

Healthcare professionals' experiences and perspectives of neonatal near misses at three public hospitals in The Gambia: a qualitative study

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Abstract

Background/Aims A neonatal near miss refers to cases where babies almost die in the neonatal period. Exploring healthcare professionals' experiences and perspectives is vital to understand the dynamics behind neonatal near misses, how to prevent them and how care can be improved. This study's aim was to explore healthcare professionals' experiences and perceptions of caring for neonatal near misses in major public hospitals in the Western 1 region of The Gambia.

Methods Semi-structured interviews were held with purposively selected healthcare professionals, including 9 midwives, 9 nurses and 9 doctors, who worked at three tertiary hospitals in the Western 1 region. Qualitative content analysis was used to generate themes and subthemes focused on the participants' experiences of providing care in cases of a neonatal near miss.

Results The main theme was 'it could be different', which included two subthemes: 'always a near miss baby at the ward' and 'ready to care'. The participants described how insufficient human and material resources and poor work environments resulted in neonatal near misses, as well as their inability to intervene in the case of many neonatal deaths.

Conclusions This study identified critical gaps in neonatal care, including inadequate investment in healthcare infrastructure, limited availability of life-saving equipment and insufficient neonatal training programmes. High clinical workload, staff shortages and increasing demand for neonatal services contribute to delays in care, which increase the risk of neonatal near-miss events and mortality.

Implications for practice Effective management of neonatal near-miss cases in low-resource settings requires strengthened neonatal training, adequate staffing and reliable access to essential equipment. Preventive strategies, including improved antenatal care, efficient clinical workflows and timely referral systems, are essential to improving neonatal outcomes.

Key words: Healthcare professionals; Neonatal near miss; The Gambia

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Introduction

A neonatal near miss describes cases where neonates encounter serious complications shortly after birth, but survive despite the risk of death (Asaye et al, 2023). Effective resuscitation techniques, prompt admission to neonatal intensive care units and collaboration between nurses, midwives and doctors are all crucial elements of saving lives in cases of a near miss (Asaye et al, 2023).

Neonatal near miss audits are a valuable approach for gathering essential data on newborn health and improving care (de Barros Medeiros et al, 2022). They offer critical insights, particularly in cases of birth asphyxia or advanced neonatal resuscitation. While the World Health Organization (WHO, 2016) has established guidelines for maternal and pediatric near-miss audits, standardised protocols for facility-based neonatal near miss audits remain underdeveloped (de Barros Medeiros et al, 2022). Rodrigues et al (2019) emphasised that the near-miss concept and criterion-based clinical audits effectively support data collection for neonatal healthcare.

There is limited research on the experiences and perceptions of healthcare professionals in low resource settings regarding neonatal near miss care (Bell et al, 2018). A study from Ghana found that the concept of a neonatal near miss was not well understood, and healthcare professionals disagreed on its value (Bell et al, 2018). Abebe et al (2021) identified that unclear responsibilities and a sense of hopelessness may have hindered healthcare professionals in Ethiopian settings from taking swift action and delivering necessary care, hindering neonatal survival. They further highlighted that the experiences and perceptions of healthcare professionals managing neonatal near miss cases in Ethiopian hospitals had not been previously explored (Abebe et al, 2021). The aim of this study was to explore healthcare professionals' experiences and perceptions of caring for neonatal near miss cases in The Gambia.

Methods

This qualitative descriptive study examined healthcare professionals' experiences and perceptions related to the management of neonatal near-miss cases at three tertiary hospitals in the Western 1 region of The Gambia. This approach is appropriate for generating clear, practice-oriented descriptions in maternal and neonatal healthcare (Sandelowski 2000; 2010).

Participants

The three hospitals, Edward Francis Small Teaching Hospital, Kanifing General Hospital and Bundung Maternal and Child Health Hospital, were purposively selected as major public hospitals providing neonatal and maternal healthcare services in The Gambia. Kanifing General Hospital and Bundung Maternal and Child Health Hospital are public general referral hospitals, receiving patients from across the country, while Edward Francis Small Teaching Hospital is the main national public referral and teaching hospital.

