

A Report on Community Diagnosis and Mobilization Conducted Between 22nd September and 6th October 2019 at Mogotio Sub-County in BARINGO County, Kenya

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Abstract

Introduction: The Community Diagnosis and Mobilization exercise was conducted between 22nd September and 6th October 2019 in Mogotio Sub-County, Baringo County, Kenya by the September 2018 Nutrition and Dietetics certificate students from Kenya Medical Training College, Kabarnet Campus. Its main intention was imparting skills and knowledge on community mobilization and diagnosis, where the community gets to understand its health and nutrition issues, and address them using the available resources.

Methodology: the activity was undertaken in three phases; pre-field, actual field work activities and post- field activities. The cross-sectional design was employed, with a total sample of 132 households. children aged 0- 59 months old and pregnant or lactating women aged 15-49 years in these households were targeted. A structured questionnaire was used for data collection in Kisanana ward (Molo Sirwe and Mukurin), Mogotio ward (Ngubereti and Sirwa) and Emining ward (Emining and Maji moto), while the tools and instruments were pre-tested in Kipsogon community unit. Analysis was done using SPSS Statistical software version 22. Logistical and ethical considerations were also made during the CDX.

Results: Majority of the people in Mogotio sub-county were married, and 57.35% of the respondents had primary level education. 94.7 % of the residents were Christians and 53.66% were farmers. A majority of the water sources in this sub-county were surface water and borehole. Boiling was majorly used for water treatment in most community units since it was cheap and safe. 57.35% of the respondents burnt their waste. 98.7% children under five years in Mogotio Sub County had received OPV1 in 2019 while 96% had received OPV3. 72% of the pregnant and lactating women were at risk of being malnourished, while 46% were malnourished. 96.6% of the children aged 6- 11 months in Mogotio Sub County had received vitamin A supplements at least once. Children 12-59 months that had been dewormed were 72.9%.

Conclusion: Health education and awareness was commendable amongst residents of Mogotio Sub-County. Moreover, there was good immunization coverage. The households reported reduced attendance of Child Welfare Clinic after 11 months. There was need to improve the levels of de-worming within Mogotio sub-county. There was also an urgent need to achieve 100 percent toilet coverage within Mogotio sub-county.

Recommendations: based on the findings of the CDX, recommendations made include increased routine mass screening in areas with low health nutrition and sanitation indicators and upscaling health and nutrition outreaches. Moreover, the CHEWs and CHVs should be trained in details for positive impacts in the community. There was also an identified need to conduct health education and implement WASH. Support training of mother-to-mother support groups, inter-sectoral collaboration and partnership, women groups and CBOs on IGAs and post-harvest handling of food were identified as crucial improvement areas.

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I. Introduction

1.1 Background Information

According to W.H.O., community diagnosis (CDX) refers to a qualitative and quantitative description of health and factors that influence the health in a certain community. It is basically the foundation for improving and promoting the health of the community members. It identifies the problems that the community faces and using available resources, suggests ways in which to address these factors and respond to community needs. This is based on the fact that CDX involves assessment, and is evidence-based and comprehensive in its approach to primary health care. Therefore, CDX is very crucial in strengthening the linkages between healthcare teams and communities for better healthcare.

Mogotio Sub-County is in Baringo County. It has three wards; Mogotio ward covering 287.53 KM², Emining ward covering 529.21 KM² and Kisanana ward covering 487. 13 KM². The sub-county has 5 divisions,

23 locations, 50 sub-locations and 216 villages. The major source of livelihood is farming and pastoralism. This sub-county has a total male population of 41,271 and female 41,463. It has one new Sub-County Referral Hospital referred to as Mogotio Sub-County Referral Hospital.

Malnutrition is a complex phenomenon that manifests as either over- or under- nutrition. While the rates of overweight and obesity have been on a steady rise, wasting, underweight and stunting are still prevalent in Mogotio Sub-county, Baringo County. The main economic activity in Mogotio is agriculture where majority of the residents, especially in the rural areas grow perennial crops for subsistence, and sisal as the permanent crop for commercial purposes. The county experiences inadequate rainfall, leading to water shortage and ineffective farming. Although the IMAM operations were scaled up in January 2015, < 60% of the malnourished children < 5 years were enrolled due to low program awareness and household/ caregiver workload. The sub-county is vulnerable to disease outbreaks and drought.

Long distance to health facilities and one-off mass screening remain key challenges to locals. Alcoholism, migration, SFP stock-out, short child space intervals, ignorance of caregivers, and stigma of malnourished children are key contributors to malnutrition in the sub-county. There is low OTP program coverage in areas > 5 Kilometres from IMAM service delivery point due to low awareness. As such, the prevalence of malnutrition in the sub-county remains high. According to SQUEAC report 2015, there were a significant number of malnutrition cases admitted with Mid Upper Arm Circumference ranging from 115mm to 124mm who were admitted to Supplementary Food Program (SFP) and Outpatient Therapeutic Program (OTP) as mitigation strategies.

