

Additional file 1: Analysis Matrix

This matrix summarizes the journey taken by each respondent, describes the outcome, potential contributing factors identified by authors and where, if relevant, they fit into the WHO Quality of care domain, or other contextual issues

Case ID	Type of Outcome & Stage of care	Outcome statement (Event description)	Potential Contributing factors (traced retrospectively)	Mapped to WHO MNCH QoC domain / Contextual issues
1) SB B.10	- Stillbirth - POD: Main district hospital	Woman arrived at facility with stomach pain, not knowing she is in labour. Was sent to labour bed and had a rapid delivery – actually delivered alone before health workers got to her. Told baby had been dead 2 days, though was not “rotten”	- Mother used herbs to turn baby’s position at 7 months - Contradiction with HW because woman said she had been feeling movements Context - Social cultural practices	- Evidence based practices (parents’ side) - Competent, motivated human resources - Respect and dignity
	Journey/pathways First went to nearby government health facility, did not get attention so went to main hospital			
2) NND B.7	- Newborn death - POD: Government health facility	Baby born alive but did not first cry at birth, was yellowish, needed to be stimulated; mouth oozing saliva & failed to breastfeed; baby cried endlessly. After a week, went to main district hospital but baby died while cannular was being placed on.	- Self-referral to district hospital - No emergency transport to navigate the traffic - Fear of Covid - Going back home to sit with sick baby for a week - Father of the baby said the staff were young nurses, still learning, unsupported by doctors Context - Mothers lack of knowledge of newborn danger signs - Covid pandemic and related restrictions	- Evidence based practices (parents) - Limited Functioning referral systems - Competent, motivated human resources
	Journey / pathways Decided to go to main district hospital (govt) on 3rd day but stopped due to heavy traffic & Covid so went home, but after a week went to that main hospital			
3) NND B.9	Newborn death (latest loss)		- Has lost 3 kids at different stages - Delivering from health center II	Evidence-based practices

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	• POD: Health center II	Baby born alive but made strange sound (sigh). HW gave baby an injection & syrup & they went home for a week. On 2nd week, baby was hot and in pain when touched – returned to same HW who gave panadol & piritex Around 1 week 4 days, no change so went to private clinic – baby was treated but without tests. Due to restricted Covid movements, they asked to go with drugs so the other HW treats them, which she did but baby worsened. Went back to Dr when treatment ended and that was when he referred to main district hospital – for blood tests. Got there and were also sent to a private facility for blood test. Back to main hospital, Dr admitted baby but nurse struggled to administer medicines and oxygen, was very rude and baby died in process of trying to fix oxygen	• Government health worker repeatedly treating newborn probably guessing • Private facility treated without tests • Restricted movements during Covid • Late referral to main hospital after treatment failed • Moving to various places looking for services • Both parents said the nurse did not seem to know what she was doing and she also said at 1 point that things were failing • Rude nurse Context • Limited access to better care • Covid pandemic and related restrictions • Essential physical resources • Mothers lack of knowledge of newborn danger signs	• Limited functioning referral systems • Competent, motivated HR • Essential physical resources • Respect and dignity • Effective communication with patient
4) NND B.2	• Newborn death • POD: Private health facility	• Baby born alive in private facility & discharged. Got high temperature 3rd week & taken to private facility for care. On 3rd day in that facility baby had difficulty breathing & was very hot, plus had something like a tumor on neck – Dr cut this and baby cried endlessly, no improvement. On day 5, father asked to take baby home. Breast feeding was also difficult	• Moving between various private clinics that could not treat the baby successfully • Parents refusal of referral to public facility due to a bad experience during labor	• Evidence based practices • Respect and dignity • Competent, motivated HR • Effective communication with patients
	Journeys / Pathways • Was 5am and delivery was quick so went to nearest place Treatment of the newborn was in multiple places • From health center II, to private clinic, eventually to main hospital			