Participants were purposively selected from the three hospitals, based on having ≥ 1 years of experience in either the maternity or neonatal unit. The final sample included a total of 27 healthcare professionals: nine doctors (out of a possible 57), nine nurses (out of a possible 81) and nine midwives (out of a possible 104). The sample size was guided by data saturation; interviews were conducted until no new themes or insights emerged, indicating redundancy of information. Saturation was achieved after interviewing nine participants per professional category across the three hospitals (three doctors, three midwives and three nurses per hospital), resulting in a total sample of 27 participants. At this point, recruitment and data collection were discontinued, as further interviews were unlikely to yield additional meaningful data (Saunders et al, 2018). This combined approach ensured that the sample size was both feasible and sufficient to capture in-depth, rich perspectives relevant to the study aim.

The selected participants were invited to participate and provided with oral information about the study. Participants were approached at the hospitals and consecutively invited to participate based on their availability and willingness.

Data collection

Data were collected via semi-structured interviews held in January 2022, using a guide developed by the authors. The guide was pilot tested with one healthcare professional to assess its clarity, relevance and suitability for data collection. This participant was selected from one of the three study hospitals and the data obtained were excluded from the main analysis. The pilot allowed refinement of the topic guide, including the addition of probing questions.

The principal researchers conducted interviews in English in secluded spaces at the hospitals, assisted by trained data collectors. The interviews were recorded and each began with sharing three short vignettes (brief stories) to initiate discussion and orient participants on the topic (Jenkins et al, 2010). Participants were invited to respond to the vignettes and open-ended questions about their experiences in caring for neonatal near miss cases and their perception of this care in the unit. Data were collected until saturation was reached (Saunders et al, 2018).

Data analysis

Elo and Kyngäs' (2008) qualitative content analysis approach was used to analyse the data. Interviews were transcribed verbatim and thoroughly reviewed to ensure familiarity with the content. The analysis was conducted iteratively, with data initially coded by identifying meaning units, which were condensed, assigned codes and organised into subcategories, which were then grouped into broader categories. Researchers engaged in ongoing discussions to refine subcategories and categories until consensus was achieved. A main overarching category was developed, supported by illustrative quotes from the subcategories.

Ethical considerations

Ethical approval to carry out the research was obtained from the Research and Scientific Committee of the School of Medicine and Allied Health Sciences of The University of The Gambia and The Gambia Government/Medical Research Council Joint Ethics Committee (Project ID/Ethics ref: R021012). Participants were provided with a study information sheet, and oral and written informed consent were obtained before the interviews.

Results

Table 1 shows participants' sociodemographic characteristics. The majority of the participants were female (74.1%), 26–35 years old (74.1%), had a degree (66.7%) and had 1–10 years' experience (81.5%)

The overall category that emerged from data analysis was 'it could be different'. The two main themes were 'always a near-miss baby at the ward' (with two subthemes) and 'ready to care' (with three subthemes), as shown in **Table 2**.

Characteristic		Frequency, n=27 (%)
Sex	Male	7 (25.9)
	Female	20 (74.1)
Age (years)	16–25	0 (0.0)
	26–35	20 (74.1)
	36–45	7 (25.9)
	46–55	0 (0.0)
	56–65	0 (0.0)
Education	Postgraduate	5 (18.5)
	Graduate	18 (66.7)
	College	4 (14.8)
	Other	0 (0.0)
Clinical work experience (years)	1–10	22 (81.5)
	11–20	5 (18.5)
Received emergency maternal, neonatal and child healthcare training	Yes	11 (40.7)
	No	16 (59.3)
Received formal training on how to care for near-miss infants	Yes	2 (7.4)
	No	25 (92.6)

Table 2. Main category, themes and subthemes of the results

Main category	Theme	Subtheme
It could be different	Always a near-miss baby at the ward	Facing the facts
		Prevention is key
	Ready to care	Investing in training
		Investing in resources and the care environment
		Effective workflow

Always a near-miss baby at the ward

Facing the facts

The participants reflected on the frequent neonatal near-miss cases that took place, with the perceived high mortality rate linked to factors such as hypertensive pregnancy disorders, infections, eclampsia with preterm birth and low birth weight.

