M Ntuli

Dept: School of Nursing

Dear Mrs. M Ntuli

Subject: Lived experiences of mothers lodging at a public hospital in South Africa

• Please ensure that you read the whole document, Permission is hereby granted for the above — mentioned research on the following conditions:

• Participation in the study must be voluntary

• A written consent by each participant must be obtained.

• Serious Adverse events to be reported to the Free State department of health and/ or termination of the study

• Ascertain that your data collection exercise neither interferes with the day to day running of Universitas Hospital nor the performance of duties by the respondents or health care workers.

• Confidentiality of' information will be ensured and please do not obtain information regarding the identity of the participants.

• Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).

• Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and to Free State Department of Health.

• Any amendments, extension or other rnoditications to the protocol or investigators must be submitted to the Ethics Committee of the University of Free State and to Free State Department of Health.

• Conditions stated in your Ethical Approval letter should be adhered to and » final copy of the Ethics Clearance Certificate should be submitted to sebeclats r/ fshealth.gov .za / inakcnamr ‹/ t?hcaIth -ov.za before you commence with the study

• No financial liability will be placed on the Free State Department of Health

• Please discuss your study with Institution Manager on commencement for logistical arrangements see 2"° page for contact details.

• Department of Health to be fully indemnified from any harm that participants and statt experiences in the study

• As part of feedback, you will be required to present your study findings/results at the Free State Provincial health

Just you find the above in order.

Kind Regards

Dr. D Motau

H EA D: HEALTH

Date:

ADDENDUM G: Letter to the Chief Executive of the Hospital

3 Kolkop Street Fleurdal Bloemfontein 9300

28 September 2020

The Chief Executive Officer Universitas Hospital BLOEMFONTEIN

9300

Dear Madam

Topic: Lived experiences of mothers lodging at a public hospital in South Africa

I am a Master's degree student in the school of Nursing, Faculty of Health Sciences, University of the Free State.

For my proposal, I am undertaking a study to explore the lived experiences of lodging mothers at a public hospital, focusing at mothers whose babies are being admitted in a neonatal care unit.

I hereby request permission to conduct a study in your hospital. Yours sincerely

MJ Ntuli

Addendum H: Editor's letter

Rephrase it!
Academic Text Editing

17 Fallopius Street, Bloemfontein
+(27) 076 081 0730
info@rephraseit.co.za

30 November 2022

Student: **M.J. Ntuli**
Student number: **1995633342**

I declare that I language edited the master's dissertation titled, *Lived Experiences of Mothers Lodging at a Public Hospital in South Africa*

During the editing process, I looked for and corrected spelling, grammar, punctuation, paragraph and syntax errors. Where I noticed inconsistencies or unclarities in the text, I made comments to draw the author's attention to the inconsistency or unclarity. I also made suggestions where changes could be made. Lastly, I double-checked the references in-text and in the reference list to make sure that they are consistent throughout. Where sources or source information were still missing, I indicated such to the author so that she could locate and add the missing information.

Disclaimer: The ultimate responsibility for accepting or rejecting the changes and recommendations rests with the student and I cannot be held responsible for any layout or language issues that might have emerged as a result of subsequent amendments to the text.

Yours sincerely

Johannes Pieter Odendaal