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	For baby's treatment, parents went to 3 different private clinics	- From home, baby taken to another private clinic & treated 2 days and worsened - Parents then went to another private clinic which wanted to refer them to public. They refused and Dr treated baby, sent them home and baby died same day, shortly after getting home		
5) SB B.4	- Stillbirth - Delivered at home	Baby born at home at 9 months, with "burns" on the skin; however mother had earlier felt reduced fetal movements, but not paid much attention to that. Birth supported by traditional birth attendant	Throughout ANC she was told baby was fine. Never attended the last ANC because she was feeling weak	
6) NND B.3	- Newborn death - POD: Main district hospital	In initial ANC baby was transverse, so mother used herbs to change position. Later, baby was said to be in "too many fluids". Baby was born alive but died shortly after birth, in less than an hour	Unclear, cause parents said baby got to 10 months but HWs said it was preterm	<i>During ANC</i> Effective communication with patients
7) SB B.8	- Stillbirth of 1 twin, but the other lived - POD: Home	She delivered alone in the house – babies came so fast but also during Covid motorcyclists were barely taking people. First child born alive, and after about 3 hours she felt pain again and gave birth to the other. The baby did not cry and had macerated skin	- Home birth - About 3-hour interval between birth of 1 child and the next - Stomach hurt a lot during pregnancy plus vaginal discharge – may have been a missed opportunity to check & treat mother - Was told during ANC that babies were disorganized in the womb Context - Covid restrictions	<i>During ANC</i> - Evidence based practices - Effective communication with patients

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8) Misc B.11	- Miscarriage (at 3 months) - Happened at home	Woke up normal and went to dig. On way back felt like urinating and instead water came out plus the fetus but no blood. Husband took her to nearby clinic. Nurse said threads had not come out and referred her to main district hospital, where she got treatment for 2 days. Discharged and 4 days later started bleeding – got more treatment from nearby government health center		
	Journeys / pathways Left home, went to clinic, referred to main district hospital; back home and later to government health facility			
9) SB B.5	- Stillbirth - POD: Health facility (unspecified)	Despite being told twice baby in wrong position, at the time of labour she was told baby was fine. However, she went into labour when she was away from home so ended up in another clinic. Baby died during labor and the HW only told her that the baby died and said she did not know why	Stomach hurt a lot during pregnancy especially from 6 months till birth. She went to health center twice and was told baby in wrong position and got medicine but pain continued	<i>During ANC and labour</i> - Evidence-based practices - Competent, motivated human resources
10) SB B.6	- Stillbirth (Spouse of 9 above)	Pregnancy was problematic with many danger signs. She was repeatedly told baby in transverse position, at 1 time she was told she has twins, eventually baby went to right position. Parents say they tried their best till baby went back to position. Everything went well until delivery, where baby died. HWs told them it was fetal distress	Unclear if the actual danger signs were ever properly handled – looks like missed opportunity to do so in ANC	<i>During ANC</i> - Evidence-based practices - Competent, motivated human resources
	Journeys / Pathways Referred to other health facilities during pregnancy due to the various danger signs			
11) NND B.1	- Newborn death - POD: Health facility (unclear but maybe private)	Gave birth at 8 months. On arrival at facility was told she had a lot of “warmth” in womb and baby was dead. But baby was born alive though in bad state, treated with medicine. 1	- Preterm baby - Unavailability of critical drug needed for baby in 1st facility	- Evidence-based practices - Essential physical resources available

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	Journeys / Pathways Baby treated at place of birth, then referred to main district hospital, then again referred to private one	drug had to be bought elsewhere & before it came, baby worsened; was referred to main district hospital for oxygen, which they got there. On 2 nd night, oxygen in this hospital run out; baby unconscious & resuscitated and they were referred again to a private health facility where they spent 1 night & baby died	- Lack of oxygen in 1st facility - Main district hospital run out of oxygen which baby was getting - Multiple referrals	- Competent, motivated human resources - Effective communication with patients
12) NND D.2	- Newborn death - POD: Private clinic nearby (This was interview with a father)	Mother gave birth at 8 months. Mother had normal delivery and was discharged the next day. Father narrated that HWs told them they could go to main district hospital and baby is incubated to get to 9 months and survive. He also said they were told in the village, survival of preterms is up to God. They went home without any other guidance. Father said baby then got malaria two times and was treated at health facility. HW was nearby and checked on baby and said he would be fine since he was preterm by 1 month but still repeated that he could have been incubated in main hospital. Baby died when he got second malaria bout	- Preterm baby - Preterm baby discharged early and without any guidance e.g. KMC - Parents were told they could go to main hospital but it was not an actual referral- more of a suggestion it seems. With the additional words that baby's survival is up to God, they went home - HWs told parents baby had malaria and was treated for this in the health facility. Despite failed treatment, parents did not seek treatment elsewhere - Mother treated for malaria multiple times during pregnancy	Effective communication with patients
13) NND D.3	- Newborn death, after 5 days - POD: Health facility (unclear the type)	Mother gave birth in facility. Baby was born sick, the head had failed to come out and had a hole on the head and she said during delivery the baby was not well handled and he swallowed "dirty stuff". Baby treated from a health facility but mother was told about "swallowing dirty stuff" and that baby would not survive. The baby died shortly after treatment.	- No immediate referral for baby born sick - Unclear sickness / diagnosis	- Evidence-based practices - Competent, motivated human resources - Functioning referral systems

