Mugaaga INOSR Experimental Sciences 11(2):134-147, 2023. ©INOSR PUBLICATIONS International Network Organization for Scientific Research

ISSN: 2705-1692

Evaluation of the Infant Mortality rate at Ishaka Adventist Hospital Bushenyi District

Mugaaga Paul

Department of Clinical Medicine Kampala International University, Uganda.

ABSTRACT

Infant mortality is defined as the death of an infant before his or her first birthday, mainly caused by dehydration, diseases, congenital malformations and infections. The main objective of this study was to establish the determinants of infant mortality in Ishaka Adventist Hospital (IAH) in the months of April-July 2017, in Ishaka municipality in Bushenyi district. A descriptive cross sectional study design was used to determine the determinants of infant mortality in the study area. Majority of respondent (98%) were female and among them, 25.5% reported to have lost at least an infant and most of these respondents (70%) were married while 5% were widowed and among these, 40% reported to have lost an infant. Religiously, majority of the respondents (80%) were Christians, while 13% were Muslim and 7% constituted other religions including paganism, which showed the greatest infant mortality rate (71.4%). Most of the respondents (65%) attained primary level of education while 5% did not go to school at all, and the highest infant mortality rate (40%) was reported among these. The respondents who reported to have had preterm births appeared to have a higher infant mortality rate (65%) than those who did not report preterm births. A higher infant mortality rate (32.2%) was realized among respondents who reported their infants to have had such co morbidities than those who didn't report any co morbidities like malaria and also a higher infant mortality rate (50%) was realized among infants who had not exclusively breastfed. Majority of respondents (80%) did not have children with birth defects while only 20% had children with birth defect, and a higher infant mortality rate of 70% was realized among these. Demographically, infant mortality rate is high among teenagers, the unemployed, the widowed, the pagans, and the uneducated. Direct determinants of infant mortality rate included preterm birth, birth defects, comorbidities and failure to breastfeed exclusively. Proximate determinants associated with infant mortality rate included teenage pregnancies, source of water, means of delivery and irregular immunization. Exclusive breast feeding for 6 months, mass immunization campaign up to grass root, intensive health education on health seeking behaviors and highlighting on dangers associated with risky behaviors and high quality monitoring and evaluation for quick action particularly for emergencies. There is also need for intersectional collaboration and initiation of income generating activities to boost their standards of living.

Keywords: Infant mortality, Breastfeeding, Morbidity, Determinants, Respondents.

INTRODUCTION

Infant mortality is defined as the death of an infant before his or her first birthday. It is a useful indicator of the nation's health because it is often associated with other factors such as maternal health, quality and accessibility of medical care and social economic conditions. The leading causes of infant mortality are dehydration, diseases, congenital malformation, infection, drugs and alcohol, sudden infant death syndrome [1-4]. Other factors that cause and/or contribute to infant mortality are prenatal care, mother marital status, social and income status, poverty race, smoking and substance abuse, air pollution and environmental factors. Infant mortality is also defined as the number of newborns dying under a year

divided by the number of live births during a year [5-8]. One of the millennium development goals (MDGs) is the reduction of infant and child mortality by two thirds by 2015. In order to achieve this goal, efforts are concentrated at identifying cost effective strategies as many international agencies have advocated for more resources to be directed to health sector and vet the leading causes of infant death have not changed in the last several years despite the advanced technology and increased focus on parental care [9]. High infant mortality rates are much more prevalent in developing nations [10-12]. Many of the relevant variables can be demographic classified as or socioeconomic. A higher level of economic development leads to an improved standard of living with better nutrition and advanced medical technology [13-17]. Education level, employment, income, family and social support and community safety are all components of social and economic determinants of health [18-20]. Amouzou [21] suggested that the increase in the mortality in sub-Saharan Africa is due to the impact of HIV/AIDS epidemic especially in this region and the continuous economic crisis, in sub-Sahara region of east and North Africa. According to Adlakha et al. [22] demographic factors such as maternal age and birth intervals generally have more of an impact in nations with the lowest level of industrialization and economic development however, with increasing social economic development. These demographic factors tend to have less impact particularly when compared to social and economic factors such as education and access to health facilities. Infant mortality is an important indicator of successful implementation of poverty eradication action plan (PEAP). Infant mortality is therefore an important health issue but it must be stressed from the beginning that the health sector is not the only sector responsible for the infant mortality outcome [23].

