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Echoes of the NICU: Understanding Parental Emotional Burden and Quality of Life Through Inductive Thematic Analysis

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Abstract

Background: Admission of a neonate to the Neonatal Intensive Care Unit (NICU) is a sudden, unanticipated life event that disrupts parents' psychological wellbeing and quality of life. While this burden is increasingly quantified, comparatively little is known, particularly in Nigerian tertiary-hospital settings, about how parents themselves make sense of the experience. Aim: This report presents the qualitative strand of a convergent mixed-methods study exploring the psychological experience and quality of life of parents of neonates admitted to the NICU at Bowen University Teaching Hospital (BUTH) and LAUTECH Teaching Hospital.

Methods: Sixteen in-depth, semi-structured interviews (nine mothers, seven fathers) were conducted between April and July 2026 and analysed using Braun and Clarke's (2006) six-phase inductive thematic analysis, with attention to rigour, reflexivity, and ethical safeguarding. Findings: Eight interrelated themes were developed: emotional and psychological turmoil; disruption of parental role and identity; financial strain and economic vulnerability; strain on marital and family relationships; the physical environment as a site of additional suffering; institutional and staff interactions; coping resources and sources of strength; and parents' own recommendations.

Conclusion: Parental distress was consistently produced at the intersection of emotional, relational, financial, and institutional pressures rather than by any single factor in isolation. These findings are discussed in relation to transactional stress-coping theory, transitions theory, and comparable qualitative literature from Nigeria and elsewhere, with direct implications for family-centred neonatal care policy in resource-constrained settings.

Introduction

Most families celebrate the arrival of a new baby in the family with joy and fulfilment in Nigeria. In most cases, however, the delight of the newborn is quickly followed by anxiety and uncertainty, when admission is required just after birth. The emergency admission to NICU brings emotional instability, mainly due to worry about the baby's survival, uncertainty about the child's prognosis and lack of familiarity with the hospital. Frequently Nigerian parents are less expectant of having a baby admitted to the neonatal intensive care unit (NICU). In addition to the stress and trauma of the infant's illness, a parent is psychologically stressed and traumatized when his/her baby is in the hospital, and frequently does not have physical, emotional, or social buffers to support him/her. This abrupt transition from anticipated joy to distress creates a profound emotional burden that shapes the early parenting experience (Ayamolowo et al., 2025; Rihan et al., 2021).

Although there is scarce national statistics suggesting the proportion of newborn admitted to NICU in Nigeria, evidence suggest high prevalence of neonatal admission in Nigeria. Importantly, parents often develop expectations for their role as parents during pregnancy, exploring and evaluating how they intend to fulfill this role. Thus, events that result in the admission of their newborn to the NICU may disrupt or delay their sense of identity as new parents. Hence, they appear to demonstrate less

confidence in their parental role, as their expectations are not met (Gibson et al., 2021). This loss of expected maternal role is evidenced as a key source of distress for mothers during neonatal unit admission, in particular, mothers of neonates expressed finding adoption of the maternal role after admission challenging, reporting feelings of disenfranchisement, and impacted care providers and support parental involvement in the decision-making process (Gibson et al., 2021).

In particular, mothers report struggling with separation from their infant, both physically and psychologically, as they are often unable to hold, touch, or interact with their infant during their neonatal stay, which often leads to increased stress, psychological disturbances due to the unconducive structural and medical environment there (Gibson et al., 2021). Also, individual or combined NICU stressors disrupt the mother-infant attachment, leading to further difficulties for the parent and other family members (Basamma et al., 2024; Bertoncelli et al., 2025; Gibson et al., 2021). Even when these mothers participate in the in-caregiving activities, including feeding, hygiene maintenance, and kangaroo mother care, the hospital environment in which they carry out these roles constitute stress and challenges not only to the mothers but also the fathers and the significant others.

In addition, studies have shown that fathers also have their fair share of these experiences (Rihan et al., 2021). Evidence suggests that during children's hospitalization, women relinquish their duties to provide support, while fathers assume certain maternal responsibilities, including caring for healthy siblings and managing household tasks, alongside their ongoing roles as family caregivers. Consequently, fathers experience negative psychological symptoms, such as anxiety associated with financial burden, trauma, and post-traumatic stress disorder (Roque et al., 2017; Siva et al., 2024). Therefore, having a baby in the NICU afterbirth significantly disrupts family life, sleep quality, leading to exhaustion, stress, altered family support, increased mental health symptoms, and impacting the quality of the parents and significant others (Al-Sarayreh et al., 2025; Rihan et al., 2021; Roque et al., 2017).

The stress and burden of care experienced by parents with infants admitted to the neonatal intensive care unit (NICU) in Nigeria are often intensified by existing regulations, operational guidelines, and the structural layout of many units. Parents’ emotional and behavioural responses to having a child in the NICU are shaped by multiple factors, including difficulties in fulfilling their parental role, exposure to complex medical technologies, the physical and organizational structure of the unit, the availability of resources, their understanding of the infant’s health condition, and the communication styles and attitudes of healthcare staff (Kawafha et al., 2025; Konukbay et al., 2024). Furthermore, most NICUs in Nigeria lack adequate bedding and accommodation facilities for mothers and significant others who are expected to remain close to the unit and provide care to their newborns, sometimes on an hourly basis. Despite these significant challenges, the experiences of parents with infants in Nigerian NICUs remain poorly documented, limiting the development of targeted interventions to address their needs. This study therefore explores the lived experiences of parents with neonates admitted to the NICU.