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14) NND D.5	- Newborn death - POD: Health facility – main district hospital	Mother had c-section, was told she needed it due to syphilis. Baby was delivered and taken to incubator and failed to breastfeed. Was given some water. Baby cried a lot for one day and turned pale and passed on after a day	- Mother had syphilis and pressure – both seem not to have been well treated (or treated at all). Missed opportunity in ANC/during pregnancy - Previous stillbirth - Problematic pregnancy with various danger signs	<i>During ANC</i> - Evidence-based practices - Competent, motivated human resources
15) NND D.6	- Newborn death - POD: Home	Mother had a normal pregnancy. She gave birth at home, with help of parents. The cord was covered and baby covered. Baby was normal but later got sick and cried the whole night. When baby eventually stopped crying in the morning, the mother dosed off. She woke up to find baby dead	- Home birth - Baby not taken to health facility after birth, so did not receive any newborn care	
16) NND D.9	- Newborn death - POD: Government health facility Journeys/pathways Went back to health facility of birth multiple times; eventually referred to main district hospital	Mother attended 4 ANCs and took all prescribed medicines. Father said that HWs were negligent during delivery and baby swallowed “dirty stuff”. They made parents buy syrups which baby was treated with and did not work. They were discharged, told to return on Monday which they did, then told to come next day for tetanus vaccine. Baby was badly off by Tuesday return & that’s when they were referred to main district hospital (government). Father said baby got tetanus. They spent 3 days in main hospital and baby died	- Negligence at birth - Poor newborn care in health facility - Delayed referral to main hospital	- Evidence-based practices - Competent, motivated human resources - Essential physical resources available - Functioning referral systems
17) SB D.1	- Stillbirth - POD: Main district hospital (government)	Mother got labour pains at 7 months. She started bleeding / fluids but these were yellow. She got the same labour pains at 8 and 9 months.	Mother had stomachache & vaginal discharge throughout pregnancy that seemed not to have been treated – missed opportunity in ANC	<i>Possibly during ANC</i> Evidence-based practices

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		At 9 months when the pains came, she went to main district hospital. HW alarmed by dirty discharge and sent her to an external facility for a scan, where it was discovered that baby was already dead-had died 2 days before. They didn't tell her though – it was the HW in main hospital who told her. She then had to deliver the baby and when this first failed, she was induced.	- Labour pains & strange discharge at 7 months - Unclear if mother reported the early pains and different discharge from 7 months to HWs	
18) SB D.4	- Stillbirth - POD: Government health facility	In the first week of the six month, mother felt the baby's movements had stopped. Her husband refused to give her money for a scan, so she asked her mother. Scan person told her the babys heart was not pumping and sent her back to ANC. The HW asked for her husband's number, called him to hospital and told him baby had died. The mother fainted and later got back to her senses', needed her pressure stabilized. The HWs asked for money for the delivery, and had to induce her. She was told which drugs to buy and sent home. (It was a week after bleeding that she noticed no movements)	- Mother got malaria, first ignored it and eventually it worsened and she had to get strong treatment - She also had bleeding, which the HW treated but did not check state of baby - Mother is also a GBV victim	Competent, motivated human resources
19) SB D.7	- Stillbirth - Main district hospital	Mother went in labour the first time to hospital but was told she wasn't due and went back home. The next time she came in labour was told same thing. She spent 2 days there and was told she was going to have surgery but delivered normally. However, the baby was tired and died in the process	- Newborn death in 2018. She said baby born well but HW knocked baby on head and it died. HW told her baby was preterm - Also said HW was very abusive during pregnancy so she was scared of her and barely went for ANC.	- Evidence-based practices - Competent, motivated human resources - Respect and dignity