Statement of Problem

Infant mortality rate (IMR) is one of the most important sensitive indicators of social economic and health status of the

community. This is because more than any other age group of a population, infants' survival depends on social economic conditions of their environment. It's one the united nations (UN) human of development index. Hence its description is very vital for evaluation and planning of public health strategies. In Kenva approximately eight out of each 100 live births die before their first birth day representing a huge wastage of potential man power so achieving the MDG means simply reduction in Kenyan IMR to about 22.0 per1000 live births by 2015. Amongst regions making insufficient progress of this goal, sub Saharan Africa remains the most troubling region. In the United States infant mortality rate is about 6.86 per 1000 births. The loss of babies remains a sad reality for many families and takes a serious toll on health and wellbeing of families as well as the nation. Uganda infant mortality rate; total 62.47 deaths /1000 live births. Male: 72 deaths /1000 live births Female; 52 deaths /1000 live births. Majority of deaths have been due to infectious diseases such as malaria. measles, AIDS and malnutrition [9]. The lower probability of dying in infancy period for females compared to males is consistent with many studies all over the world. It has been reported that for biological reasons males are more prone to die in the first month of life. The probability is almost the same after overcoming the executive breast feeding period [24]. Despite concerns over the most recent poverty numbers, Uganda has experienced rapid economic growth over the past fifteen years with concomitant reduction in poverty numbers, despite this progress, there is concern in Uganda that living standards are not improving by anything like quantitative analysis of house hold expenditure suggests. Other dimensions of wellbeing especially health are not improving in particular infant mortality rate [25]. Infant mortality in Uganda has stagnated at a high level over the last 5 years without improving much over the last 30 years. An obvious question is therefore to examine why this is happening [23]. Infant mortality rate can be associated with the wellbeing of the

population. High infant mortality rates could reflect improper childcare. A population with diseased and un healthy individuals who grow up to form sickly prone to disease. dampens adults economic progress in many ways; it decreases work productivity, it does not allow utilization of natural resources that would otherwise be accessed under good health conditions. it harms the next generation by decreasing enrollment of children in school and finally it increases medical care expenditure [26].

Aim of the Study

To assess the determinants of infant mortality among infants attending Ishaka Adventist Hospital (IAH) in the months of April- May 2017, Ishaka municipality in Bushenyi, district.

Specific Objectives of the Study

- To find out how the sociodemographic factors relate to infant mortality in IAH, Ishaka municipality in Bushenyi district.
- To assess how direct determinants relate to infant mortality in IAH, Ishaka municipality in Bushenyi district.
- To determine how proximate determinants relate to infant mortality in IAH, Ishaka municipality in Bushenyi district.

Area of Study

Ishaka Adventist Hospital is located in the Ishaka-Bushenyi municipality in Bushenyi District. It is composed of 3 divisions i.e. Ishaka, Nyakabirizi and Central Division and each division is divided into wards which are further divided into cells. Ishaka town council which is the area of study is in Igara County- Bushenyi district in the South Western of Uganda. It's bordered by Kasese in the North, Kamwenge in the North East, Mbarara in the East, Rukungiri in the West and Ntungamo in the South. The district has a total land of 3949 square kilometer and a population density of 181 persons per square kilometer and a total population of 738,355 (as per 2002 population and housing census). It's mainly inhibited by Banyankore but others

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Research Questions

- How are the socio-demographic factors related to infant mortality in IAH, Ishaka municipality?
- How are the direct determinants related to infant mortality in IAH, Ishaka municipality?
- How are the proximate determinants related to infant mortality in IAH, Ishaka municipality?

Study Justifications

Infant mortality rate is a factor that that can be associated with the wellbeing of the population. A population with diseased and unhealthy individuals who grow up to form sickly adults prone to disease dampens economic development in many ways [26].

Therefore, this research study will be beneficial to the parents and guardians to learn how to care for their infants very well right from prenatal period.

It will benefit the district health office Bushenyi district to get information about the determinants of infant mortality in the district. The community will benefit from health education on sanitation, nutrition and early detection of diseases like malaria using signs and symptoms. The community will also be advised to always seek for treatment for their infants from the nearby health facility and avoid selfadministering medications.