Theoretical Framework

The theoretical frameworks used to understand the psychological experiences and quality of life of parents whose neonates were admitted to selected tertiary hospitals in Ogbomoso Oyo state, Nigeria were the Transactional Model of Stress and Coping (TMSC) and Social Support Theory (SST) (Cohen & Wills, 1985; House, 1981; Lazarus & Folkman, 1984). These were deemed suitable as neonatal hospitalisation is a potentially stressful event due not only to the health of the baby but also to the psychological, social and environmental, financial and institutional demands placed on parents. The framework thus served as a foundation for exploring aspects of parents' experience of the demands, their resources, coping strategies, and the implications of these experiences for the quality of their lives.

The Transactional Model of Stress and Coping

Lazarus and Folkman (1984) conceptualise stress not as a fixed property of an event but as the outcome of a transaction between a person and their environment, mediated by cognitive appraisal. In this model, a parent first appraises the NICU admission as a threat, harm, or challenge (primary appraisal), then appraises the resources available to manage it financial, relational, spiritual, informational (secondary appraisal). Coping strategies are broadly problem-focused (aimed at changing the stressor) or emotion-focused (aimed at managing the distress it produces). This model is well suited to a setting in which the medical stressor (the infant's condition) is often outside parents' control, so that much of what parents describe as "coping" is emotion-focused prayer, family support, and small clinical improvements read as reassurance rather than problem-focused, since the latter is often foreclosed by cost and institutional constraints beyond their control.

2.2 Transitions Theory

Meleis et al. (2000) describe health-related transitions — including the transition to parenthood — as processes with identifiable properties (awareness, engagement, disruption, and time span) and conditions that facilitate or inhibit healthy passage through them. An uncomplicated birth allows the transition to parenthood to unfold through expected rituals: holding the baby, naming, visitors. NICU admission interrupts this transition mid-course, replacing expected milestones with unfamiliar, clinical ones. Transitions theory is used to interpret Theme 2 (disruption of parental role and identity) as more than an inconvenience: it is a structurally blocked transition, in which the environmental and institutional conditions of the NICU actively inhibit, rather than merely delay, parents' progression into the parental role they had anticipated.

Together, these two frameworks direct attention to (a) how parents appraise the admission and the resources available to them, and (b) how the admission interrupts an expected life transition — both of which recur, empirically, across the eight themes.

Methodology

Research Design

The study adopted a descriptive qualitative study design, in which the interviews were conducted and transcribed verbatim. This design was chosen to explore parent emotional burden and quality of life, answered by interview data that a numeric scale cannot, by itself (Kudu et al., 2025). The qualitative strand reported here followed an inductive thematic analysis approach, broadly consistent with Braun and Clarke's (2006) six-phase framework, and is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

3.2 Study Setting

The study was conducted in the neonatal intensive care units of two Oyo state teaching hospitals, Bowen University Teaching Hospital (BUTH) and LAUTECH Teaching Hospital which was selected to capture parental experience across two distinct institutional contexts while holding constant the broader socio-economic and healthcare-financing environment common to Nigerian tertiary care (Ogundare et al., 2022). Bowen University Teaching Hospital and LAUTECH Teaching Hospital, located in Ogbomoso, Oyo State were chosen to represent the two different institutional environments to capture the parental experience. The public healthcare system is in contrast to the privately managed and faith-based BUTH, which has a Baptist missionary background and has a stated Christian doctrine of compassionate, holistic care. The differences in ownership, governance and institutional orientation offer a point of departure for examining how the nature of the context in which the parent works might influence the experiences of care. These situations can be studied in a similar socio-economic and health care policy context, while the financing arrangements for individual hospitals and family situations may vary.

3.3 Population, Sampling, and Sample Size Justification

The population of interest was mothers and fathers of neonates currently admitted to the NICU at either site. A purposive sampling strategy was used to recruit parents who varied in role (mother/father), length of admission (from 24 hours to over three weeks), and pregnancy/birth circumstance (including singleton and twin pregnancies, and pregnancies complicated by co-twin loss), so that the sample could speak to a range of admission experiences rather than a single trajectory. Recruitment continued until the research team judged that no substantively new codes were emerging from successive interviews (thematic saturation), which occurred at sixteen participants (nine mothers, seven fathers); this is consistent with sample sizes reported in comparable qualitative NICU studies internationally, which range from around ten to thirty participants (Bertoncelli et al., 2025; Kudu et al., 2025; Rihan et al., 2021). Inclusion criteria were: being a biological parent of a neonate currently admitted to the NICU at either site; aged 18 years or older; and able to communicate in English or a language available through an interpreter. Parents who were, at the time of approach, assessed by ward staff as too acutely distressed to be approached were excluded from recruitment at that time and were approached again later in the admission.

3.4 Data Collection

Data were collected through in-depth, semi-structured interviews using a piloted interview guide covering parents' emotional response to admission, experience of the parental role, financial and practical burden, relationship with staff and family, coping resources, and recommendations for improvement. The guide was piloted with two parents not included in the final sample, after which minor wording changes were made for clarity. Interviews took place between April and July 2026, mostly in the late afternoon or early evening, in a private space within each hospital setting, and lasted between approximately 20 and 45 minutes. With participants' consent, interviews were audio-recorded and transcribed verbatim; non-verbal cues (crying, hissing, long silences) noted by the interviewer at the time were retained in the transcript as bracketed annotations.

