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Research Article

The Lived Experience of Mothers Whose Newborns Are Hospitalized with Congenital Anomalies in a Tertiary Hospital in Central Uganda

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Abstract

Background: There is minimal literature in Uganda that describes mothers' experiences of caring for their hospitalized newborns with congenital anomalies. Mothers who give birth to newborns with congenital anomalies often experience untold stress, worry, and fear of losing their newborns to the anomalies. This study aimed to explore the lived experience of Ugandan mothers' whose newborns are hospitalized as a result of the congenital anomalies. *Method:* Descriptive phenomenology by Edmund Husserl, was used to explore and describe the universal nature of the mothers' lived experience during their newborns' hospitalization. Nine eligible mothers who had their newborns hospitalized with congenital anomalies were sampled, and a semi structured interview guide was used to probe their experiences. The interviews were audio recorded and later transcribed verbatim for analysis using the Colaizzi method of qualitative data analysis. *Results:* Three major themes emerged and these were mixed feelings and emotions, healthcare concerns and responsibilities, and participants' support system and support needs. The sub-themes were feeling shocked, feeling worried, feeling scared, unknown cause of the anomalies, anticipation of blame, financial woes, pregnancy concerns, the load of care giving responsibilities, faith during hospitalization, familial support, peer support and encouragement, relationship with the nurses, and support needs. *Conclusion:* Hospitalization of newborns with congenital anomalies requires nurses to not only take care of the newborns, but also pay close attention and offer care to their mothers during hospitalization. Nurses were crucial in providing and influencing the care mothers received, to reduce their physical and emotional vulnerability during their newborns' hospitalization. *Recommendations:* Policy makers should integrate mental health assessments and support services into the maternal and newborn care units. Nurses should actively involve mothers in the care of their newborns by teaching them how to bathe, feed, and bond with the newborns irrespective of the anomalies. Health professionals should also clarify the medications and treatment plans and share the necessary information about congenital anomalies with the mothers. Nurses should collaborate with other professionals to ensure timely screening of congenital anomalies during antenatal, communicate screening results, establish clear referral pathways, and offer guidance on the appropriate delivery facilities for such high-risk pregnancies.

Keywords

Mothers' Lived Experience, Newborns, Congenital Anomalies, Family Centered Care, Descriptive Phenomenology, Colaizzi Data Analysis Method

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1. Introduction

Becoming a mother is often celebrated as a transformative life event, with maternal identity closely tied to the expectation of delivering a healthy newborn. However, this expectation is disrupted when a baby is born with a congenital anomaly, an event that presents profound psychological, emotional, and social challenges. Research indicates that delivering a newborn with a congenital anomaly can cause maternal stress, anxiety and depression with lasting effects on maternal mental health and family dynamics [1, 17]. Congenital anomalies are defined as structural or functional malformations that develop in a fetus while still in the womb, and are typically detected at birth [20]. The anomalies not only threaten the infant's health but also challenge the mother's sense of self-worth, relationships, and her capacity to navigate motherhood under these unforeseen circumstances.

From a critical perspective, the transition into motherhood in the context of congenital anomalies is not merely a personal struggle, but also a healthcare system concern. According to [17], the implications of congenital anomalies stretch beyond the adverse psychological effects on mothers' well-being, and put additional strain on healthcare system resources. This underscores the need for health systems to adopt holistic and family-centered care interventions that extend beyond the treatment of hospitalized infants, to include their mothers' psychosocial and emotional adjustment.

Apparently, there is a significant gap in empirical literature documenting the lived experiences of Ugandan mothers whose newborns are hospitalized as a result of congenital anomalies [13]. This gap reflects a broader neglect of maternal perspectives within neonatal care, despite overwhelming evidence that links maternal well-being to improved infant's outcomes, recovery and bonding. This study therefore sought to explore and describe the lived experiences of Ugandan mothers whose infants are hospitalized with congenital anomalies. Exploring the lived experiences in this context is not only of academic importance, but also of practical significance for nursing care and health policy formulation, as the insights from studies can inform the development of culturally sensitive interventions like counseling sessions, peer support groups, community awareness programs and antenatal education which can help to prepare mothers for possible anomalies.

1.1. Background

The diagnosis of congenital anomalies often occurs at birth, although advances in antenatal screening and technology allow for earlier detection in some cases [20]. The anomalies may appear as isolated birth defects or as parts of complex syndromes that are linked to genetics or environmental exposures [6, 20] Regardless of the cause, a newborn with a congenital anomaly typically requires specialized medical and surgical care, often necessitating prolonged periods of hospitalization. Such prolonged hospitalization not only places heavy demands on healthcare systems but also disrupts the mothers' social and emotional support networks, exacerbating their psychological distress [8].

Epidemiologically, congenital anomalies remain a pressing global health concern. Although their incidence is estimated at 3–7% worldwide, prevalence rates vary across settings and reflect differences in health system capacities and surveillance mechanisms. In Uganda, for example, a cross-sectional study at Mulago Hospital reported a significant prevalence of 440 congenital anomalies per 10,000 live births [13]. System-specific anomalies showed a wide variation with cardiovascular anomalies at (32.3%), musculoskeletal (18.8%), chromosomal (10.9%), central nervous system (9.6%), gastrointestinal (6.9%), genital (5.3%), and respiratory (4.2%). The least common anomalies were of the renal and urinary systems estimated at (2.8%), although their impact on morbidity remains profound [7]. These figures signal both the scale of the problem and the urgent need for systematic surveillance, prevention strategies, and maternal health education in Uganda.

Critically, the burden of congenital anomalies disproportionately falls on women in low- and middle-income countries, where preventive measures such as folic acid supplementation, adequate nutrition (balanced diet), routine antenatal screening and fortified foods are not readily available [2]. Mothers in these contexts face an abnormal and often traumatizing birth experience that is characterized by fear, guilt, and feelings of helplessness [17]. Unlike mothers of healthy infants, these women are confronted with profound stressors that disrupt early maternal role formation. This highlights a critical gap in maternal care, specifically, the need for targeted psychosocial interventions, including counseling, emotional support, and structured guidance to buffer the distress and strengthen mother-infant interactions [10, 20].

The implications of congenital anomalies stretch far beyond perinatal morbidity and mortality. The survivors may live with permanent disabilities, requiring long-term care that stretches household resources and perpetuates maternal psychological distress [7]. Maternal accounts from high-income settings such as Sweden further reveal a gap between the healthcare services provided, and the mothers' perceived support needs. According to [4], it was reported that while many mothers acknowledged receiving adequate healthcare services, they simultaneously expressed dissatisfaction with the limited opportunities for meaningful dialogue with health professionals. This disconnect underscores the importance of patient-centered communication in neonatal care where emotional, informational, and relational support are prioritized alongside the clinical management.