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			For the stillbirth, maybe the delay to deliver baby was a cause / not doing c-sec	
20) SB D.8	1st was a stillbirth - POD: Home 2nd was a stillbirth - POD: Home	<i>First stillbirth</i> At 4 months of pregnancy, mother went to health facility and was told baby not in right position. She says at facility she was told to use herbs to change this, which she did and position changed. At 8 months she went to health facility and was told to do a scan cause baby might have died, there were no movements but had no money so couldn't do it. At the end of pregnancy she delivered alone at home, baby came out dead but with no injuries. Home delivery was because labour came suddenly, she couldn't walk to far facility & everyone else was away <i>Second stillbirth</i> Again, labour came suddenly at 9 months & she delivered at home. During delivery when she would want to urinate, some skin of baby would come out. In the earlier months she went to health facility and baby was alive.	<i>First stillbirth</i> - Did not do requested scan - Home delivery - Use of herbs - Did not have enough food most times due to lack of money - Didn't go to hospital after to see what caused baby's death – lack of awareness of parents <i>Second stillbirth</i> - Previous stillbirth 2 years before of unknown cause - Home delivery	Evidence-based practices
21) NND J.2	- Newborn death - POD: Health facility in the village (private FBO)	Baby was born in a health facility in the village but was tired and only lived for about 30 minutes. The facility did not have oxygen	- Baby was tired - Facility did not have oxygen	- Evidence-based practices - Essential physical resources available - Functioning referral systems
22) NND J.8	Newborn death	Mother got labour pains, went to health facility and was checked. Dr said she would deliver at 4	Delayed labour?	Evidence-based practices

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	• POD: Health facility (unclear type)	and left. At 4 she hadn't given birth. Her escorts asked dr to operate her due to pain but Dr checked her & asked her to be patient and said she wasn't in pain. Mother eventually gave birth at 7. But the baby was tired and only took a few breaths when put on mothers' stomach, did not cry and died.		• Competent, motivated human resources • Effective communication • Respect and dignity
23) NND J.4	• Newborn death • POD: Home	Mother went into labour at 7 months and gave birth at home. While they had sent for someone to take her to hospital, labour was rapid and by the time they returned she had delivered. Birth was successful and baby cried, visitors came to see the baby. However, the baby lived for one day only. The mother came out of the bathroom and found baby had died.	• Preterm baby • Baby was not taken to hospital for care after home birth • Possible missed opportunities in ANC to emphasize that even when birth happens at home and all seems ok, babies should immediately be taken to hospital for care	
24) NND J.6	• Newborn deaths – lost twins • POD: Roadside Journeys/pathways •	Mother was on her way to hospital but labour was quick and she gave birth on the roadside. There were no <i>boda bodas</i> (motorbikes). She then proceeded to hospital (unclear which type), and was told her babies were preterm, needed to be covered and directed to go to the main district hospital for appropriate care. However on arrival at main hospital, babies were already dead. Mother said she had a lot of pain during pregnancy – stomach ache, couldn't bend, walking was hard plus headaches.	• Preterm babies • Mother had a difficult pregnancy and though she was sent for a scan, it seems the different issues were not addressed • Transport delays getting to both health facilities.	<i>During pregnancy/ANC</i> • Evidence based practices • Competent, motivated human resources
25) NND J.3	Newborn death POD: Health facility (unclear the type)	Mother gave birth to baby in health facility but says the baby seemed to have malaria. Mother said the doctor never checked on them in hospital, simply told them to go home. At night	• Baby apparently not checked in hospital • Parental actions & awareness ○ Did not return sick baby to hospital	• Evidence-based practices • Competent, motivated human resources

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		the baby had a high temperature but was not taken to hospital. Mother bought and gave baby syrup, expecting temperature to go down but the baby died.	○ Gave syrup without checks • Previous loss, seems to be stillbirth	• Effective communication
26) SB J.7	Stillbirth at 7 months POD:	Mother spent about 2 months without feeling baby movements. She was in the village that time and when she returned to marital home is when she went to the health facility. She was sent for a scan and told baby was already dead and rotten. Mother also had episodes of bleeding during pregnancy, which got treated once and resumed. Also mentioned painful ribs.	• Mother did not immediately seek care when baby movements stopped • Uncontrolled bleeding • Other body pains	
27) SB J.1	Stillbirth POD: Health facility (unclear the type) Journeys/pathways Returned to same hospital twice	Mother went to the health facility (unclear level/ownership) at 7 months with a stomach pain. Dr told her she would deliver but she did not, so was treated and sent home. She said the placenta closed. At 8 months she again got stomachache and went to the facility. Told them she couldn't feel baby move either. Dr checked, said baby was alive but slow movement. She went back home, returned in intensive labour and gave birth, baby was dead and had wound on hand	• Health workers did not do scan to ascertain what was wrong • Sent her home despite her explanation of not feeling the baby • Had older child who died from sickle cells • Before the pregnancy that ended in stillbirth, mother had emergency surgery for "too much pus in stomach"	• Evidence-based practices • Competent, motivated human resources
28) SB J.10	Stillbirth at 9 months POD: Health facility (unclear the type)	Mother went into labour at 9 months, early in the morning and went to hospital [unclear which type], where she spent the whole day and delivered the next day. Dr checked and said she was ready to give birth. Mother was not told whether baby was alive or not. However on giving birth, she saw baby was	• Unclear whether it was fresh stillbirth or not. Mothers account seems to differ from what doctor said • Maybe the long labour was a contributing factor	• Evidence-based practices