METHODOLOGY

tribes like Bakonjo, Batooro, Bakiga and other tribes' especially from the foreign students studving at Kampala International University-Western campus who also live there. Bushenyi has a tropical type of climate with rain season in January, April, May, June, September, October, November and half of December. Dry season is in February, July and August. The soils are fertile for food crops like Matooke, Beans, Maize, Tea, Coffee, Cotton are main cash crops for the District. The hospital is a 110-bed community hospital that is owned and administered by the Seventh Day Adventist Church in Uganda. It primarily caters to the health needs of the people who live and work within Ishaka-Bushenyi region as well as people from the neighboring districts. As

of May 2017, the hospital's professional staffs included: 1 Chief Executive Officer, I Human Resource and Administration officer, 4 Medical Doctors, 8 Clinical Officers and about 70 nurses, midwives, nurse's aides and other subordinate staffs. The hospital runs two health training schools; a nursing and medical laboratory training school.

Study Population

The study was done in IAH in Ishaka Municipality, Bushenyi district among parents or guardians who brought their children to the hospital.

Study Design

A descriptive cross sectional study design was used to determine the determinants of infant mortality in the study area.

Sample Size

This was calculated using Fisher`s formula $n = z^2 p q$

n= defined sample size

z = standard deviation of desired degree of accuracy

p= population proportion with the desired characteristics

r= amount of error acceptable

q= population proportion without desired characteristics

p=0.92

$$q = (1-p)$$

r= 0.05

 $n= (1.96)^2 \times 0.92 \times 0.08 \\ (0.05)^2$

n=100.

Sampling Methods

Simple random sampling method was used to select respondents among parents who

Socio-Demographic Data

In this study, majority of the participants (60%) were in the age range of 25-34 years while majority were female by sex 98% and majority reported to be married (70%) while majority (80%) were Christians and majority were found to be peasants (85%).

brought their Children to the health facility visited by the investigator.

Data Collection Method

Data was collected using questionnaires.

Data Analysis and Presentation

Data was analyzed manually using tallies and electronic calculator. Then the data was presented in the form of bar graphs, tables and pie charts.

Data Quality Control and Pretest

The questionnaire was written in simple and ordinary English that could easily be understood. The questionnaire was pretested to ensure clarity and translated to local language. Respondents were randomly picked to avoid bias.

Ethical Consideration

- i. An introductory letter was sought from the SAHS administrator.
- ii. The letter was given to IAH administrator to permit me to conduct and collect data from the hospital.
- iii. Participants were explained about the study in the language they best understood and a signed consent obtained from them before being enrolled for the study. Confidentiality was maintained by coding the questionnaires.

Inclusion Criteria

Parents who brought their children during the month of April-May 2017 were given questionnaires and were included in the study.

Exclusion Criteria

Parents and guardians who were coming back for review to IAH, Parents and guardians who brought their children before and after the months of April and May 2017.

RESULTS

The study also revealed that the biggest number of participants had at least attained a primary level of education (65%) and lastly majority of the participants reported to be Banyankore by tribe (80%), all these details are shown in the table below.

Characteristics	Category	Number	Percentage
Age	15-24	20	20
	25-34	60	60
	35-44	16	16
	Above 45	4	4
Sex	Male	2	2
	Female	98	98
Marital Status	Married	70	70
	Single	1	1
	Divorced	24	24
	Widowed	5	5
Religion	Christian	80	80
	Muslim	13	13
	Others	7	7
Occupation	Business	5	5
	Employed	7	7
	Peasants	85	85
	Others	3	3
		0.7	~ -
Level of education	Primary	65	65
	Secondary	20	20
	Tertiary	5	5
	None	10	10
Taille e	Demonstrale	00	20
Tribe	Bahyankole	80	80
	Bakiga	15	15
	Baganda	4	4
	Others	1	1

http://www.inosr.net/inosr-experimental-sciences/ Table I: shows socio-demographic characteristics of respondents (n=100)

Characteristics	Category	Number	Percentage	Have lost an infant	Have not lost an infant
Age	15-24	20	20	12(60%)	8(40%)
	25-34	60	60	6(10%)	54(90%)
	35-44	16	16	5(31.1%)	11(68.9%)
	Above 45	4	4	2(50%)	2(50%)
Sex	Male	2	2	0(0%)	0(0%)
	Female	98	98	25(25.5%)	73(74.5%)
Marital Status	Married	70	70	14(20%)	56(80%)
	Single	1	1	1(100%)	0(0%)
	Divorced	24	24	9(37.5%)	15(62.5%)
	Widowed	5	5	2(40%)	3(60%)
Religion	Christian	80	80	18(22.5%)	62(77.5%)
	Muslim	13	13	2(15.4%)	11(84.6%)
	Others	7	7	5(71.4%)	2(28.6%)
Occupation	Business	5	5	1(20%)	4(80%)
	Employed	7	7	1(14.2%)	6(85.8%)
	Peasants	85	85	23(27%)	62(73%)
	Others	3	3	0(0 %%)	3(100%)
Level of	Primary	65	65	19(29%)	46(71%)
education					
	Secondary	20	20	2(10%)	18(90%)
	Tertiary	5	5	0(0%)	5(100%)
	None	10	10	4(40%)	6(60%)
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Tribe	Banyankole	80	80	22(27.5%)	58(72.5%)
	Bakiga	15	15	3(20%)	12(80%)
	Baganda	4	4	0(0%)	4(100%)
	Others	1	1	0(0%)	1(100%)