1.2. Theoretical Framework

The theoretical framework used for this study is qualitative descriptive phenomenology, as was postulated by Edmund

Husserl. In this framework three frames of reference are emphasized for studying a lived-experience phenomenon in its pure and universal sense. The frames of reference include the live-world plane of interaction between the researcher and participants, transcendental subjectivity (which is the neutrality and openness to the reality of others), and the identification of eidetic essences or universal truths [19].

The "live-world plane of interaction" between the researcher and participants involves extended one-to-one engagements and contact with the objects of research through which the meaning of lived experience may be unraveled. According to [19], this concept also emphasizes that engagements must involve attentive listening, interaction, and participant observation so as to create representations of reality.

Transcendental subjectivity refers to the constant assessment of the impact of the researcher on the inquiry, with a focus on neutralizing all preconceived opinions, biases, and prior knowledge about the phenomenon under study [19]. This concept emphasizes the process of remaining neutral and open-minded to the reality of participants' experiences, which is achieved by bracketing all personal values, preconceptions, prior knowledge, and personal biases about the phenomenon under study.

The identification of eidetic essences or universal truths refers to the analysis of participants' accounts to identify the common features that are considered representative of the true nature of a phenomenon under investigation [12]. For a description of the lived experience to be considered a science, commonalities in the experiences of participants must be identified so that a generalized description is made possible. The universal essences or truths are then considered to represent the true structure of the lived experience [12].

1.3. Operationalization of the Theory

The concept of the "live-world plane of interaction" between the researcher and participants was operationalized by holding one-on-one in-depth interviews with the mothers in the field regarding their newborns' hospitalization experience. In order to gather detailed experiences from mothers, a questionnaire was developed to guide the in-depth interviews.

By staying neutral and open to the realities of the mothers' experiences, the concept of transcendental subjectivity was operationalized through identifying and suspending the researcher's personal ideas and biases whilst listening and reflecting on the mothers' experiences. A reflective journal was maintained to document any new and surprising findings, while a reflexive journal was also maintained to keep record of the researcher's personal opinions, thoughts, areas of role conflict, biases, and any prior knowledge that could hinder studying the mothers' lived experiences in a neutral and objective manner [14].

The concept of identifying eidetic essences (universal truths) was operationalized through searching for the common features appearing in mothers' narrated experiences. It involved repeated reviews of the mothers' transcripts to find common elements, extract significant statements, and formulate meaning from the statements extracted. The formulated meanings were then aggregated and synthesized to form clusters of themes and sub-themes that gave an exhaustive general description of the mothers' lived experience [14].

Finally, the validation of the study findings was done through the "member checking" technique, where the researcher went back to the mothers and discussed the study results with them to confirm if the results truly reflected their feelings, meanings, and experiences. In instances where mothers portrayed dissatisfaction with the meaning of the research results, their transcripts were reviewed again with them to verify what they actually meant.

2. Methodology

2.1. Study Design

This research used a qualitative study approach that applies the phenomenology research design to explore the lived experience of mothers whose newborns are hospitalized with congenital anomalies. Phenomenology is a study-design approach that explores and identifies the essential structures of people's everyday life experiences [14]. The aim of a phenomenology investigation is to understand the universal character of a lived experience and the meaning that participants attribute to it. This approach is the most appropriate because descriptive phenomenology as authored by Edmund Husserl emphasizes the application of the investigator's objective mind to guide the discovery of the universal character and nature of a lived experience in its fundamental form.

2.2. Study Setting

The study was conducted in one of Uganda's national referral hospitals, a tertiary health facility. This site was purposefully chosen for the study because it is where mothers are referred to for specialized care when they deliver newborns with congenital anomalies. The hospital has a bed capacity of about 50 patient beds in the pediatric surgical unit, where mothers and their newborns are admitted for surgical management. Additionally, the hospital has an outpatient clinic for managing children with such birth anomalies and the scheduling them for surgical correction.

2.3. Study Population and Sample Size

This study was carried out amongst mothers who were caring for their hospitalized newborns with congenital anomalies irrespective of how long they had been hospitalized. The study participants were mothers recruited from the inpatient ward of pediatric surgery where they are admitted with their newborns having congenital anomalies. The process of enrolling mothers was done until no new information arose from the mothers'

narratives during the follow-up questions. The enrollment process ultimately determined the actual sample size which was nine mothers. After achieving saturation at eight mothers, one more mother was interviewed to confirm the study findings bringing the total sample size to nine.

2.4. Inclusion and Exclusion Criteria

The inclusion criterion was any Ugandan mother caring for their hospitalized newborn with congenital anomalies, and able to communicate in English, Luganda, Runyankore, or Rukiga. The exclusion criteria was any Ugandan mother caring for her hospitalized newborn who was critically ill and thus unable to participate in the study, and any mother who declined to consent for participation.

2.5. Sampling Method

Purposive sampling method was used for recruiting the participants. Purposive sampling is a strategy in which a researcher chooses eligible participants who can best contribute to the purpose of the study [14]. The eligible mothers chosen were those admitted on the ward caring for their hospitalized newborns with congenital anomalies. Purposive sampling was suitable for the study to intentionally select mothers who had the experience of caring for their hospitalized newborns with congenital anomalies.

2.6. Data Collection

The mothers were contacted on a one-on-one basis and requested to consent for participating in the study. A mother who consented was then taken to a private, quiet room in the hospital for an interview. Two mothers were interviewed on each day of the study, and a token of thanks (10,000 Uganda shillings) was given to each participating mother in appreciation of their cooperation during the interview. An interview guide containing question probes was developed and used to allow mothers express themselves in detail regarding their experiences of caring for their hospitalized newborns.

The questionnaire was composed of three sections. Section one contained the demographic characteristics of the mothers; section two contained a description of the mother's experiences during the care and hospitalization of their newborn; and section three contained a discussion of the mother's needs, concerns, and the support she would like to have. Additionally, the researcher used an Android smart phone to make audio recordings of mothers' narratives of their experiences, and paper and pen were also used to write down information that required more clarification.

2.7. Data Management and Analysis

The diary used in writing, the consent forms, and the recorder containing the mothers' audio files were all kept securely under lock and key to avoid any unauthorized access to them. The phone recordings were also secured using a phone password and computer password that are only known to the researcher to ensure privacy. The researcher transcribed all the audio data collected into a Word document for analysis. The mothers' responses that were recorded in local dialects, like Luganda, and Runyankore, were directly transcribed in English by the researcher, and a second neutral peer was contacted to cross-check the researcher's translations for accuracy.