3.5 Data Analysis

Transcripts were analysed using Braun and Clarke's (2006) six-phase inductive thematic analysis: The researchers read the transcripts repeatedly to get to know parents' accounts and made initial impressions, reoccurring concerns, and general observations in analytic memos. Secondly, two independent researchers coded the data set, open coding line-by-line. Both the explicit meanings, such as the financial expenses and sleep disturbance, and the implicit meanings, such as guilt, shame, resignation or faith were addressed. All of the researchers structured codes within a spreadsheet with supporting extract and participant identifier, and proposed themes. They then came together and compared and combined their coding; they discussed their discrepancies of interpretation and settled differences by reverting to the passages in the transcript. Overlapping codes were merged and the definitions of codes were clarified to yield a single coding structure. Third, the researchers analyzed the relationships between the merged codes, and clustered the codes that shared meaning patterns into candidate themes. Fourth, candidate themes were checked with the supporting extracts to see whether they were coherent and distinct and whether they were grounded in the participants' accounts, and with the full data set to see whether they were coherent and distinct. This interpretive review followed the outline of the theoretical sensitivities but not without the expectation that accounts would fall into designated categories. Fifthly, the researchers narrowed the scope and boundaries of each theme, defined the central organising concept of the theme and gained consensus on a theme name that communicated the theme meaning. Lastly, the themes were elaborated to a written narrative that linked the interpretation to the study goals. Quotations were chosen to support each theme and to represent a range of parental experiences rather than to seek out the more unusual or extreme types of quotation.

3.6 Trustworthiness and Rigour

Rigour was addressed using Lincoln and Guba's (1985) four criteria for trustworthiness in naturalistic inquiry, summarised in Table 2.

Table 3: Trustworthiness Strategies Applied

The criteria used in guiding rustworthiness were the ones set forth by Lincoln and Guba (1985). Credibility was enhanced by auditing transcripts against the tapes, reflexive journalling, peer debriefing and analysis of alternative patterns which were contradicted by the reflecting accounts. Auditing of codebook development was maintained to facilitate dependability, and both researchers independently coded the transcripts, which were then re-coded together in a discussion to resolve disagreements and merge codes. Increasingly confirmed by using quotations from original transcript excerpts and by keeping memos to record researchers' assumptions. Transferability was achieved by providing detailed descriptions of the study sites, participants and the conditions during the interviews, which will help other readers determine relevance to similar contexts.

3.7 Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committees of both study institutions prior to data collection (LTH/OGB/EC/2026/728 & BUTH/REC-27962). Written informed consent was obtained from each participant after the purpose, voluntary nature, and limits of confidentiality of the study were explained; participants were informed that they could decline any question, pause, or withdraw at any point without any effect on their infant's clinical care. Interviews were conducted in a private space to protect confidentiality, and transcripts were de-identified and stored under participant numbers (R1–R16) rather than names. Because the subject matter was foreseeably distressing, the interview guide was structured to move from lower- to higher-sensitivity questions, and the interviewer was briefed to end an interview immediately if a participant showed signs of acute distress. In the case of Respondent 12, her interview was terminated once she became withdrawn and unresponsive, notifying the ward's clinical and psychosocial support team, as pre-specified in the study distress-response protocol. This decision is announced here as an illustration of a protocol working as intended but is not counted as failure to collect data.

3.8 Researcher Reflexivity and Positionality

Consistent with an interpretivist qualitative approach, the research team maintained a reflexive journal throughout data collection and analysis, recording reactions to particularly distressing accounts (including Respondent 12's and Respondents 2 and 4's accounts of co-twin loss) and interrogating how these reactions might shape coding decisions. The interviewer's position as a researcher affiliated with the hospital setting, rather than a treating clinician, was disclosed to participants at the outset of each interview to reduce the likelihood of socially desirable responses about staff conduct; this positionality is nonetheless acknowledged as a possible influence on what participants felt able to disclose about institutional care (Theme 6), and is revisited as a limitation.

Qualitative Participant Overview

Table 1 summarises who took part, where, and when. Ages of admission ranged from just over 24 hours (R16) to 24 days (R11) at the time of interview; two respondents (R2 and R4) were parents of twins who had lost one baby. One interview (R12) was stopped before the recommendations questions because the mother had become visibly withdrawn and distressed, consistent with the distress-response protocol.

Table 1: Qualitative Participant Demographics and Admission Characteristics

ID	Site	Role	Notes on admission
R1	BUTH (H2)	Father	Twins; day 7 of admission
R2	LAUTECH (H1)	Mother	Twin pregnancy, 27+2 weeks; co-twin died; ~1 month admitted
R3	LAUTECH	Mother	2 days admitted
R4	LAUTECH	Father	5 weeks admitted; twin; co-twin lost, near-loss of surviving twin
R5	LAUTECH	Father	3 days admitted
R6	LAUTECH	Father	5 days admitted; long-awaited pregnancy
R7	LAUTECH	Mother	5 days admitted, post-CS; repeat NICU experience
R8	LAUTECH	Father	~2 weeks admitted
R9	LAUTECH	Mother	31 weeks preterm; ~2 weeks admitted
R10	LAUTECH	Father	5 days admitted
R11	LAUTECH	Mother	24 days admitted; transferred in
R12	LAUTECH	Mother	21 days admitted; interview discontinued due to distress
R13	BUTH	Mother	~3 weeks admitted; aspiration
R14	BUTH	Mother	Baby born ~7 months gestation
R15	BUTH	Mother	Preterm, 7 months; transferred in
R16	BUTH	Father	Just over 24 hours admitted

Results

The information was analysed to identify eight interconnected themes (summarised below in Table 2, and detailed in themes 1-8): Each one of these is presented separately for clarity, but they all overlapped in the parents' own experiences, financial worry fuelled sleeplessness, which fed into emotional exhaustion and emotional exhaustion influenced the way in which staff interaction was perceived.