Table II: Showing how socio-demographic factors associate to infant mortality (n=100).

Direct Determinants of Infant Mortality

The study revealed that, few of the participants (20%) reported to have ever had a preterm birth while majority (62%) reported that their infant had ever had co-

morbidities at one time and majority of participants also reported to have exclusively breastfed their infants while only 20% of the participants reported their infants had birth defects, all these details are as shown in the table below.

Table III: shows distribution of the direct determinants of infant mortality (n=100) among the study participants at IAH, Ishaka-Bushenyi District.

Characteristics	Category	Number	Percentage
Preterm Birth	Yes	20	20
	No	78	78
Co morbidities	Yes	62	62
	No	38	38
Exclusive	Yes	70	70
Breastfeeding			
	No	30	30
Birth defects	Yes	20	20
	No	80	80

Among the participants that reported preterm births, majority of these (65%) reported to have lost an infant, while of

those that reported to their infants to have had co-morbidities, majority of these.

Table IV: shows how direct determinants	s relate to infant mortality (n=100)
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Characteristics	Category	Number	Percentage	Have lost an infant	Have not lost an infant
Preterm Birth	Yes	20	20	13(65%)	7(35%)
	No	78	78	12(15.4%)	66(84.6%)
Co morbidities	Yes	62	62	20(32.2%)	42(67.8%)
	No	38	38	5(13.2%)	33(86.8%)
Exclusive Breastfeeding	Yes	70	70	10(14.3%)	60(85.7%)
	No	30	30	15(50%)	15(50%))
Birth defects	Yes	20	20	14(70%)	6(30%)
	No	80	80	11(13.8%)	69(86.2%)

Proximate Determinants of Infant Mortality

The various proximate determinants of infant mortality got from the participants were as follows as represented in table V.

Characteristics	Category	Number	Percentage
Source of water	Tap water	50	50
	Other sources	50	50
Teenage Pregnancy	Yes	70	70
	No	30	30
Prompt	Yes	80	80
Immunization			
	No	20	20
Mode of delivery	From home	35	35
	From Health facility	65	65

Table V: shows the direct determinants of infant mortality (n=100)

Table VI: shows how proximate determinants associate to infant mortality (n=100).

Characteristics	Category	Number	Percentage	Have lost an infant	Have not lost an infant
Source of water	Tap water	50	50	7(14%)	43(86%)
	Other sources	50	50	18(36%)	32(64%)
Teenage Pregnancy	Yes	70	70	20(28.6%)	50(71.4%)
	No	30	30	5(16.7%)	25(83.3%)
Prompt Immunization	Yes	80	80	13(16.3%)	67(83.7%)
	No	20	20	12(60%)	8(40%)
Mode of delivery	From home	35	35	15(42.9%)	20(57.1%)
	From Health facility	65	65	10(15.4%)	55(84.6%)

DISCUSSION

Demographic Data

Most of the respondent age factors especially maternal age lays an impact in child care. These are in line with findings of impact in nations with low levels of industrialization, age as one of the factors that have (60%) were between ages of 25-34 years. Majority of respondent (98%) were female and among them, 25.5% reported to have lost at least an infant. This is attributed to the fact that in Africa, the art of looking after children is mostly bestowed up on women especially among the low educated communities. The practice of irresponsibility by the male partner puts infants at a greater risk of mortality from the course as women get overwhelmed with the burden of meeting the treatment costs. This finding concurs with finding of Huisman [27], who stated that gender can determine health inequality and particular diseases man and women suffer from. Poor women tend to have diabetes, cancer and infant mortality.