Data analysis was done using the Colaizzi method of analyzing qualitative data. The data was coded and analyzed manually, with each particular interview as a unit of analysis. The analysis involved reading and re-reading mothers' transcripts, extracting significant statements, formulating meaning from the significant statements, and categorizing the formulated meanings into clusters of themes. The themes were then analyzed and synthesized to form a comprehensive general description of the mothers' lived experiences. The general description was then reduced by removing redundant statements to form a fundamental structure that describes the mothers' lived experiences.

2.8. Trustworthiness and Integrity

Authors of phenomenology studies strive to obtain integrity and trustworthiness by demonstrating confirmability, credibility, and dependability during the research process as described below.

2.8.1. Confirmability

Confirmability, which refers to the quality of data being neutral and objective [14], was enhanced by conducting a member-checking process that involved taking the researcher's interpretation of the study findings back to the mothers to confirm if the researcher's interpretation actually represented their feelings and experiences.

2.8.2. Credibility

According to [14], credibility is defined as the degree of trustworthiness and confidence in the study results. This was enhanced by having research experts in phenomenology who cross-checked the appropriateness of the methodology and how it was applied to achieve the study results.

2.8.3. Dependability

Dependability refers to the ability of data to remain consistent across time and under various circumstances [14]. This was enhanced by doing data and method triangulation whereby different data collection methods were applied like audio recording, physical observation, and the use of a questionnaire to probe the mothers' experiences. The researcher also actively listened and observed the mothers' nonverbal communication to collect more comprehensive data about the mothers' feelings and emotions during the interviews.

2.9. Ethical Considerations

Administrative clearance was obtained from Mulago National Referral Hospital (M.N.R.H.) where the study was done. The study was approval under reference number: MHREC 2713. A written permission was also obtained from Uganda Christian University's Research Ethics Committee under application reference number UCUREC-2023-778.

2.9.1. Consent and Privacy

Informed consent was obtained from each of the participants. To ensure confidentiality and privacy, the mothers were informed that they would be interviewed and audio recorded from a secure private room to which they agreed.

2.9.2. Benefits and Risk

There was no benefit to the researcher. One potential risk of the study was its ability to cause psychological pain to the mothers as they narrated their experiences. This was mitigated by having a social worker/counselor notified to intervene and calm down any mother in case of an emotional breakdown during the interviews.

3. Results

The findings are described in themes and sub themes that were obtained from the interviews, and are presented in two sections, that is; demographic characteristics of the participants, and participants' lived experiences of delivering and hospitalizing their newborns with congenital anomalies. These sections represent the major categories of the interview probes that were used during data collection.

3.1. Demographic Characteristics of the Participants

The participants hailed from different parts of Uganda and represented different religious denominations. Their real names were hidden for anonymity purposes, and were given pseudo-names for this research. The majority of the participants reported being married and with children, while one of them was unmarried. The mothers' education backgrounds were of primary or secondary level education, with six out of nine mothers reporting to have no formal gainful employment. All mothers were of youthful age ranging between 19 to 33 years of age.

Table 1. Demographic Characteristics Distribution of Study Participants.

Participant	Age	Employment Status	Marital Status	Education Level	Number of Children
01	22	Employed	Married	Primary Education	1
02	31	Unemployed	Single	Secondary Education	2
03	25	Employed	Married	Secondary Education	2
04	28	Unemployed	Single	Primary Education	3
05	30	Employed	Married	Secondary Education	3
06	26	Unemployed	Single	Secondary Education	4
07	24	Employed	Married	Secondary Education	2
08	29	Unemployed	Single	Primary Education	4

3.2. Participants' Lived Experiences Explored

This section describes the experiences of mothers whose newborns were delivered and hospitalized as a result of congenital anomalies. It highlights the experiences during pregnancy, delivery and hospitalization of the newborns. The application of Edmund Husserl's theoretical framework in this section provided a robust theoretical foundation for exploring the mothers' lived experiences as it emphasizes the discovery of universal nature or truths of a lived experience. This aligned well with the goal of the study which was to identify the common themes that cut across the mothers' narratives, irrespective of their variations in socio-economic and cultural backgrounds. The major themes that emerged were; mixed feelings and emotions, healthcare concerns and responsibilities, support system and support needs. Several sub themes also emerged and these are discussed under the major themes.

3.3. Mixed Feelings and Emotions

Under this major theme, it was noted that the majority of mothers interviewed experienced a diverse range of feelings and emotions at the realization that their newborns had congenital anomalies and required hospitalization. Several sub-themes

emerged from this section and these included: feeling shocked, feeling worried, feeling scared, anticipation of blame, and faith during hospitalization. Some of the mothers acknowledged feelings of being shocked and scared on seeing the physical appearance of their newborns, while others reported breaking down in tears and getting worried about their newborn's health and survival chances. Whereas several mothers voiced their concerns of being emotionally challenged by their delivery and the need to hospitalize their newborns, other mothers expressed a sense hope and faith as they witnessed their newborns showing signs of improvement in health.

3.3.1. Feeling Shocked

The experience of delivering a newborn with a congenital anomaly caused the majority of the mothers to feel surprised and shocked on seeing the health condition of their newborns. The mothers indicated being shocked by the appearance of the newborn and the unforeseen need for hospitalization. One of the mothers who expressed her feelings of shock was quoted saying "*At first, I was shocked at the appearance of the baby. Then I thought that it might be satanic and evil forces that caused it…I have never seen this in my life.*" (Brendah, 29 year old). Another mother who felt shocked at the delivery of her newborn was heard to say, "I *got shocked and scared and began wondering what the problem was… because I did everything they told me to do. The nurses there told me that she will be fine*."(Sharon, 19 year old)

3.3.2. Feelings of Worry

The lived experience of delivering and hospitalizing newborns with congenital anomalies caused some of the mothers to feel so worried about their babies' need for medical intervention, and their survival chances. Some of the mothers acknowledged being worried about the nature of their babies' appearance and health condition, while others reported being worried about the medical and surgical interventions that were to be done for correcting the anomalies. One of the mothers was quoted saying "*We reached a time and the baby was very sick, he was put on oxygen. Me and my mother felt so scared and worried thinking that the child may not survive. I even came crying all the way from Kabarole in the ambulance*." (Martha, 20 year old). Another mother who reported her worry regarding the needed medical interventions was heard saying, "*I did not expect this. I thought I will be going home after delivering. But I got worried on realizing that the baby will also require an operation*". (Doreen, 27 year old)