‘It is very frequent because recently there is a high rate of induction in the labour ward due to hypertensive disorders of pregnancy and even today, we are having an induction because of eclampsia at 32 weeks and because of that we have a lot of near-miss babies from preterm delivery and small for gestation and from low birth weight as well’. Doctor, hospital 2

‘We receive cases of near-miss babies on a daily basis, and at any given time there is always a near-miss baby in the ward, many of whom are born prematurely or with low birth weight due to complications like maternal hypertension or infections’. Doctor, hospital 3

Participants acknowledged the demands of managing such cases and reported strong emotions; they were happy when a baby survived and sad if a baby died or was left with a lifelong disability.

‘My experience is both positive and negative depending on the outcome of the cases because they are a critical category of neonates that we take care of and sometimes the battle ends in our favour and sometimes not’. Nurse, hospital 1

‘So, it was a very big experience for me because I never thought the baby would be alive but with vigorous resuscitation, the baby survived’. Doctor, hospital 2

Prevention is key

The participants emphasised that promoting preconception care for girls and young women was the starting point for reducing near-miss cases. They felt that this should extend through antenatal services, including infection screening and nutritional guidance.

‘One thing I just want to emphasise is to prevent these near misses, it must start from preconception care. Yes, even before you plan on getting pregnant. Preconception antenatal care is really important in preventing these neonatal near misses’. Doctor, hospital 3

Informing women and their families about pregnancy danger signs and ensuring timely care was seen as essential. The participants also felt that community-wide awareness was needed, as many women lacked knowledge of when to seek care. The participants felt that community sensitisation would help them recognise danger signs and seek timely help.

‘One near-miss I have received was from a 29-year-old woman, a primigravida who was in labour but before she came, she had a delivery in the car. When she

came, we examined the baby who was in respiratory distress and was stained with meconium. The baby was blue. So even the Apgar score of 5 minutes was about five. So we resuscitated the baby and then referred to the neonatal intensive care unit, but when the baby got there, I think the second day of admission, the baby started convulsing and the baby was lost on the third day of life. I think if she came early to the hospital, we would have prevented that neonatal death'. Doctor, hospital 1

'First and foremost is to start with the community, community sensitisation is very important during pregnancy that if they see certain signs they can rush to the hospital. If they rush to the hospital, we on the ground should also intervene as soon as possible. During delivery we should monitor our patient very closely intrapartum. If you monitor them closely you will be able to pick some of these near misses. If some of these problems are not picked up, that may result in neonatal near misses'. Doctor, hospital 3

The participants emphasised that reducing delays in accessing timely and appropriate emergency obstetric care at healthcare facilities was crucial for preventing neonatal near-miss cases. They stressed the need for policy and management-level preventive measures, as system-wide delays often stemmed from inadequate staffing and a lack of specialists and resources, causing frustration.

'Sometimes you can have two babies. And yes, at the same time, who needs oxygen or who needs suctioning. Resource-wise, we only have one oxygen and we have one suctioning machine so that also is a problem'. Doctor, hospital 3

'We don't have resources here. Right now, we have shortage of gloves, shortage of syringes. So that one is a facility related problem. Staff problem right now in the neonatal ward, even in my ward [high dependency unit] there is a problem'. Midwife, hospital 3

Ready to care

Investing in training

The participants highlighted the need for more specialised neonatal care staff and increased investment in training. They felt that midwives should be trained to deliver timely initial care for babies with birth asphyxia before a paediatrician arrives, reducing neonatal morbidity and mortality.

'Training should be given to midwives and doctors that are stationed at the gynaecology department. We need to improve the care that we give to the neonates'. Doctor, hospital 2

'To provide training programmes for staff to increase their knowledge and skills on neonatal care or bring specialists who will train nurses on neonatal [intensive care unit] and also to provide material resources'. Nurse, hospital 3

'Training is the most important thing; you cannot do something that you don't know anything about ... Personally, I don't even know anything about near misses ... I've heard the word somewhere, I don't even know where, but you cannot say anything, you cannot do anything without knowing what you're doing. So first of all, training should be done to equip the places or hospitals with necessary neonatal resuscitation equipment and then ongoing training should not be once but at least ongoing every 3 months'. Midwife, hospital 3

The participants described how healthcare professionals who were not trained in neonatal care were reluctant to engage in providing care, which could endanger life in neonatal near miss cases.