Most of the respondents (70%) were married while 5% was widowed and among these, 40% reported to have lost an infant. This is attributed to the high rate of early marriages in the study area. Marriage indirectly influences the survival of an infant as there is collective responsibility of rising up the infant. These findings are with line with the ministry of finance, planning and economic development report [23], which stated that in marital status matters, mothers who are widowed divorced or separated experience higher infant mortality than the married ones. These findings are also concurring with the finding of Benef et al. [8] who stated marital status as being one of the factors affecting infant mortality. Majority of the respondents (80%) were Christians, while 13% were Muslim and 7% constituted other religions including paganism, which showed the greatest infant mortality rate (71.4%). Religious morals influence the type of care parents give to their infants. This may increase or decrease infant mortality for example Christians and Muslims generally do not believe in human sacrifice to their gods of fortunes while other religions do believe in human sacrifice to their gods of fortunes or to appease them. In turn their may sacrifice their infants or even for other people in order to get fortune like riches, good harvest among other things. These findings concur with WHO report 2000 which stated that Christianity/ Islam may be associated with low mortality while traditional religions or atheism may associate with high mortality [28].

Majority of respondents (85%) were peasants while 3% engaged in other activities like fishing, and offering occasionally manual labor in unsafe areas and these showed the highest infant mortality rate (27%). These results show that there is high level of unemployment in the study area. This makes most residents to have little income and as such unable to overcome daily challenges including treatment costs in case the infant fells sick and therefore infants from this kind of family are at risk of dying any time should there contract a medical or surgical emergency. These findings agree

with findings of Moaddel [17] who stated that high infant mortality rates are prevalent in developing nations than industrialized nations, many of the relevant variables being social economic factors. Most of the respondents (65%) attained primary level of education while 5% did not go to school at all, and the highest infant mortality rate (40%) was reported among these. many respondent s at least attained primary education after which there could not proceed to secondary school as they could not afford school fees among other reasons low level of education has an impact on the reasoning capacity of an individual and hence parental care offered to the children, this concurs with UN report, that cited education level as one of the determinants of health. Majority of the respondent (80%) were Banyankole while only 20% constituted other tribes like Bankozo, Iteso, and Bagishu. Infant mortality rate was highest among the Banyankole (27.5%) since most of the respondents (80) were of this tribe. Cultural practices also impact on the health of infants such as tattooing, false teeth extraction to mention but few [29].

Direct Determinant of Infant Mortality

All of the female respondents (100%) had ever been pregnant. Most of respondents (70%) had pregnancies lasting for nine months while 20% had pregnancies for less than seven months. Almost all 99% the stated that their respondents who pregnancies lasted for less than seven months stated that their infants didn't grow up well. The respondents who reported to have had preterm births appeared to have a higher infant mortality rate (65%) than those who did not report preterm births. Preterm birth is associated with several complications including infections and birth asphyxia. hypothermia. This predisposes infants to early death. Preterm birth is rising in most countries and is now the leading cause of death in children under five [30].

Most of the respondents (60%) said that their infants suffered from malaria while only 2% constituted others that included chicken pox, constipation and malaria in the study area. The weather conditions in

the study also favor the breeding of mosquitoes as there are two seasons that is rainy and dry season. The mosquitoes breed well in stagnant water, none use of insecticides treated nets makes family members more vulnerable to mosquito bites and hence malaria infection. A higher infant mortality rate (32.2%) was realized among respondents who reported their infants to have had such co morbidities than those who didn't report any co morbidities like malaria. These findings are in line with UNICEF and other reports that stated that malaria is one of the most leading risk factors for infant mortality and sub optional growth and development [31-34]. Malaria has a serious social and economic impact in Africa, slowing economic growth and development and perpetuating the viscous circle of poverty [35, 36, 37, 38, 39, 40]. A big number (70%) said that they breastfed their infants as often as possible while a few did not. A higher infant mortality rate (50%) was realized among infants who had not exclusively breastfed. Such infants are prone to infections or even malnutrition and this carries a great risk of infant mortality. These findings concur with findings in [30] which states that malnutrition makes children more vulnerable to severe diseases and is underlying factor in about one third of (www.harrisburg child death health start.com). Majority of respondents (80%) did not have children with birth defects while only 20% had children with birth defect, and a higher infant mortality rate of 70% was realized among these ones. Congenital birth defects such as congenital heart defect predispose infants to early death especially in our setting (Africa), where majority of families are financially handicapped and cannot meet the costs cardiac operations. Those whose families grew up well could have been having minor birth defects such as cleft lip, cleft palate, clubfoot among others. This is in line with Angella Morrow [37], who stated that congenital defect also known as birth defect occur while a fetus is developing in womb and that the most severe congenital defect proves fatal and lead to infant death [37].