3.3.3. Feeling Scared

The feelings of being scared and fearful permeated several of the mothers' experiences during the hospitalization of their newborns with congenital anomalies. Some of the mothers perceived their hospitalized newborns as being at high risk of death which made them feel scared to the extent of breaking down emotionally in tears. One of the mothers was quoted as saying, "*When I saw the baby's condition, I got so scared and cried…and even coming here, I came crying…thinking that the child may die.*" (Namukasa, 32 year old). Another mother was heard saying, "*After I noticed the baby's condition, I got shocked and scared and began wondering what the problem was… because I did everything they told me to do. The nurses there told me that she will be fine*". (Sharon, 19 year old)

3.3.4. Anticipation of Blame

Another subtheme that kept recurring in some of the mothers' transcripts was their concern and anticipation that they would be blamed for delivering such unhealthy newborns with congenital anomalies. One of the mothers who anticipated being blamed by her in-laws was quoted saying "*They were understanding. They did not blame me because the baby was born sick. I think they understood that sickness can happen to everyone….including the newly born babies*". (Jackie, 29 year old) Another mother who anticipated being blamed by the husband was heard saying "*…we were all confused and worried about the baby's situation. My husband was a bit stronger than me. He appeared okay, and he did not blame me for anything*" (Jalia, 32 year old) The other mother who shared a similar sentiment of anticipating to be blamed, judged or cursed was heard saying, "*When person sits alone in that situation, a lot comes into their heads....you feel like you are cursed, you feel like you are abandoned, you feel like…a lot…everything is on you*".(Sharon, 19 year old)

3.3.5. Faith During Hospitalization

Despite the various responsibilities, challenges, and concerns mothers reported experiencing during their newborns' hospitalization, a few mothers expressed a sense of relief, hope, and faith, on seeing the health of their newborns improve. One of the mothers was quoted as saying "*I have no much challenges….now what can I say? At this time, I don't actually see any problem with the baby now. He even appears to be doing well, because I can now give him milk and he takes it well. He really wants to breast feed. I have no complaints.*" (Martha, 20 year old)

3.4. Health Concerns and Responsibilities

In this theme of health concerns and responsibilities, the mothers' accounts described particular healthcare concerns, challenges, and responsibilities that surrounded their newborn's delivery, illness and hospital stay. These are further discussed and explored in the sub themes below that emerged out of the main theme. The sub themes include: unknown cause of the anomalies, pregnancy concerns, financial woes, and the load of care giving responsibilities. Specific quotes from the mothers' narratives are also used to highlight the mothers' particular experiences.

3.4.1. Unknown Cause of the Anomalies

Another recurring concern that emerged from some of the mothers' accounts was their apprehension and uncertainty about what could have caused them to give birth to newborns with congenital anomalies. Several mothers were concerned about the causes of such congenital anomalies in their newborns. One of the concerned mothers was heard to say "*At first, I was shocked at the appearance of the baby. Then I thought that it might be satanic and evil forces that caused it…I have never seen this in my life. Me I would like to ask,…what brings about such sickness. Like,… what causes them?*" (Brendah, 27 year old) Another mother was quoted saying "*I saw it later and the nurse told me that we should immediately bring the child here....then I started asking myself what could have happened….because I used to do the scan stuff, and they never told me anything. After I noticed the baby's condition, I got shocked and scared and began wondering what the problem was… because I did everything they told me to do.*"(Sharon, 19 year old)

3.4.2. Pregnancy Concerns

Out of the nine mothers interviewed, five of them reported having got infections during pregnancy. The other four indicated that they did not experience any form of illness during the pregnancy period. The nature of the reported illnesses included malaria, fevers, infections, and lower back pains. One of the mothers who got sick during the pregnancy was quoted saying "*I have not been well at all this entire pregnancy. I have been falling sick often, and going to hospitals for treatment. I have been getting on and off fevers throughout the pregnancy.*" (Martha, 20 year old). Another mother who got sick during pregnancy was quoted saying "*I got sick with malaria at 3 months of the pregnancy…I was also over vomiting and had no appetite for eating. I however got treatment for malaria and became fine*." (Sharon, 19 year old)

Another recurring feature that was noted in the mothers' narratives was the unexpected health condition of their newborns on delivery, despite having done ultrasound scans during pregnancy that were interpreted as normal by the health workers. One of the mothers who undertook the ultrasound scan was quoted saying "*Yes I did the three scans during antenatal. But they did not tell me anything like that. The scans were normal but when I delivered the midwives there told me that it is just a big umbilicus" and that will go back and reduce in size*." (Irene, 31 year old) Another mother who undertook an ultrasound scan was quoted saying "*After delivery I was excited and happy. I did not see anything at the beginning. I saw it later and the nurse told me that we should immediately bring the child here....then I started asking myself what could have happened….because I used to do the scan stuff, and they never told me anything*." (Sharon, 19 years old)

3.4.3. Financial Woes

The majority of the mothers identified financial constraints as one of the significant challenges they encountered during their newborns' hospitalization. They described financial constraints as the lack of money to buy particular items they needed to use during the hospitalization experience. Such items included medicines like amino acids, theater items that the hospital could not avail, money for doing ultra sound scans and buying other items like baby's sanitary pads, soap, sugar, and food. One of the respondents was quoted as saying, *"…I have no money to cater for us. My mind ran to the finances that I was going to need to have him treated. They have sent us to do a scan but the money I am expecting has not yet come. I was also told that the baby will need to be operated and that we shall need to buy some theatre items they will use. I was worried about the finances…mainly*." (Irene, 31 year old)

3.4.4. Load of Care Giving Responsibilities

The newborns hospitalized as a result of congenital anomalies have special needs, care, and attention they require from their mothers. While some mothers reported seeing their newborns' health improving and having no much challenges in their care giving roles, the majority of the mothers reported that the nature of their care giving responsibility was quite demanding and resource-intensive. One of the mothers who felt strained by her care giving responsibilities was quoted saying "*The baby needs constant monitoring to not remove the cannula. The doctors and nurses struggled to put it and also the tube in the nose. It is sometimes hard to get a good night sleep because I need to make sure they are not removed*."(Sharon, 19 year old). Another mother was quoted as saying "*The only challenge I see is that sometimes I have to go and buy some medicines and other things from outside and I end up leaving my baby alone. I am alone here and the baby can remove those tubes in the nose and on the belly. So sometimes I tell another colleague to help me and keep watching on the baby when I go outside*."(Justine, 25 year old)

3.5. Participants' Support Systems

Under this theme, it was discovered that mothers received different forms of support and encouragement that enabled them to cope with their newborns' hospitalization experience. Several kinds of support, coping measures, and support needs were highlighted and these are presented below as sub themes, namely; familial support, peer support and encouragement, relationship with nurses, and spiritual support. While the majority of the mothers acknowledged receiving different kinds of support from their significant others, some mothers still highlighted the desire to have more of their support needs met.