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		dead and was told it had died 3 days before. Mother says she had been feeling movement all along, even on last day.		
29) SB J.5	Stillbirth at 8 months POD: Health facility (unclear the type)	Mother got strong malaria and lower abdominal pain. She went to the nearby clinics and bought medicine. However, she started bleeding and it was a smelly discharge. She said she was "lazy" and didn't have money, so by the time she went to get checked, the baby was already dead. Mother said she spent one month and a week without feeling baby's movements but thought reason was because she had been sick.	- Unclear if malaria was confirmed and what drugs she took - Had sickness in stomach that was not checked - Took long to go for check up when bleeding started - Mothers lack of awareness about danger signs - Lack of money – contextual factor (later in the interview she mentioned money needed to pay health workers at the government hospital as another deterrent)	- Evidence based practices (specifically to pharmacies and clinics that sell malaria drugs to pregnant women recklessly) - Competent, motivated human resources (their extortion of money deters care seeking)
30) SB J.9	Stillbirth at 7 months POD: Home	Mother said she was fine, not sick. One morning she suddenly got labour pains, her stomach ached a lot. So she decided to go to hospital but first went to bathe, which is when the loss occurred. The baby dropped out in the bathroom at home.	Unclear	
31) MiSc S.1	Miscarriage at 3 months POD: Health Center (unclear the type – seemingly private) Journeys/Pathways - Went to 2 facilities – in the 1st she wasn't given attention - Took long to heal, went for treatment	Mother went to 1 st facility with a lot of pain & bleeding, but says the health worker kept on ignoring her despite pleading to be checked. She eventually left and went elsewhere At this health center she was given medicine for 4 days plus an injection a day. When she went for first injection, she used the loo and felt baby almost coming out, could touch it. Health worker gave her 4 hours for baby to	- Previous miscarriage, unclear if cause was known - Delay in the first place where she was ignored - Maybe referral to main hospital could have been immediate?	- Respect and dignity - Competent, motivated human resources - Evidence-based practices - Functioning referral systems

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	that did not work at another health facility and then went back to the one where she had the baby removed for further treatment and recovered	come out or would be referred to main district hospital. She was induced by drip and after a few hours contractions stopped and couldn't touch baby anymore. When nurse checked, there was a lot of blood. Subsequently, baby was removed in parts. Mother was given a drip and some medicine. She took very long to heal		
32) NND S.2	Newborn death; baby born at 8 months and 2 weeks and lived briefly POD: Main district hospital	Mother woke up 1 morning, felt she was walking or sitting on something. Around 4pm when she felt worse and had contractions is when she called husband and went to hospital and gave birth. Baby went on oxygen, was crying but could not breastfeed and died at night.	• Preterm baby • Had another newborn death same year, baby born tired after long labour and died in a few hours • Mother also treated for malaria during pregnancy	• Evidence based practices
33) MiSC NND S.4	Newborn death at 4 days Place of delivery: Home assisted by TBA PODeath: District hospital Journey/Pathways Baby born at home, supported by TBA and taken to district hospital later	Mother got stomachache in the morning, stayed in that state all day and gave birth at home, supported by TBA around 9pm. Baby's cord was cut and they slept with everything fine. After 1 day, baby cried and started vomiting yellow; skin folding "like an old person's. Baby was then taken to the district hospital. They spent a night there and in the morning midwife said it seemed the baby was not being breastfed. Mother said she was doing so. Around 4pm baby was put on feeding tube. He started passing out things like blood through stool like tomato seeds, yet he had never	• Home birth • Baby not taken to hospital till it fell sick after 2 days • Was the newborn care appropriate?? • Mother had a miscarriage the previous year	• Evidence based practices possibly