‘Most of the staff are not interested in caring for neonates and they always run away from them because they are not specialised in neonatal care’. Nurse, hospital 2

Additionally, the patient:nurse ratio was very high, which reduced the quality of care.

‘The human resource is still lacking, like one nurse taking care of 20 babies which is unreasonable and will compromise the care being given’. Nurse, hospital 1

Investing in resources and the care environment

The participants highlighted how the shortage of life-saving equipment necessary for neonatal near-miss cases made new equipment critical. The participants often had to improvise when essential materials were unavailable and the absence of resources (surfactants, incubators, resuscitaire and radiant warmers) directly impacted care.

‘The main issue here is material resources because sometimes the material that we need in the care of these neonates is not available. So, the only thing that you have is to improvise’. Nurse, hospital 2

The lack of equipment led to frequent referrals to the only well-established neonatal ward in the capital, often resulting in neonatal death because of delays in receiving care and poorly equipped ambulances for transportation.

‘From my experience in managing near-miss neonatal cases, sometimes we succeed and sometimes we don’t. We do not have well-equipped ambulances from the referral health facilities, so after their initial resuscitation, complicated babies especially those with birth asphyxia are received in our paediatric unit. These multiple referrals and poor ambulance services often cause serious delays, and some babies die before they can receive proper care’. Doctor, hospital 1

‘We don’t have a neonatal ward. So when we have babies with neonatal complications or with birth asphyxia usually, we resuscitate them and then we send them to our paediatric neonatal unit to be reviewed by doctors. So if they feel that they cannot do much, they further refer them to the hospital in the capital for neonatal care’. Midwife, hospital 2

The participants’ ability to deliver optimal care was sometimes hindered by the lack of available medication, requiring families to obtain them. When families could not afford or access these medications promptly, it delayed necessary care for neonates.

‘When medications are not available sometimes it takes time before the family members buy them, causing the delay’. Nurse, hospital 1

The lack of guidelines for neonatal near-miss cases led to delays.

‘We do not have clear guidelines or protocols which makes it difficult to manage critically ill neonates promptly. Without step-by-step guidance, important interventions can be delayed or missed, especially in emergency situations where stress and pressure are high. This lack of structured guidance contributes to delays in care, which can worsen the baby’s condition and lead to serious complications, including irreversible brain damage and even death’. Midwife, hospital 2.

Effective workflow

The participants highlighted the importance of an effective workflow in caring for neonatal near-miss cases. They reported that healthcare professionals must act quickly and efficiently, with the first person to receive the neonate beginning immediate resuscitation and calling the doctor if needed. They highlighted that any delay would endanger the baby and emphasised that effective teamwork is crucial for providing care.

‘First of all, I usually assess them, initiate resuscitation, call for help, give oxygen, set an intravenous line and call for the doctor on call to come’. Midwife, hospital 1

‘When a near-miss baby is received, everyone has to act quickly. The first person starts resuscitation immediately and calls the doctor if necessary. If there is any delay or lack of equipment, the baby’s life is at risk’. Nurse, hospital 3

The participants reported that neonates referred to the neonatal ward required critical care and attention because most had life-threatening conditions, including multiple organ damage, hypoglycaemia or recurrent apnoea. If not treated quickly, these conditions could lead to complications such as irreversible brain damage and sometimes death.

‘For 2 years I have been working in the neonatal unit and seen quite a lot of cases of [neonatal near miss]. Most of them were discharged healthy and some could not survive’. Nurse, hospital 3

The participants explained that admitted neonates were categorised into two groups: those born in the hospital, sent to the inborn ward, and those not born in the hospital, sent to the outborn ward. Applying this structure laid the foundation for effective and life-saving care if fully implemented, as it helped prevent cross-infection and reduced the need for antibiotics.

‘Dividing the neonatal ward into inborn and outborn units is important for organising care and reducing the risk of cross-infection’. Doctor, hospital 1

Discussion

The overall theme from the participants’ responses in relation to caring for neonatal near-miss cases was that ‘it could be different’. Near-miss cases were common and the participants felt that it was crucial to be prepared to care for these neonates. They believed that preventing severe neonatal near miss cases could reduce the healthcare burden and neonatal mortality rates. Their suggestions for improving care included ensuring staff were trained and knowledgeable and improving the availability of critical resources.