3.5.1. Familial Support

The majority of the mothers reported having one or two dedicated significant others or relatives as their support persons during their newborn's hospitalization. However, one of the mothers reported having been denied to allow her caretaker be with her in the hospital. The support persons were

mainly relatives who reacted with sympathy to encourage and comfort the mother during their newborn's hospitalization. It was also identified that some of them extended physical support in form of money and food supplies to enable the mothers cope with the hospitalization experience.

The majority of mothers regarded their spouses as being supportive and concerned about their newborns' congenital anomalies and hospitalization experience. However, one mother reported feeling bad when her spouse refused the suggestion of bringing their newborn to urban hospitals citing financial challenges and safety concerns in non-native communities. The mother was quoted saying "*I felt bad because he never wanted us to come this side to the hospital when we have no money. But I said I must go…whether there is money or not.*" (Kansiime, 20 year old). The other mother who acknowledged her spouse as quite supportive and concerned was heard saying, "*He is caring as usual and supporting. I think that is good because he feels concerned too about the baby's sickness.*" (Olivia, 30 year old)

Other mothers reported receiving encouragement, support and comfort from their siblings who were able to call them on phone and to visit them in the hospital. One mother was quoted saying "*They felt pity for me and keep encouraging me when we talk on phone. They also sent me some money for food and to comfort me. They really felt sorry for me and encouraged us to come to the hospital*." (Martha, 20 year old). One mother was however heard to say that she has only one sibling and is not aware of her newborn's hospitalization due to communication gaps. "*I have only one sibling who is also abroad outside Uganda. He is not aware that we are in hospital and I have not communicated with him for a long time now. I lost his contact and changed mine several times. We are not in touch*." (Namakula Jackie, 29 years old)

3.5.2. Spiritual Support

In the midst of the various concerns and responsibilities that mothers experienced during the hospitalization of their newborns, some of the mothers acknowledged using of prayers to manage and cope with the challenges they encountered. One of the mothers was quoted saying "*I just keep praying that my child gets better and we get discharged. Sometimes that is the only thing you can do*" (Justine, 25 year old). Another mother who regarded prayer as a coping means was quoted saying "*Me I just pray to God to heal my baby and we get discharged. Otherwise it is hard here when you are broke*." (Jalia, 32 year old)

3.5.3. Peer Support and Encouragement

While several mothers acknowledged receiving support and encouragement mainly from their relatives, other mothers reported managing and coping with their challenging experience through peer support. One of the mothers who had no relative as a caretaker was quoted saying "*Like now that I do not have a caretaker here, I have to rely on my fellow mothers for help like in case I want to buy something from outside. I have to send another mother who maybe going there*." (Justine, 25 year old) Another mother who was heard acknowledging the impact of peer support was quoted saying "*Many things are needed here and they are all for buying. Things like amino acids, we have to combine money as five mothers and buy one bottle*". (Justine, 25 year old)

3.5.4. Relationship with the Nurses

While several of the mothers reported receiving adequate health care services from nurses they perceived as caring and supportive, one of the mothers recounted experiencing very harsh and unkind remarks from a nurse who she quoted as often talking rudely to the mothers. The mother was quoted saying "*I was not happy with what she said. She often talks rudely to mothers in ways that are very hurting. We would love to be treated and handled with kindness and politeness. That thing made me feel really bad*." (Jackie, 29 years old) However, one of the mothers who expressed her gratitude regarding the health workers was quoted saying, "*I have no much challenges…because the staffs are really caring and concerned. Whenever I call any of them to come and see the baby, they come fast. I think they are trying to do their best."*(Justine, 25 year old).

3.5.5. Support Needs

While it was identified that some mothers were grateful for the support they received from family members and health workers, it was also discovered that some of the mothers still had other support needs they desired to have fulfilled. These included food, finances, medicines, a clean environment with abundant supply of water, and theatre items to use in the operations of their newborns. One respondent who was grateful for the health workers support was quoted saying "*The health workers are very caring and supportive. Ever since I came here, different health workers come and work on the baby and go. They are concerned. They taught me how to breastfeed and clean up the baby*" (Martha, 20 year old).

One of the respondents who acknowledged the need for financial support was quoted as saying "*A mother would like to be supported with finances because some medicines here are for buying. Like amino acids. I was also told to buy some theatre items…they gave me a list of things for buying. Financial support is what I can say we need*."(Justine, 25 year old)

Another recurring desire for material support was the mothers' request for the hospital to provide essential medicines and supplies to them. One of the mothers was quoted saying "*We would love to be supported with the medicines. The medicines are the important thing. I wish they could provide us the medicines so that we do have to buy from outside pharmacies…like the amino acids…and also the theater items to use. If they could help and give us these things here in the hospital, it would help us a lot*." (Jalia, 32 year old).

***Table 2.** Summary of the Themes, Subthemes and Key Findings.*

Major Theme	Sub-Themes	Summary of Key Findings
1. Mixed Feelings and Emotions	1) Feeling Shocked 2) Feelings of Worry 3) Feeling scared 4) Anticipation of blame 5) Faith during Hospitalization	Mothers experienced intense emotional turmoil upon seeing their newborns' physical abnormalities. Initial shock was followed by worry about survival, fear of loss, and concerns about stigma or blame. Over time, faith and hope emerged as important coping mechanisms.
2. Healthcare Concerns and Responsibilities	1) Unknown cause of the anomalies 2) Pregnancy Concerns 3) Financial woes 4) Load of care giving responsibilities	Mothers struggled with financial strain related to treatment costs. They experienced physical and emotional exhaustion from constant monitoring and care. Many sought explanations for the anomaly, often turning to cultural or spiritual interpretations in the absence of medical knowledge.
3. Support Systems and Support Needs	1) Peer support and encouragement 2) Relationship with nurses 3) Familial support 4) Support needs	Mothers relied heavily on peer mothers, nurses, and family members for emotional, practical, and financial support. While many reported positive nurse interactions, some described negative encounters. Additional needs included counselling, hygiene facilities, health education, and financial aid.

4. Discussion of Findings

4.1. Demographic Characteristics

All the participants in this study had an infant born with a congenital anomaly and majority were mothers of low maternal age ranging from 19 to 27 years old. This characteristic portrays a tendency of lower maternal age women giving birth to newborns with congenital anomalies, a pattern that corresponds with the findings of [3, 18] who similarly identified low maternal age as a significant risk factors predisposing mothers to deliver newborns with congenital anomalies. Additionally, [3] also documented that the odds of delivering a baby with a congenital anomaly are high in females who are greater than 35 years of age.