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		passed stool. They put him on oxygen about 5pm and he finally stopped crying. However, baby passed on about 4am		
34) NND S.7	Newborn death at 24 hours POD: Health center II (PNFP)	At 9 months, the mother was taken to the health center II. She was in labour but not yet ready to give birth. When baby was eventually born, he was tired and needed resuscitation. Baby lived 24 hours and died	• Tired baby • Maybe quality of newborn care and resuscitation • Typically, health center IIs not meant to conduct deliveries. Perhaps they should have referred baby after resuscitation	• Evidence based practices possibly • Competent, motivated human resources • Functioning referral systems
35) NND S.5	Newborn death PoD: Health center (Government)	Mother had a stomach ache at 8 months and was taken to health facility, knowing she wasn't yet 9 months. Midwife examined her, gave her coartem and said labour had just started so they should go home and return if pain increases. Pain got worse at 1am and they worried how to go back but got someone to take them around 2am. Father narrated that as she delivered as soon as they reached but alone, because the midwife delayed to come to attend to them. He said baby was panting, probably got cold from hypothermia, and eventually died around 10am. He said midwife was just moving around and did not refer them	• Preterm baby • Birth poorly handled • Poor newborn care • Mother got treated some weeks before (sickness not mentioned)	• Evidence-based practices • Competent, motivated human resources • Functioning referral systems
36) NND S.6	Newborn death POD: Main district hospital Journeys/pathways	Mother first got a terrible headache, followed by body aches then shivering and feeling very cold. Legs started paining, then she couldn't feel them. Contractions started around 4pm amidst these other signs.	• May not have had malaria but potentially pre-eclampsia undiagnosed? • Stayed in labour for long without emergency c-sec	• Evidence based practices • Competent, motivated human resources • Respect and dignity

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	- Was first taken to a nearby health center - Referred to main district hospital	She was taken to nearby health center where health worker said she had malaria but referred her to the main district hospital There she was told she would be worked on following day since she had malaria. However by 2am she felt worse, started bleeding at 5am and when midwife was called she said baby was getting out. She ended up having a natural birth, after a previous cesarean and a big baby Baby was said to be tired and put on oxygen. Mother didn't have breast milk and baby tried to feed and cried. Later in the morning, baby had high temperature and was panting. Mother was called and found baby being resuscitated twice, and eventually baby died. (Mother reported that health worker was rude and slapped her during that resuscitation)		
37) NND SB S.9	Newborn death POD: Health facility (unclear the type)	Also had a c-sec. They first treated mother's pressure because it had risen up. The baby was alive for a day then died. The second baby was eight months old	- Previously had a stillbirth – she went to hospital in labour and was told baby had no heartbeat and had died because the mother had high pressure. She had a c-sec cause baby was too big - Pre-eclampsia - Preterm baby	Evidence-based practices
38) NND SB S.8	Stillbirth POD: Regional referral hospital	When labour started, she went to the main district hospital. However, she was bleeding and the hospital did not have blood for group O. She was transferred to the regional referral	- Difficult labour with bleeding - Time spent seeking care in 2 places and being transferred	- Essential physical resources available - Functioning referral systems

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	Journey/Pathways First went to the main district hospital Then was transferred to the regional referral hospital	hospital but by the time she arrived, the baby was dead. Mother also had a blood transfusion (Same mother later had a twin birth where one twin died during labour and the other ended up on oxygen but survived)		
39) SB S.3	Stillbirth POD: Private health facility	Mother said she attended ANC regularly and did not have any sickness like malaria. It's in the first months where in pregnancy she has extreme vomiting then stabilizes at 5 months. She went for routine ANC on a Tuesday at a private health center, where midwife listened to baby's heartbeat and mother heard it. The only thing was her and the midwife had different due dates. The mother decided to go for a scan at another private facility to confirm due date and sex on Friday. However she was shocked to learn from scan that the baby was dead. She rung a health worker friend who sent her to another private clinic where doctor verified results. She was induced and gave birth to the dead baby	No known reason or indication	
40) SB S.10	Place of delivery: TBA's home	On the day the baby died, the mother had a lot of pain in the uterus area the whole day. She went to the nearby Traditional Birth Attendant (TBA). She said she regularly got herbs from her because her husband would fight if she asked for money for drugs.	- Seeking healthcare from a TBA who gave herbs without medical tests - Mother suffered domestic violence, including physical beating and emotional stress during pregnancy, with a history of domestic violence in previous and current pregnancy (she was pregnant at time of interview)	Contextual issues