Representative speech is provided for each theme; gestures and vocal cues are only included where they are used and where they contribute to the meaning of the words.

Table 2: Thematic Map

S/N	Theme	Illustrative subthemes/codes
1.	Emotional and psychological turmoil	Shock/disbelief; hopelessness; suppressed gendered emotion; anticipatory grief
2.	Disruption of parental role and identity	Inability to hold/feed; missed naming ceremony; maternal guilt
3.	Financial strain and economic vulnerability	Unplanned costs; asset sale; unpaid consumables
4.	Strain on marital and family relationships	Narrowed conversation; partner absence; blame; partner as anchor
5.	Physical environment as a site of suffering	No rest space for fathers; crowded mother's inn; hospital layout
6.	Institutional and staff interactions	Compassion vs. neglect; poor communication; rigid visitation
7.	Coping resources and sources of strength	Faith/prayer; family support; incremental clinical gains; social comparison
8.	What parents say would help	Cost transparency; rest space; proactive counselling; antenatal preparation

Theme 1: Emotional and Psychological Turmoil

Nearly all parents would regard the news of their baby's admission as a rupture - a moment that was shocking and out of the blue for them. In nearly all sixteen narratives, regardless of the length of the admission, the emotions of shock, sadness, fear and pervasive hopelessness re-occurred. From the perspective of transactional stress-coping model, it is the phase of primary appraisal – the announcement, almost invariably, is experienced as a threat, and not a challenging event. (Lazarus & Folkman, 1984).

Shock and disbelief

The unexpected need for neonatal admission generated shock and disbelief among some parents, particularly where pregnancy and delivery had created expectations of returning home with a healthy baby. The sudden transition from childbirth to neonatal hospitalization disrupted these expectations and left some participants struggling to comprehend the situation.

"I have never imagined that I can ever be in this position, that this can ever happen."

(R1, father, H2, 15/4/2026)

"I was terribly sad and heartbroken. I had thought of a lot of things, but then I still give thanks to God."

(**R10, father, H1, 3/6/2026).**

Persistent sadness and a sense of hopelessness

Emotional distress was not limited to the initial period of admission. Some parents described continuing sadness and periods of hopelessness as hospitalization persisted. Uncertainty about the neonate's recovery, prolonged admission and repeated exposure to the hospital environment contributed to the emotional burden experienced by participants

"It has been a state of full hopelessness, yet we are spending… I have cried sometimes when I'm alone, even though I am not supposed to do that as a man, but this is so overwhelming."

(R5, father, H1, 21/5/2026).

"The stress has overwhelmed me. I must say the truth, I've never gone through this kind of stress in my life."

(**R9, mother, H1, 1/6/2026).**

For some, the distress went beyond words. When Respondent 12 was asked what could be done to make her stay more comfortable, she fell into a long silence and did not answer; the interview record notes that she looked worried, discouraged, and dull, and the interview was discontinued out of concern for her well-being. This silence is itself a finding: for some parents, the experience was too raw to be narrated at all.

Suppressed, gendered emotion

Fathers in particular described actively suppressing visible distress, framing composure as a masculine obligation even while admitting to private breakdowns.

"No, no, no, no, I took it in as a man… I needed to be strong regardless of the situation."

(R6, father, H1, 22/5/2026).

For the two respondents whose babies were part of a twin pregnancy in which one infant died (R2 and R4), grief was layered directly onto the ongoing anxiety of caring for the surviving twin.

"I still experience sadness sometimes, especially at the sight of other twins in the unit… they were supposed to be two."

(**R2, mother, LAUTECH, 15/4/2026).**

"There was a day I came, and they told me that the second had gone too. I just wanted to see her and ask them to give me her body. Then I noticed that she had a heartbeat again."

(**R4, father, LAUTECH, 20/5/2026).**

Theme 2: Disruption of Parental Role and Identity

Parents repeatedly described feeling stripped of the ordinary rituals of new parenthood: holding, feeding, naming, celebrating.

Inability to hold/feed

This loss was experienced not simply as inconvenience but as a structurally blocked transition into the parental role, an attack on identity as a mother or father, rather than a temporary delay (Meleis et al., 2000).

"The effect is that I cannot carry my child in my arms and say that these are the children God has gifted me."

(**R1, father, H2, 15/4/2026).**

"I can only go to see the baby; I couldn't carry the baby. I have always felt like carrying the baby, but I couldn't; hence I am very sad about it."

(**R3, mother, H1, 30/4/2026).**

"Nothing to zero, I'm just buried in the care of the baby, no focus on myself… I'm living to survive."

(**R7, mother, H2, 27/5/2026).**

missed naming ceremony

Missed milestones, naming ceremonies chief among them, surfaced again and again as a concrete symbol of everything the admission had taken away.

"Tomorrow is supposed to be their naming ceremony, no singular preparation because we have not been able to carry them home."

(**R1, father, H1, 15/4/2026).**

maternal guilt

Some mothers also carried guilt, quietly questioning whether they had caused the admission themselves.

"Sometimes I just think backward, what have I done wrong? What didn't I do well?" (**R2, mother, H1, 15/4/2026).**

Theme 3: Financial Strain and Economic Vulnerability

For virtually all of the respondents, the fear of losing money was as great as the fear of having to deal with the uncertainty of the medical situation. Parents complained of erratic and rising costs, of medicines and food having to be purchased outside of hospital and at the last minute, of the need to sacrifice savings, business and even personal wealth to stay current. This is in line with quantitative evidence from Oyo State tertiary hospitals indicating that the vast majority of families paying for the admission of their babies in these hospitals spend more than 10 per cent of their household incomes, which is considered catastrophic health expenditure (Ogundare et al., 2022).