The participants in this study were generally of lower educational backgrounds with the majority unemployed and having no formal source of income. This characteristic can influence the delivery of unhealthy newborns with congenital anomalies as it can hinder mothers' access to good healthcare, folic acid supplementation, nutrition of a balanced diet, and fortified foods, especially in LMIC's where healthcare systems are inadequately funded. The poor socio-economic background was similarly documented by [2], as a significant factor that is strongly associated with the delivery of congenital anomalies in mothers from low-and middle-income countries.

Eight out of the nine participants in this study were married and acknowledged obtaining adequate support from their family members and significant others. However, the one mother who was unmarried also reported getting adequate support from her relatives. This finding implies that irrespective of one's marital status, the delivery of a newborn with a congenital anomaly consequently draws empathy from one's relatives to help in supporting the hospitalized child and mother. There is also no researched literature that is contrary to this revelation.

The demographic profile of the mothers, particularly their young maternal age, low educational attainment, and lack of formal source of income, reflects the critical social determinants that influence neonatal outcomes. While previous studies [3, 18] have statistically linked such factors to higher rates of congenital anomalies, the lived experiences described here highlight how these socio-economic vulnerabilities not only contribute to the occurrence of anomalies, but also shape mothers' experiences of care-giving, access to care, and emotional resilience.

4.2. Participants' Lived Experiences Explored

In this study, mothers recounted their delivery and hospitalization experiences with great emotion and openness which generated the three major themes and 15 sub-themes. The three major themes are mixed feelings and emotions, healthcare concerns and responsibilities, and support system and support needs. In alignment with Edmund Husserl's de-

scriptive phenomenology framework, the concept of intentionality was seen being played out as the mothers deliberately ascribed meaning to their newborns' health conditions, the societal reactions, and the support they received, as opposed to being mere passive recipients of their lived experiences.

4.2.1. Mixed Feelings and Emotions

This major theme emerged as one of the significant experiences of these mothers, including its subthemes like feeling shocked, feelings of worry, felt scared, anticipation of blame, and faith with hope during hospitalization. The mothers reported experiencing an array of these mixed feelings and emotions on learning that their newborns were unhealthy with a rare medical condition that required surgery if they were to survive. This left many of the mothers confused, helpless, and out of control; wondering what could have caused them to give birth to newborns with such abnormal appearances. This was a sentiment similarly shared in other studies like [8, 17] which reported that delivering infants with congenital anomalies was a frightening experience with a potential of causing long term negative psychological effects on the mothers mental health states.

The situation was worsened by the fact that they had no earlier knowledge of the existence of such congenital anomalies, and neither were they identified during their antenatal visits. The emotional shock from seeing external anomalies like gastroschisis acted as a phenomenological rupture that challenged the mothers' previous expectations of normal birth and motherhood. In Edmund Husserl's terms, this constitutes a "bracketing" of normalcy, where the everyday understanding of a normal childbirth was suspended, and a new uncertain horizon of its meaning emerged.

4.2.2. Feeling Shocked

All the mothers reported experiencing the unexpected shock upon seeing the physical condition and abnormal appearance of their newborns, typical of external congenital anomalies like gastroschisis and omphalocele, where babies are born with their intestines protruding outside the abdomen. This significant shock triggered a range of emotional responses, like disbelief and confusion, leading the mothers to question the circumstances that surrounded their pregnancy, babies' births and their hospitalization. This finding was similarly documented by [15] who noted that the parents of a hospitalized newborn may not only feel overwhelmed by the hospitalization experience, but also experience the initial emotional shock of seeing their baby hospitalized with a rare congenital anomaly.

In this present study, the shock was exacerbated by the mothers' cultural beliefs, where some of them like Brenda were quoted attributing their newborns' congenital anomalies to be due to evil supernatural forces. This consequently caused some the mothers to feel more disappointed, helpless and out of control over their newborns' illness and hospitalization.

4.2.3. Feelings of Worry

Worry was another significant emotion that deeply affected the mothers' and their newborns' hospitalization experience. The worrisome experiences narrated in this study emphasized the mothers' anxieties about their newborns' health, survival prospects and family stability. This finding was similarly documented by [16] who noted that after the birth of a newborn with a congenital anomaly, the parents often experience overwhelming worry and anxiety at the failure to have a healthy baby.

The mothers' stories in this study revealed a profound sense of vulnerability and anxiety, as many struggled to comprehend their newborns' rare illnesses, the unusual medical and surgical interventions, and the impact of this rare experience on their family stability. Martha's emotional journey in the ambulance highlighted the urgency and seriousness with which she perceived her situation upon realizing that her baby was critically ill and needed immediate healthcare interventions.

4.2.4. Feeling Scared

Feelings of being scared and fearful were the other significant and strong emotions that resonated with all the mothers' experiences in this study. This finding was similarly noted by [17] in their study about mothers whose newborns were hospitalized in a Neonatal Intensive Care Unit (NICU). The mothers in their study reported feeling scared of the critical health condition they saw their newborns in, and this conveyed a deep sense of impending loss of the lives of their newborns. The mothers' emotional breakdowns and tears while recounting their experiences vividly illustrated the intensity of their fears and worries. This made their stories relatable to others who have faced similar threats of losing their newborns to such fatal, but less publicized health conditions.

4.2.5. Anticipation of Blame

The anticipation of being blamed as a result of giving birth to a newborn with a congenital anomaly added another layer of complexity to the mothers' emotional burden. Some of the mothers in this study reported having thoughts that they were going to be blamed for having the abnormal deliveries. Jalia's quote in this study underscores her sense of relief in not being subjected to such blame, criticism, and judgment from relatives. According to [4], it was even reported that some of the mothers tend to wrongly blame themselves for the abnormal deliveries, a phenomenon that has negative effects on the mothers' mental health state.

In cultures where such health conditions are stigmatized, mothers often worry about being judged and blamed for giving birth to an abnormal baby. This reflected the mothers' inner conflict and struggle to preserve their family identity, and stability, while also trying to accept the new reality. Additionally, the anticipation of blame also implies that some cultures still hold stigma for mothers who deliver newborns with complex health conditions like congenital anomalies. This finding

is consistent with those of [5, 16] who similarly documented that some cultural beliefs surrounding congenital anomalies can exacerbate the emotional stress and strain experienced by mothers through stigmatization and blame.

4.2.6. Faith during Hospitalization

Amidst the distress and challenges that mothers encountered during their newborns' hospitalization, they reportedly found solace in the act of praying and the prayers of their family members. They acknowledged having hope and faith that their newborns will one day be completely cured, after they had observed signs of improvement in their health. This made some of the mothers to feel hopeful that their newborns can still survive and grow.