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		The mother also reported that she had been badly beaten and had gone to get some medication after. However, as she was getting out of the door to go to the toilet, the baby almost fell out in the doorway so she squatted. The TBA was escorting her guests when her child called to tell her that the baby had come out but is dead. The mother says the baby came out when the body was all broken and the TBA sent for an ambulance.	Mother said she fed poorly	
41) Misc W.8	Miscarriage – between 4 to 4.5 months POD: Home Journeys/Pathways Miscarriage happened at home. Mother went to private facility after 4 days of bleeding to seek further care	Mother woke up with a back ache. All of a sudden, while she was standing in the sitting room, she started bleeding so much. When she ran out of the house to call her mother in law, the baby fell out. Mother explained that the previous day, there was an earthquake and culturally this is believed to cause pregnancy loss. To counter this, her mother in law asked her to rub her back with some cinders and also gave her herbs to swallow. After the miscarriage, they bought drugs and pressed her body with warm water.	- Could be the herbs swallowed? - Mother emotionally/mentally stressed - Also previously lost a child though unclear what age	Contextual issues
42) MiSC W.4	1st Miscarriage happened about 1.5 months – at home 2nd miscarriage also about the same time	<i>First miscarriage</i> Mother did not have any problem but woke up around 5am bleeding. She bled till evening when a small thing fell out, which elders said was a child	- Had 2 miscarriages in one year (May and December) - Aside from basic check after 1st one to ensure baby was out and she was ok, doesn't seem to have done a more detailed check for possible causes.	- Contextual issues - Previous APO

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		- Next day she went to health facility for check, got drugs and was fine otherwise <i>Second miscarriage</i> - Got stomach pains at night and rung her grandmother who told her to go home. The next morning she went but still with stomach ache. Her granny said the cause was spiritual issues from another side of the family - Mother continued to bleed all day, until baby came out at night. Baby was buried next day and mother did not go to hospital	- With 2nd miscarriage, mother also did not go to hospital when bleeding started - Maternal and community beliefs in cause of miscarriage as spiritual	
43) NND W.9	Newborn death at about 4 days POD: Home of Village Health Team member (Community health worker) Journeys / Pathways Went to main district hospital after 3 days; spent a night and was referred to regional referral hospital but baby died before getting there	Mother came from the garden and got very sudden contractions, and her water broke. She was taken to the nearby VHT to be examined, but she literally gave birth as soon as she got there. A <i>boda boda</i> (motorbike) was called to take her to hospital but arrived when she had delivered and rain had started. Mother went back home with the newborn. However, baby was okay at first then stopped suckling, was crying and turned yellow. Mother went to health facility after 3 days. She said the baby was very small, less than a kg. The health workers examined the baby and said it was suffering from tetanus and hunger. The child was given drugs, spent one night there and when condition worsened, they were referred to the regional referral hospital. But	- Community birth and baby was not taken to hospital immediately after - Delayed care seeking for newborn, done when baby was already in a bad state.	- Evidence-based practices - Functioning referral systems

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		baby died while they were leaving the main district hospital		
44) NND W.1	Newborn deaths (both twins died) POD: Home Journeys/care pathways After babies were born at home, they were taken to the main district hospital, where they died.	Mother went into labour at 3pm. However she was home alone and unable to call anybody for help or to get a motorbike. The labour was rapid so she laid a polythene on the floor and pushed out both babies. Around that time is when people returned home and run to call the nearby health worker to cut the cords. The babies were wrapped up and taken to the main district hospital that very day by other people helping, while the parents followed shortly after. They arrived when babies were still alive and on oxygen. However, the health workers were reportedly needing to be begged for attention. Additionally, mother says she was told by those who went ahead that the health worker hit one baby on the head who then died. The other also died shortly after	- Babies born preterm - Homebirth - Some delays in getting to hospital although they did try to hurry considering circumstances - Slow response / negligence of health workers on arrival - Lack of clarity on whether the baby was hit on the head and why.	- Functioning referral systems - Competent, motivated human resources - Evidence based practices
45) NND W.7	Newborn death at about 4 days POD: Traditional birth attendant's (TBA) facility Journey/Pathways - Mother gave birth at TBA's - First went to nearby health center when baby got sick	Mother went into labour at night and went to the Traditional birth attendant's (TBA) "health facility". She was in labor until 1pm the next day when she gave birth. Baby was reportedly well and suckled and they went home at 2pm. Shortly after, baby got a very high temperature, so they rushed baby to nearby health center (seems public), which said they don't have a room for young kids and referred	- Gave birth at TBA's facility and was not immediately taken to hospital: maybe got infection in that process - Lack of maternal awareness that after community birth, baby should go to hospital	Essential physical resources available