Unplanned costs

Respondents described neonatal admission as creating unexpected and continuing economic demands at a time when they were already dealing with uncertainty and concern about their child's health. They experienced the financial burden through hospital-related expenditure, pressure on available household resources, and, in some cases, disruption of normal work and income-generating activities.

"I'm just spending without earning more… the money, see the bills just for seven days, is too much, how will I cope?"

(**Respondent 1, father, BUTH, 15/4/2026).**

"It has turned me into a beggar. I can't go to work, all savings have been spent, and yet we are still spending without hope."

(**Respondent 5, father, LAUTECH, 21/5/2026).**

Asset sale

The financial demands associated with neonatal hospitalization became severe enough for some participants to consider or resort to the sale of personal or household assets to obtain money for the

neonate's care. This illustrates the extent to which prolonged or costly hospitalization could exhaust readily available financial resources and require families to adopt more drastic financial coping measures.

"Day before yesterday, I had wanted to go and sell my motorbike since we have no money again, not until someone calmed me down."

(**Respondent 10, father, LAUTECH, 3/6/2026).**

Unpaid consumables

Several parents pointed to a specific, recurring frustration: being asked to procure medication or equipment without being told in advance what it would cost, leaving them unable to plan or budget.

"There should have been an estimated amount per day, to get prepared… [looked stressed] but the staff said he can't tell, no matter how much I tried."

(**Respondent 10, father, LAUTECH, 3/6/2026).**

For those without a partner physically present, the financial pressure could also strain the relationship itself, as discussed further in the next theme.

Theme 4: Strain on Marital and Family Relationships

Couples described losing the ordinary texture of their relationship, conversation, humour, physical closeness, almost entirely, replaced by a single, narrow focus on the baby's survival and the next bill to be paid.

Narrowed conversation

Some participants described a noticeable change in communication with their partners during the period of neonatal hospitalization. Conversations became increasingly centred on the hospitalized baby, treatment, hospital expenses and immediate concerns surrounding the neonate’s condition. Consequently, opportunities for the usual forms of communication and interaction between partners became limited.

"We hardly talk about any other thing about our life, except for the welfare of the child… our life revolves around the child."

(**R4, father, H1, 20/5/2026).**

"We would have been together, planning together joyfully, but now everything is disoriented and scattered already."

(**R3, mother, H1, 30/4/2026).**

The accounts suggest that neonatal hospitalization could temporarily reorganise marital communication around the crisis confronting the family. Although concern about the neonate understandably became the dominant focus, the narrowing of conversations also reflected how hospitalization affected the normal relational experiences of parents.

Partner absence

The absence or limited availability of a partner was another challenge described by some participants. Managing the demands associated with neonatal hospitalization without the consistent physical or emotional presence of a spouse could increase feelings of isolation and place additional responsibilities on the parent who remained with the neonate. For some mothers, this strain deepened into a felt absence of emotional partnership, even where a husband remained financially involved.

"His own is for me to call if I need to get something, and he would send the money, but for him to come and console me as a partner, no, he won't come."

(**R11, mother, H1, 6/6/2026 (mother cries).**

"The other day, the father said he was no longer coming… I was totally frustrated and psychologically overwhelmed."

(**R12, mother, LH, 8/6/2026).**

Partner absence therefore represented more than physical separation. It could reduce the immediate emotional and practical support available to the parent during an already demanding period, thereby increasing the burden associated with neonatal hospitalization

Blame

For some participants, the stress surrounding the neonate's condition also created circumstances in which blame emerged within interpersonal or family relationships. Attributions of responsibility for the neonate's condition could compound the emotional distress already associated with hospitalization and potentially create tension between partners or other family members. One respondent described being blamed by her partner for the premature delivery itself, a claim she experienced as an additional, unjust burden on top of everything else.

"He started saying the baby came prematurely because I was scared with the fire incident and stressed myself."

(**R15, mother, H1, 11/7/2026).**

“I am not happy with the father, his attitude has not been too positive, he is not forthcoming… since we’ve been here, he has been seriously nagging, faulting me to be the cause of the admission. Our relationship has not been good since the admission. I am not happy about it.”

(R13, Mother, H2)

The emergence of blame demonstrates how the uncertainty and emotional intensity associated with neonatal illness could extend into family relationships. Rather than functioning solely as a source of support, interpersonal relationships could sometimes become an additional source of psychological and relational strain.

P**artner as anchor**

In contrast to experiences of absence, restricted communication and blame, some participants described their partners as an important source of stability and support. A supportive spouse could provide reassurance, encouragement, companionship and practical assistance, helping the parent manage the emotional and practical demands associated with the neonate’s hospitalization.

"Just have each other. We have each other. And we are blessed with a really great set of family members."

(**R4, father, H2, 20/5/2026).**

What keeps me going… my baby, my baby… and my husband.”
(R9, Mother, H1)

“I was able to be there for my child… as a father who has waited for years before having children.”