Martha's quote captures this change from being desperate, to having a more positive outlook, which portrayed the mothers' ability to adapt and become resilient in the face of their newborns' challenging hospitalization experience. This finding was similarly documented by [11] when it was discovered that engaging in faith and spiritual activities helped to positively boost the mothers' mental health states when they faced the uncertainty of their newborns' survival during hospitalization. Overall, this theme of mixed feelings in the mothers' experiences highlighted the complexity of the emotions that developed when the mothers were faced with the medical challenge of hospitalizing their newborns with congenital anomalies.

4.2.7. Healthcare Concerns and Responsibilities

Healthcare concerns and responsibilities is another significant theme that surrounded the mothers' experiences of delivering and hospitalizing their newborns. From this major theme, several subthemes emerged and these were financial woes, load of care-giving responsibilities, and causality.

4.2.8. Financial Woes

Many of the mothers reported facing financial difficulties like the inability to afford buying basic items like food, soap and sanitary pads, consequently making them feel inadequate and anxious about their ability to take charge of their newborns' hospitalization. Mothers like Irene expressed their worry and difficulty in meeting the costs related to their baby's treatment, such as the costs for ultrasound scans and buying theatre supplies. This revealed that the mothers were financially vulnerable and unable to handle their newborns' hospitalization expenses. This finding was similar to what [5] noted amongst their respondents when they acknowledged that hospitalizing newborns' with congenital anomalies subjected the mothers to heavy financial burdens that were associated with the treatment costs.

4.2.9. Load of Care-giving Responsibilities

Some mothers in this study reported having failed to have a good night sleep due to the need for constantly monitoring their newborns' who had medical tubes and other equipment connected to their bodies. These kinds of care-giving demands and responsibilities left many of the mothers emotionally and physically exhausted as they cared for their hospitalized babies. This finding was similar to what [9] documented in their study that described the hospitalization experience as one that is marked by overwhelming financial, physical and social demands.

Sharon's quote highlighted the impact of these overwhelming care-giving demands and responsibilities, while also emphasizing the mothers' love and determination to prioritize their newborns' care, even at the cost of their own comfort and rest. These experiences demonstrated how far mothers can go to make sure that their babies are effectively cared for, despite the hospitalization hardships they encountered. This served as a reminder of the power of maternal love and compassion that in the face of profound difficulties that families experience.

4.2.10. Unknown Cause of the Anomalies

The mothers acknowledged with deep concern, how they got to deliver newborns with congenital anomalies, yet had expected to deliver healthy babies. For many of the mothers, this experience was rare and unprecedented, thus the search for answers about the causes of these congenital anomalies dominated their minds. Mothers like Brendah and others expressed their need for more knowledge and understanding about congenital anomalies, which led them to link their newborns' health conditions to existential fears like witchcraft, or the illnesses they encountered during pregnancy. This revelation portrayed that the quest for more knowledge and understanding of their newborns' congenital anomalies maybe both reassuring and calming, but also a potential source of additional psychological stress since they had no prior knowledge of the existence of such anomalies.

4.3. Participants' Support Systems

During their newborns' hospitalization, the mothers faced several challenges and subsequently relied on their support systems like family members, relatives, nurses and doctors, and the peer mothers to cope with their challenging experiences. Despite the emotional toll and care-giving burden, mothers in this study demonstrated adaptive resilience by forming informal peer networks and valuing familial and professional support. Their narratives suggest that healing and coping were not only clinical but relational, and the support from peer mothers, and nurses was pivotal in mitigating psychological distress and promoting resilience. From this major theme, several other subthemes emerged, and these included; familial support, peer support, relationship with nurses, and familial support.

4.3.1. Familial Support

All the mothers in this study acknowledged receiving various forms of help and support from their family members, and

relatives. This support ranged from receiving physical items like food, finances, and soap, to receiving spiritual support like comfort, encouragement and prayers. Many of the mothers regarded their spouses, siblings and parents as being caring and supportive during the hospitalization period, a result that was consistent with other findings from [8, 16] who similarly documented that mothers in their studies were grateful for the support they received from their significant support persons. The mothers in this study however reported that such support was unable to fully meet their needs like finances to buy the expensive drugs, and other theatre supplies for their newborns' surgery. This implies that although the family members could not meet all of the mothers' support needs during their newborns' hospitalization, the mothers were still thankful and appreciative of the love, support, and contributions they received through their family members.

4.3.2. Peer Support and Encouragement

This support from fellow mothers was notable when the mothers experienced financial difficulties to purchase certain expensive medicines. In response, the mothers decided to collaborate together and pooled resources to enable them buy such expensive medicines like amino acids. These financial constraints and other medical hardships encouraged the mothers to work together, consequently strengthening their peer relationships in the process. Justine's quote highlights the collaboration and unity that emerged when the mothers faced similar medical hardships despite hailing from different religious, tribal and cultural backgrounds.

It was also revealed that mothers who lacked relatives as caregivers relied on their fellow mothers for support in running errands like buying utility items from shops located outside the hospital premises. This phenomenon demonstrated the mothers' ability to establish comradeship, unity and peer support for one another whenever they faced similar medical hardships. The value of such support systems was also acknowledged by [8, 11] in their study of mothers who were caring for their hospitalized infants with gastroschisis and esophageal atresia.

4.3.3. Relationship with the Nurses

Several of the mothers acknowledged being helpfully supported by their attending nurses, although one mother encountered a rude and harsh experience with the nurse in-charge. Justine and Jalia's quotes highlight their contentment with the healthcare services, alluding to the sensitivity and concern that nurses portrayed in getting the mothers' concerns addressed. This implies that despite experiencing a wide range of conflicting feelings and emotions during their newborns' hospitalization, mothers were still able to recognize and appreciate the nursing care that was provided. This consequently reflected the mothers' ability and potential to trust and establish supportive relationships with their attending nurses and doctors, a finding that was similarly documented by [20].

The one mother who reported experiencing rude remarks from the nurse in-charge appeared so disappointed in the nurse, implying that negative interactions even though few, often have lasting emotional consequences in a high-stress environment like a hospital. This is a revelation of the moral authority that nurses carry and ought to reflect upon during their communication with such vulnerable mothers, and nursing practice in general.

4.3.4. Support Needs

Several mothers acknowledged receiving different kinds of support like food, money, and encouragement during their babies' hospitalization. However, despite receiving these different kinds of support, mothers still echoed their desire to have more support extended to them in the form of hygienic washroom facilities, counseling services, meals, financial assistance, and health education on how to handle their fragile babies. This result was similarly documented by other studies like [11, 16] who had found that mothers of hospitalized infants with gastrointestinal anomalies still needed more support in the form of information to reduce their anxiety and improve their self esteem in caring for their hospitalized infants. This is a revelation that much as mothers desire to have their newborns cared for, and treated to recovery, they still desire more support from the health workers like counseling, reassurance, and health education on how to effectively perform their maternal roles and responsibilities to the hospitalized newborns.