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	Referred and went to main district hospital a few hours later when baby got sick	them to main district hospital, where they went, about 4pm. They started treatment but child stopped breastfeeding, and all milk put in mouth would pour out. Child turned yellow on 2nd day and was put in machine for about 1 day, though kept crying and was vomiting “yellow things”. Baby died around the 4th day and parents went home to bury		
46) NND W.2	Newborn death, just over 2 weeks old POD: Private health facility Journey/Pathways - Started at health center during labour & was referred - Went to main district hospital which gave drugs and discharged her - Back home and then to private facility where she was operated on - Baby referred to national referral hospital	Mother went into labour that was on and off for about 1 week. So she first went to small health center on Friday, which told her they don’t conduct deliveries and her contractions are few so they referred her to main district hospital. She went to main district hospital on Sunday and was told the uterus hasn’t opened but maybe the child has malaria. She was given drugs, urine checked and scan done though scan results told to husband not her. She was told to return for operation if labour resumed. On leaving, the pain intensified and she study bleeding. Lady and her mother chose to go to a private facility because they had suffered at main district hospital. There, she was told uterus had just opened. She was operated in the morning when doctor came.	- Baby born with abnormality - Probably labour could have been handled better in main district hospital, thus faster newborn care - Having to move from another district to national referral for care repeatedly - Mothers next birth also ended up in newborn death. Baby was born well but then turned yellow, started foaming at the mouth and died shortly after (about 4 hours after birth); health workers said baby had a lot of malaria	- Evidence-based practices - Competent, motivated human resources

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	* Interview also done with father	However, baby was born with intestines coming out of vaginal area, so was referred to the national referral hospital where they went next day (in another district). Even there they first needed connections to get to right ward, having spent night in wrong place unattended to. Baby was worked on, that place covered with a polythene that was changed frequently and discharged after 3 days with more treatment but not operated. They went back for check after 1 week as told and were told baby would be fine, though wasn't breastfeeding well and were told to buy certain baby food and that baby should be 10kgs before operation. On return home, baby was still in pain and died after 3 days.		
47) NND W.3	Newborn deaths of twins POD: Main district hospital Journeys/Pathways - Went to main district hospital - Was sent somewhere else for scan - Back to main district hospital - Referred to regional referral hospital	Pregnancy was difficult, with abdominal pain from the start, for which health workers gave her different drugs. The last time she went with bad stomach ache just before birth, she was examined by a student nurse who said maybe she was using dirty toilets, but no older midwife At 6 months she woke up with labour pains at 8am that kept increasing and her water broke. When she pressed the abdomen, a lot of blood started coming out. She was taken on a boda (motorbike) to main district hospital.	- Babies born preterm - First hospital having inadequate oxygen - Having to go to another hospital about 30 minutes away - Mother also had troublesome pregnancy - Last check was by a student nurse, which was a missed opportunity possibly for health workers to detect what was happening. Mother did not even know she was expecting twins - No mention of KMC being done	- Essential physical resources available - Competent, motivated human resources - Evidence-based practices

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		She was told she was having a miscarriage, sent to scan and 2 babies discovered. Shortly after she gave birth around 10am and both were put on oxygen. There was little oxygen though so they were referred to the regional referral hospital where they went by ambulance. The one born earlier died that day, while the other died after 3 days.		
48) NND W.5	NND at 6 months POD: Main district hospital	The mothers stomach started paining and she was bleeding at night. She woke up in the morning still bleeding and went to the main district hospital. She was first given tablets, but the pain increased. She was then given injections to bring contractions. She delivered but the baby died after about 10 minutes	• Preterm baby • Mother had previous miscarriages (or preterm births)	○ Previous APO
49) SB W.6	Stillbirth at 7 months, lost twins Place of delivery: TBA	Mother says she went for antenatal at a government health facility frequently but the health workers were always puzzled, saying they are not seeing anything. They told her to go to the scan, which she did 4 times, but each scan was saying that there is a lot of water in the stomach and kids are swimming in water. They needed to do an operation so that the children are removed and taken to an incubator. However, her husband did not have the money for the operation. After 2 weeks she had a terrible backache, with a discharge from her private parts. After 2 days	• Health workers uncertain • Lack of available care at required time • Poverty	• Evidence based practices • Competent, motivated human resources

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		she went to seek care but it was a Sunday and nearby health facility was closed so she said she was advised to go to the Traditional Birth Attendant (TBA). Shortly after she gave birth to the first baby. The second one delayed and the lady put her on a drip, then baby came out. People present told her they were already dead when born.		
<i>*Two sets of respondents were couples, so only one is recorded in this matrix because the details are the same</i>				