(R6, Father, H1, 22/5/2026)

This finding demonstrates the protective role that supportive marital relationships could play during neonatal hospitalization. The presence and involvement of a partner could provide parents with an important interpersonal resource at a time characterised by uncertainty, emotional distress and substantial caregiving demands (Cohen & Wills, 1985)

Theme 5: The Physical Environment as a Site of Additional Suffering

Beyond the emotional weight of the admission itself, the physical conditions in which parents waited compounded their distress. A recurring and almost universal complaint was the absence of any sanctioned resting space for fathers, who described nights spent on staircases, plastic chairs, or open verandas, exposed to mosquitoes and rain.

"I sleep on a plastic chair… no space nor provision was made available for fathers to sleep."

(**Respondent 16, father, BUTH, 11/7/2026).**

"There was a day it rained, and we were badly drenched by rain on the stairs, but we had no option."

(**Respondent 10, father, LAUTECH, 3/6/2026).**

Even the accommodation set aside for mothers, the so-called 'mother's inn', was frequently described as cramped, noisy, and lacking privacy.

"The bed space is too close, no privacy oooh, we are managing it since it's not our house."

(**Respondent 9, mother, LAUTECH, 1/6/2026).**

"Is very small, no privacy oooh, manageable compared to none."

(**Respondent 1, father, BUTH, 15/4/2026).**

Several parents also pointed to the physical layout of the hospitals themselves, laboratories, cash points, and pharmacies located far from the neonatal unit, as an unnecessary source of exhaustion, particularly at night.

"As big as this compound, I was the only one going up and down at midnight, no one with me, no assistance."

(Respondent 16, father, BUTH, 11/7/2026)

Theme 6: Institutional and Staff Interactions-Between Compassion and Neglect

Parents' descriptions of hospital staff were rarely uniform; within a single interview, a respondent could describe both moments of real kindness and moments of what felt like careless cruelty.

"There was a time a staff member was calling twin mothers, and I answered, and she told me, ' Why am I answering her? Did I have a twin on admission? It was very hurtful for me to bear, like someone crushing a fresh wound."

(Respondent 2, mother, LAUTECH, 15/4/2026)

"The doctors are trying, the nurses are trying, doing their work, at least with the limited infrastructure they have."

(Respondent 8, father, LAUTECH, 28/5/2026)

A specific and recurring complaint concerned communication: parents frequently felt kept in the dark about costs, test results, and prognosis, and experienced this as disempowering.

"They wouldn't tell you what the result is all about; they'll still say go and do this, go and do that."

(Respondent 16, father, BUTH, 11/7/2026)

"I didn't have full information on the treatment of the baby… they just call us when they need us to get something done."

(Respondent 10, father, LAUTECH, 3/6/2026)

Rigid visiting and presence policies were another sore point, particularly where they were felt to override a parent's own emotional needs.

"I even told the consultant, is it a must that I must come here? What about my mental health? I don't want to come, but they insisted."

(Respondent 2, mother, LAUTECH, 15/4/2026)

Theme 7: Coping Resources and Sources of Strength

Despite the weight of everything described above, parents were rarely without some anchor. Three sources of strength recurred throughout the data: faith, family, and small, incremental signs of clinical improvement, consistent, in transactional stress-coping terms (Chapter 2), with predominantly emotion-focused coping in a context where the underlying medical stressor is largely outside parents' control (Lazarus & Folkman, 1984).

Prayer and Faith

"It is prayer, it is prayer, that is it. Prayer is the sword of a Christian, and I will continue to pray."

(Respondent 13, mother, BUTH, 11/7/2026)

Family and informal support networks

"My mother-in-law, there's no day the least time she will call is four times, maybe more."

(Respondent 4, father, LAUTECH, 20/5/2026)

Small clinical improvements as emotional lifelines

"Even with 0.5 grammes, 0.1 is something. That has been another consolation."

(Respondent 4, father, LAUTECH, 20/5/2026)

"What has been encouraging and has kept us going… is that we are seeing improvement in the care of the baby."

(Respondent 14, mother, BUTH, 11/7/2026)

Some parents also drew quiet comfort from social comparison, seeing others in the unit whose situation appeared worse, or whose babies were being discharged.

"We see people whose own is worse, it's very worse. But then we are still among those that are grateful."

(Respondent 2, mother, LAUTECH, 15/4/2026)

Theme 8: What Parents Say Would Help

Every respondent, without exception, was asked what would improve their situation, and their answers converged on a small number of concrete, largely unglamorous recommendations.

Subsidised or free care, and clearer, earlier information about likely costs, so families can plan rather than be ambushed by each new bill. Dedicated, decent rest space for fathers as well as mothers; several parents were explicit that fathers should not be treated as an afterthought. Counselling, spiritual care, and peer support, offered proactively rather than only on request. Antenatal education that includes the possibility of NICU admission, so that parents are not learning about incubators and blood donation for the first time in a crisis. More consistent empathy from staff, including simple courtesies such as explaining test results and costs before demanding action. Practical improvements to hospital layout, laboratories, pharmacies, and cash points located closer to the neonatal unit to reduce exhausting, repeated trips.

"Health is wealth… but you see, you should just be telling them. Has there ever been a time they wanted to discharge somebody, or even before discharge, that the parents said we can't afford to pay any kobo again?"

(Respondent 8, father, LAUTECH, 28/5/2026)

"If government cannot afford it being free, it doesn't necessarily mean the whole money should come from the parents; it can also come from family members, communities can do donation."