4.4. Application of the Theoretical Framework

Qualitative descriptive phenomenology as postulated by Edmund Husserl uses three frames of reference to study a lived-experience in its pure and universal sense, and these were applied in studying the mothers' experiences. The first frame of reference, creating a real-world plane of interaction, was established by fostering a conversational environment between the researcher and the mothers to facilitate the one-on-one interviews while recording them. The second frame of reference, which is ensuring "transcendental subjectivity," was applied in bracketing the researchers' pre-existing knowledge and personal opinions to avoid bias, while also using open-ended question probes to remain neutral to the mothers' experiences.

The third frame of reference, identifying the eidetic essences or universal truths about the mothers' lived experiences, was applied in analyzing the mothers' narratives to discover the common features and themes that cut across their' experiences. These three frames of reference enabled the exploration and description of the mothers' lived experiences in their organic nature.

5. Recommendations

5.1. Nursing Practice Implications

Given the mental health challenges mothers face during

their newborns' hospitalization with congenital anomalies, nurses and psychosocial counselors should provide them with family-centered counseling services. These service interventions should focus on emotional processing, resilience building, and coping strategies to strengthen the mothers' ability to perform their parental roles with confidence and self-esteem.

Nurses should establish collaborative partnerships with mothers to ensure they provide holistic care, addressing not only the medical needs of the newborns, but also the emotional and practical needs of the mothers. Creating such supportive environments enhances maternal confidence and competence in performing their care-giving roles and responsibilities. It also enables the nurses to implement holistic nursing care processes that attend to the mothers' needs and concerns as well.

Healthcare professionals should adopt and strengthen family-centered care approaches when managing hospitalized newborns with congenital anomalies. This should include continuous communication of the newborn's health status, active involvement of mothers and their family members in care processes and decision-making, and providing them empathetic support to reduce maternal stress and anxiety during their newborns' hospitalization.

5.2. Health Education Implications

Nurses and other healthcare professionals should receive regular training programs on how to assess and support the physical and emotional well-being of mothers during the hospitalization of their newborns with congenital anomalies. Such trainings should equip healthcare staff with the requisite knowledge, skills and competencies for conducting tailored mental health assessments and interventions.

Nurses and other healthcare professionals should provide comprehensive health education to women of reproductive age regarding congenital anomalies, including their potential causes, prevention strategies, and methods for early detection during antenatal visits. These educational sessions should be integrated into the routine antenatal care visits and delivered in a supportive manner.

Given the study's grounding in Husserl's descriptive phenomenology, nursing education should emphasize reflective practice, bracketing assumptions, and understanding patient experiences from their own perspective. This enables the provision of deeper empathy and individualized patient care.

5.3. Health Policy Implications

Policy makers should support stronger collaboration between nursing departments, radiology units, and obstetric services to enhance prenatal screening, detection, and diagnosis of congenital anomalies. The policies should mandate timely communication of the screening results, establishment of clear referral pathways, and guidance on the appropriate delivery facilities for such high-risk pregnancies.

Policies should require the integration of mental health assessments and support services into maternal and newborn care units. This includes ensuring the availability of trained psychosocial counselors and nurses for providing continuous emotional and psychological support to mothers of newborns with anomalies.

Health systems should formally integrate comprehensive health education on congenital anomalies including causes, risk factors, prevention, and early detection into routine antenatal services. The policies should ensure that such education is standardized, culturally sensitive, and consistently delivered across health facilities.

Hospitals and community health programs should establish and strengthen peer-support groups where mothers can share experiences, receive encouragement, and learn coping strategies. This approach has shown to be effective in Rwanda and other low-income settings in enabling mothers to cope with their newborns' hospitalization.

Health systems integrate community health campaigns and programs that address misconceptions and stigma associated with congenital anomalies. Public education may alleviate maternal shame and encourage supportive social environments.

5.4. Future Research Directions

Firstly, there is a need for more research about the root causes of congenital anomalies in low-income and resource-limited settings, with particular attention to genetic, environmental, and nutritional risk factors. Understanding these determinants could guide the development of context-specific preventive strategies and inform antenatal care interventions that are both cost-effective and scalable. Secondly, further studies should focus on the psychosocial support and therapeutic interventions for mothers of newborns with congenital anomalies. This research should evaluate counseling approaches, emotional support systems, and structured guidance programs to determine their impact on maternal mental health, care-giving confidence, and mother-infant bonding during hospitalization.

Finally, there is a relative absence of studies exploring family dynamics and paternal perspectives in the context of congenital anomalies. Current literature emphasizes maternal experiences, but future research should investigate how newborn illnesses like congenital anomalies affect marital relationships, paternal involvement, and overall family functioning. Such research is essential for designing culturally sensitive, scalable interventions to support recovery and resilience in affected families.

5.5. Limitations

One of the limitations of this study was that some of the probing questions used in the interview portrayed a conflict of interest where the researcher's role would sometimes conflict

with the employee role during data collection. The other limitation is that the study findings cannot be automatically transferred to other settings because it aimed at exploring the individual mothers' experiences, as they encountered them. Another limitation was the inability to totally eliminate selection bias towards mothers whose newborns had externally visible congenital anomalies, as opposed to those with internal congenital anomalies.

6. Conclusion

The birth and hospitalization of newborns with congenital anomalies presents the mothers several challenges that affect their physical and emotional well-being, care-giving capacity, and financial stability. This study revealed that mothers often rely on family members and extended relatives for support, including peer support from fellow mothers, and maintaining good relationships with health workers so as to cope with this difficult experience of caring for hospitalized newborns with congenital anomalies. To address the challenges mothers experience during their newborns' hospitalization, healthcare professionals and other stakeholders should create supportive environments and interventions that offer comprehensive care to both the newborn and the attending mother. This can help mothers to effectively adjust and cope with their identity and maternal responsibilities in a complex healthcare setting.

Abbreviations

ANC	Antenatal Care
CA	Congenital Anomalies
FCC	Family-Centered Care
GS	Gastroschisis
LMIC	Low- and Middle-Income Countries
MNRH	Mulago National Referral Hospital
MOH	Ministry of Health
NICU	Neonatal Intensive Care Unit
PCC	Patient-Centered Communication
PTSD	Post-Traumatic Stress Disorder
REC	Research Ethics Committee
SSA	Sub-Saharan Africa
WHO	World Health Organization

Conflicts of Interest

The authors declare no conflict of interest.

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