Proximate Determinants of Infant Mortality

Proximate determinants of infant mortality, most of the respondents (70%) had their pregnancies before 20 years of age while 30% had their first pregnancy after 20years of age, nearly half of the respondents 49% experienced complications during pregnancy while 51% didn't experience complications. Teenage pregnancy is always at high risk of pregnancy and birth complications and this predisposes to infant mortality. Complications like cephalopelvic disproportion could lead to assisted deliveries such as vacuum extraction of caesarian delivery and this also may cause injury to the infant and hence predispose them to infections. The respondents who reported to have had teenage pregnancies were seen to have a higher infant mortality rate (28.6%) compared to those who did not report any teenage pregnancy. These findings are in line with Uganda ministry finance, planning and economic of development (UMFPE) [23], which stated that teenage pregnancies have a higher risk of leading to infant mortality. This is also in line with the findings of Angela Morrow [37]. Half of the respondents [50%] obtain water from the tap while the rest (50%) obtained water from other sources which included rain water. Usage of water from other sources was seen to be associated with a higher infant mortality rate (36%) compared to usage of tap water. These results indicate that most of the respondents do not still have access to safe water and this is also a risk factor for diarrheal diseases .this is worsened by poor human excreta disposal .this also means that the risk of fecal contamination is high, all these factors tantamount high rate of morbidity and mortality more so to infants as their immunity is still developing (www.healthpus24.com). Majority of the respondents [80%] took their children for prompt immunization while only 20% did not. The greatest percentage took their children for prompt immunization, this is attributed to mass increased campaign drive bv government of Uganda such as `kick polio out of Uganda` and free cost of

immunization to the public offered by the government. The infant mortality rate was seen to be highly associated with those promptly who did not receive immunization (60%) compared to those who promptly received immunization. The few, 20% who did not take their children for immunization could be still having false local belief about the vaccines or biasness towards health workers. Immunization helps to prevent fatal diseases like diphtheria, measles, polio, tetanus, meningitis hepatitis, influenza among others. Therefore, if the infants are not immunized then they are at increased risk of dying from these diseases. These findings are in line with UMFPE report [23], which stated that immunization if mothers and children can help to prevent morbidity and infant mortality caused especially by measles and tetanus unfortunately some people still continue to avoid completing

According to the results from this study, it can be concluded that, demographically, infant mortality rate is high among teenagers, the unemployed, the widowed, the pagans, and the uneducated. Direct determinants were found to be having a big impact on the infant mortality rate and these included preterm birth. birth defects, co-morbidities and failure to breastfeed exclusively. Proximate determinants were also found to be playing a big role in the infant mortality rate among infants at IAH and these included teenage pregnancies, source of water, means of delivery and irregular immunization.

Recommendations

- i. Exclusive breast feeding for 6 months should be encouraged at every level of health delivery.
- ii. Government of Uganda should continue with mass immunization campaign and this should be extended up to grass root to avoid the risk of some people missing due to long distance or un awareness.
- iii. Ministry of health in conjunction with district health office Bushenyi
 - 1. Egesa, W. I., Odong, R. J., Kalubi, P., Yamile, E. A. O., Atwine, D.,

doses. Most of the respondents (65%) delivered from health facilities while (35%) delivered from home. Infant mortality rate was seen to be highly associated with home deliveries (42.9%) than hospital deliveries. Home deliveries are always associated with conditions which can predispose to infections such as un sterile instruments for cutting the cord and improper care of the umbilical cord its self since the delivery is in most cases conducted by unskilled person and this generally puts mother and infant at risk of dying since the un skilled person cannot recognize signs indicating emergency urgent attention requiring such as blood transfusion. resuscitation. rehydration among others. These findings also agree with UMFPE report in 2002 [23] which stated that home deliveries and unsupervised deliveries are likely to cause complications and puts the mother at risk.

CONCLUSION

should carry out intensive health education on health seeking behaviors and high lighting dangers associated with risky behaviors like smoking, alcoholism, to mention but a few.

iv. Ministry health of should institutionalize high quality monitoring and evaluation with feedback loops allowing for quick action particularly for emergency response. This therefore calls for equipping every hospital with basic equipment's necessary and ambulances.

v. There is also need for intersectional collaboration by elucidating bottle necks experienced in trying to reduce infant mortality for example malnutrition should be prevented by improved agricultural l practices introduced by ministry of agriculture and fisheries.

vi. Government should help people initiate income generating activities to boost their standards of living.

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