(Respondent 9, mother, LAUTECH, 1/6/2026)

A Note on Silence

One interview deserves separate mention. A mother twenty-one days into her baby's admission, answered early questions in short, flat sentences before falling into repeated long silences. When she was asked what should be done so as to make her feel better she did not respond but rather the interviewer noted that she 'looked worried, discouraged and depressed… looked dull and sad' and, according to the protocol, the interview was ended. The researcher has made this decision responsibly and appropriately and here is reported as a finding, not as a data gap: For some of these parents a prolonged NICU length of stay can be emotionally exhausting to the degree that they can no longer voice their own needs. The researcher notified the clinical team in the ward after the interview when Respondent 12 could be offered appropriate psychosocial follow-up – this is part of the ethical conduct of qualitative research with vulnerable participants and is reported here not as a footnote of the study but as an essential element to ensure the child's safety. Any programme development that is based on this population must be developed to acknowledge and respond to this kind of silence, for parents who can still seek support by speaking.

Discussion

In fact, these sixteen stories convey a feeling of uniformity: uniform across two hospitals, uniform across mothers and fathers, and uniform across days in the hospital ranging from one to almost a month. The psychological nature of the admissions experience was patterned or repetitive, regardless of the medical circumstances: there was an initial shock which disoriented the parents altogether; a period of financial concern, disturbed sleep and strained relationships and a gradual stabilisation as the baby improved, although slowly.

The fact that the emotional and the practical were both so closely linked is what sticks with us most. Financial stress was not presented as a separate issue from psychological stress; when parents' financial matters caused it, they at the same time were concerned about how well they were providing for their children. Rather than being merely uncomfortable, the father who sleeps on a staircase, was convinced that his role as a father had become invisible because of the institution. Many of the issues these parents discussed would likely not have been addressed by counselling alone and there would have been a much tighter connection between the distress and the issues of cost, space and communication, for a psychological approach to touch on these matters on its own would not have reached the issues (Daliri et al., 2024).

It should be noted also, what parents didn't ask for. Few couldn't be found who desired luxury, or even comfort in the truest sense. Most asked only to be informed beforehand about the cost of the event, and prognosis after an event, to provide someplace decent to sit or lie down while waiting, and to be treated as a human being going through something huge instead of an inconvenience to the routine of the hospital. These are modest requests—this isn't a complaint from a single parent, but a pattern, as they keep repeating themselves in sixteen interviews in total.

Lazarus and Folkman's (1984) transactional model of stress offers one way of making sense of why this distress did not simply fade with time. If stress is produced by an ongoing appraisal of threat against available resources, rather than by the admission as a single fixed event, then each fresh bill, each unexplained test result, each night with nowhere to sleep would have reopened that appraisal rather than simply adding to a running total. Seen this way, it is unsurprising that the coping strategies parents described- prayer, leaning on extended family, celebrating a baby's 0.1-gramme weight gain, comparing their situation to someone else's- were almost entirely emotion-focused rather than problem-focused. There was, for most of these parents, no direct way to act on the cost of care or the shortage of rest space; what remained available to them was managing how the situation felt, not changing it. That fits with earlier findings that religiosity and spiritual coping are central to how NICU parents in comparable settings get through the experience (Daliri et al., 2024; Kudu et al., 2025; Rihan et al., 2021), though it also raises a less comfortable point: when emotion-focused coping is the only coping available, the burden of adjustment sits entirely with the parent, and the institution is let off the hook.

Meleis et al.'s (2000) work on transitions is perhaps most useful for making sense of Theme 2. Parents didn't say that they could not hold or name their baby—it was more like they said that in some real sense they weren't yet a parent. That is more a "stalled" transition than a "delayed" one, and aligns with the larger evidence that NICU admission disrupts the normal trajectory of parent-infant bonding and the normal progression in taking on the parental role (Al Maghaireh et al., 2016). It also offers a practical consequence that can be mentioned here: actions like kangaroo care, supported early holding, involving parents in routine care are not 'comfort moves', they could also be the ones to get a stalled transition moving again (Konukbay et al., 2024; Meleis et al., 2000).

The emotional profile that runs through these interviews- shock, sadness, a settled hopelessness, and, among fathers particularly, an emotion held back in public and only admitted to in private is not unique to this sample. Similar patterns appear in qualitative NICU research from Jordan (Rihan et al., 2021), Ghana (Kudu et al., 2025), and Türkiye (Kawafha et al., 2025), and Al Maghaireh et al.'s (2016) systematic review found much the same thing across the wider literature it drew together, as did Roque et al.'s (2017) scoping review of parental mental health in the NICU. Whatever else is specific about Nigeria, or about BUTH and LAUTECH, the initial shock of admission and the difficulty of parent-infant bonding under these conditions appear to be close to universal.

Where these findings seem to go further than much of that literature is in how central and how specific financial strain was to parents' distress, rather than sitting alongside it as a separate concern. In health systems where care is publicly funded or covered by insurance, cost tends to appear in the literature as background stress. Here, parents described specific, catastrophic financial moments a motorbike nearly sold, an unpaid blood-donation bill, being sent to buy a consumable with no idea what it would cost as central to the story they were telling about the admission, not incidental to it. That is consistent with the wider evidence that most families managing a neonatal admission in Nigerian tertiary hospitals pay out of pocket, and that the majority of them cross into what is technically defined as catastrophic health expenditure (Ogundare et al., 2022), and with broader evidence that out-of-pocket financing in Nigeria

falls hardest on households that can least absorb it (Onah & Govender, 2014). What the interviews add to that quantitative picture is the texture of the decision itself, not just that families spent beyond what they could afford, but what, specifically, they had to choose to sell or go without to do it.