A key finding was the reported shortage of essential resources for neonatal care. This aligns with Bell et al (2018), whose study in 12 developing countries identified inadequate supplies as a major barrier to basic neonatal care. Similarly, Bolan et al (2021) highlighted supply shortages in The Gambia, Tanzania and Uganda.

This study also highlighted the significant impact of inadequate human resources on neonatal care. A shortage of specialist doctors and neonatal nurses contributes to high neonatal mortality rates and increased workload, leading to stress and reduced quality of care (Bolan et al, 2021; Asaye et al, 2023). To address this, Bolan et al (2021) and Asaye et al (2023) recommended that the government provide better working conditions, incentives and training opportunities for healthcare professionals.

Most of the present study’s participants lacked specialisation in neonatal care, with only two formally trained in managing neonatal near-miss cases. They reported that their general pre-service training was insufficient, affecting their ability to prevent neonatal deaths. Previous research has also reported that in low- and middle-income countries, pre-service training on neonatal management is often inadequate (Bolan et al, 2021). In hospitals in Malawi, the quality of care for births and newborns was compromised by the shortage of specialist healthcare professionals (Gondwe et al, 2022). Addressing this gap would likely improve newborn outcomes.

Implications for practice

Shortages of essential equipment negatively impacted the care that the present study’s participants could provide in cases of neonatal near miss. The authors recommend that the government in The Gambia increase investment in essential equipment for effective neonatal near miss care. Timely management of conditions such as asphyxia and neonatal

Key points

- This study explored the experiences and perspectives of healthcare professionals when caring for neonatal near-miss cases, highlighting the need for prevention and prompt intervention.
- The participants often encountered near-miss cases and emphasised the importance of preventing such cases through preconception and antenatal care and community education.
- Prevention of neonatal near misses requires interventions at the policy, leadership and management level to ensure adequate staffing and resources to provide high-quality care.
- The participants felt that preventing neonatal near miss cases was key to reducing the burden on the healthcare system and the neonatal mortality rate.
- Additionally, investment in training and specialised staff were highlighted as crucial to improving the quality of care provided.

sepsis also requires regular in-service training in supportive environments (Wondimu et al, 2021). It has been recommended across multiple similar studies that to reduce cases of neonatal near misses, there is a need for more staff and more in- and pre-service training for healthcare professionals (Bell et al, 2018; Carvalho et al, 2020; Asaye et al, 2021; Bolan et al, 2021; Asaye et al, 2022, 2023; Endawkie et al, 2023; Kalabamu et al, 2025). The authors strongly recommend that The Gambian government invest in specialised neonatal training for better neonatal near miss outcomes (Gondwe et al, 2022).

Strengths and limitations

This study's strength is its comprehensive data collection and analysis from a diverse range of healthcare professionals, minimising bias and supporting replication (Mwita, 2022). However, the small sample size limits generalisability (Mwita, 2022), underscoring the need for further research using mixed methods.

Conclusions

Managing neonatal near misses in The Gambia is challenging as a result of the limited available resources, understaffing and inadequate specialised training. Despite healthcare professionals' efforts, these issues impede timely, effective care. Key gaps include a lack of investment in critical infrastructure, life-saving equipment and comprehensive neonatal training programmes.

Moving forward, initiatives should focus on strengthening healthcare systems by increasing funding for neonatal infrastructure, improving specialised training and enhancing community outreach for preconception and antenatal care. Additionally, improving the staff:patient ratio by employing more staff is crucial to addressing workforce shortages. Addressing hospital delays and optimising resource allocation will also be essential. By prioritising these areas, the healthcare system will be better prepared to handle care in neonatal near-miss cases, leading to better outcomes.

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Author contributions

All five authors contributed to the conceptualisation and design of the study. Data collection was conducted by AKF and MK. Data analysis and manuscript preparation were handled collaboratively by all authors, who reviewed and approved the final manuscript.

Conflicts of interest

The authors declare that there are no conflicts of interest.

Data sharing

Data for this study are available from the authors on reasonable request.

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