The absence of any sanctioned rest space for fathers is worth dwelling on a little longer than the other environmental complaints, because of how consistently and specifically it came up. Much of the international literature on NICU parental experience has historically been written with mothers as the assumed resident parent, and fathers' experience has been comparatively under-examined (Kawafha et al., 2025). The fact that fathers here, across two different hospitals, independently described the same absence: no chair, no space, nowhere sanctioned to be suggests this is not an oversight specific to one ward but a pattern in how family-centred care has been designed, or rather not designed, around fathers. It is also, unlike some of the more diffuse findings in this report, a genuinely fixable one: a bench, a room, a policy decision, rather than a change in institutional culture.

Parents' accounts of staff compassionate in one breath, careless in the next, sometimes within the same interview, match what has already been reported elsewhere: satisfaction with NICU staff tends not to be uniform, and tracks closely with how well and how promptly staff communicates about the baby's condition and the cost of care (Al Maghaireh et al., 2016; Gibson et al., 2021). One complaint in this data set stood out as less thoroughly documented elsewhere: parents being sent to procure medication or equipment without being told in advance what it would cost. This may be a specific consequence of the informal, itemised procurement arrangements that persist in some Nigerian tertiary hospitals, and it deserves to be treated as its own addressable problem rather than folded into a general statement about "poor communication."

The qualitative strand acts as a whole in three ways. It provides a Nigerian tertiary level perspective on the psychosocial nature of parenthood in NICU that is not fully captured in the higher-income literature, as financing is largely done out-of-pocket, and so influences the psychology of NICU parenthood. Makes the contextual shift from 'financial stress' to specific, concrete, fixable institutional practices: procurement costs in the public service are not disclosed, no rest for fathers, no consistency in how results are dealt with; that's just a social determinant that does not get to the grinding concrete of how things are handled in institutions. Meanwhile, by reporting a withheld interview as a finding, instead of an absence of data, it reflects and suggests how such research is better conducted with parents who, for the moment, are too fatigued to articulate their experience.

Implications and Recommendations

The recommendations below are drawn directly from what parents themselves proposed, organised into three levels of intervention and interpreted in light of the discussion above.

Institutional and Clinical Level

1. Provide clear, itemised cost estimates as early as possible in the admission, updated as treatment changes, directly addressing the undisclosed-cost complaint identified in Theme 3.
2. Standardise the location of laboratories, pharmacies, and payment points close to the neonatal unit.
3. Build routine communication of test results and treatment plans into ward rounds so parents are not left to ask repeatedly (Gibson et al., 2021; Konukbay et al., 2024).
4. Include brief, structured empathy and communication training for frontline staff, recognising that most parents already distinguished caring staff from harsher ones (Bertoncelli et al., 2025; Konukbay et al., 2024).

Environmental and Structural Level

1. Provide a dedicated, secure resting space for fathers and other support persons, not only mothers, directly addressing the structural gap identified in Theme 5.
2. Improve the existing mother's inn for privacy, bedding, sanitation, and protection from mosquitoes.
3. Where possible, offer a modest allowance for food, recognising that parents frequently went without proper meals while focused on the baby's care.

Psychosocial and Community Level

1. Introduce proactive, opt-out counselling and spiritual care rather than services parents must seek out unprompted, with a specific protocol for recognising and responding to parents who, like Respondent 12, become unable to articulate distress in words.
2. Incorporate the possibility of neonatal admission into antenatal education, so parents enter the experience with some prior orientation (Kudu et al., 2025).
3. Explore subsidised care models that draw on a mix of government, NGO, and community contributions, as several parents suggested, rather than placing the full cost on individual families (Daliri et al., 2024; Ogundare et al., 2022).
4. Facilitate peer support among parents currently on the unit, several of whom described comfort simply in exchanging stories with others going through the same thing.

Recommendations for Future Research

1. A formal joint display integrating this qualitative strand with the study's quantitative distress and quality-of-life scores, to test the convergence and divergence patterns proposed.
2. Longitudinal qualitative follow-up from admission through discharge (or bereavement), to capture how the themes identified here evolve.
3. Focused investigation of undisclosed procurement costs as a discrete institutional practice, given its apparent centrality to parents' financial distress in this sample.
4. Comparative qualitative research across additional Nigerian and West African tertiary NICU settings to test the transferability of these findings.

Conclusion

In this study, almost all parents were, on their own, trying to do the best they could – and were providing very little help – with a fragile mix of faith, family and hope for the next gram of baby weight. Quality of life for the children was not what it had been before—one mother remarked that it had become down to “endure now”—but because the systems in which they lived permitted little else. The eight themes that emerge here and that span from psychological turmoil to a lack of institutional care and financial vulnerabilities to inconsistent requests to an open-ended list of others are well-established in the reports from Jordan, Ghana and Türkiye (Al Maghaireh et al., 2016; Konukbay et al., 2024; Kudu et al., 2025; Rihan et al., 2021), incorporating a distinctly Nigerian strand based on out-of-pocket cost. Together they draw what it really costs, in human beings, to sustain a premature or sick baby's life in an environment like this. The specific and practical changes these sixteen stories will illustrate, read alongside these, on their own terms, and accompanied by the quantitative strand of this study, will bridge the gap to that cost that these parents were able, in the end, to be generous about describing in detail.

Declarations

Ethical Approval

Ethical approval was obtained from the Health Research Ethics Committees of both study institutions prior to data collection (LTH/OGB/EC/2026/728 and BUTH/REC-27962). Written informed consent was obtained from each participant after the purpose, voluntary nature, and limits of confidentiality of the study were explained.

Consent to participate

All participating individuals provided written informed consen

Consent for publication

Not applicable.

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Competing interests

The authors declare no competing interests.

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Table

Table 3 is not available with this version