1.2 Objectives

1.2.1 Main Objective

Determine the nutrition status and health of children aged 0- 59 months and pregnant or lactating women aged 15-49 years.

1.2.2 Specific Objectives

1. Estimate the present acute malnutrition prevalence in children 0 – 59 months old
2. Determine morbidity rates among household members over a three month recall period.
3. Estimate Measles, Oral polio vaccines (OPV1-3), and BCG immunization coverage
4. Determine de-worming, Zinc supplementation for diarrhea, Vitamin A supplementation, and MNP's supplementation coverage among children 0-59 months.
5. Estimate the nutritional status of pregnant or lactating women aged 15- 49 years
6. Establish the status of household food security, sanitation, water, and hygiene practices
7. To determine the health care service delivery to the target group
8. To estimate time taken before acquiring service delivery

1.2.3 Process Objectives

1. Conduct a community entry
2. Conduct data collection and analysis
3. Evaluate the sub-county's healthcare system and partnerships
4. Disseminate feedback to the key stakeholders.

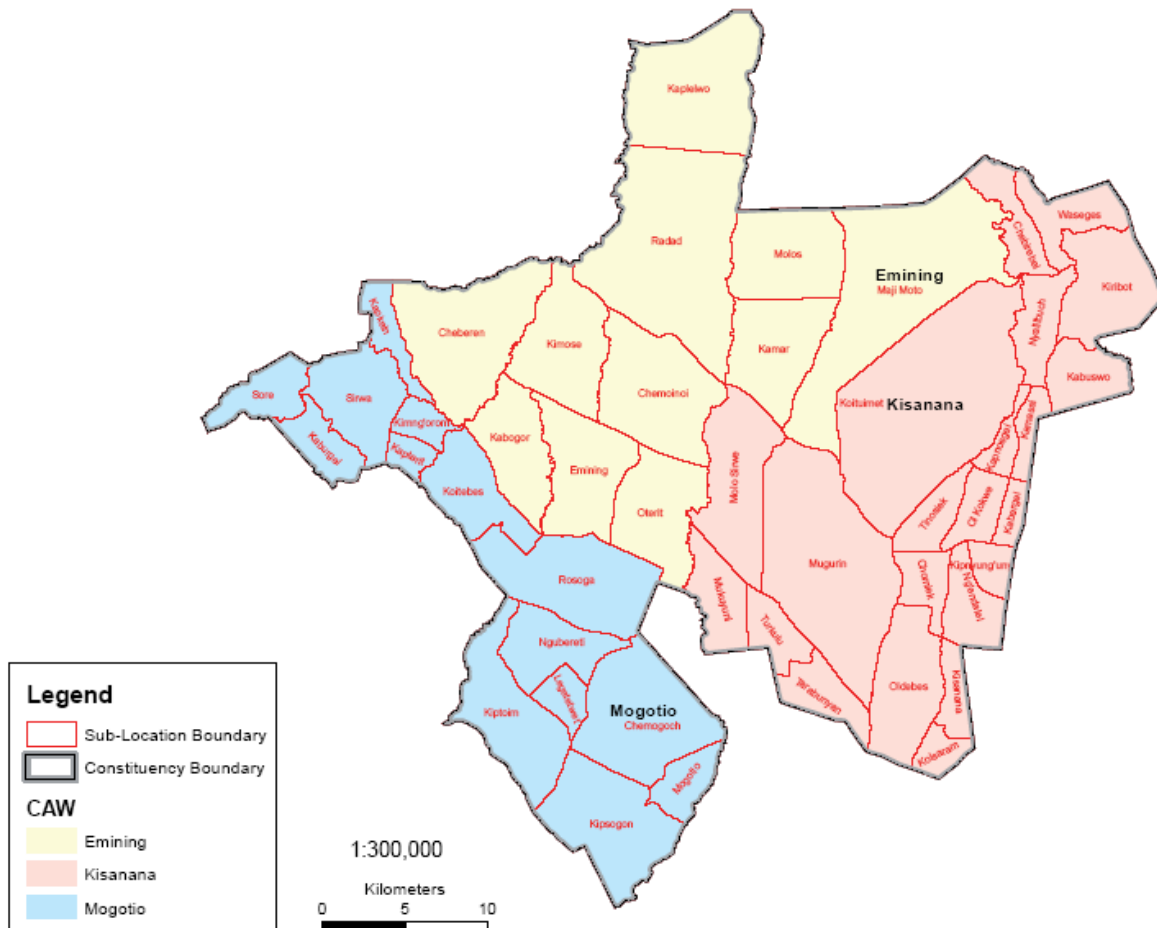


Figure 1: Mogotio Sub-County Map

II. Methodology And Organization

2.1 Organization of the CDX

The CDX started with engagement of the stakeholders so as to create rapport, and brief them about the objectives, methods, and purpose for the community diagnosis. The lead in this was the Baringo County Health Office, who also officially trickled the information down, up to the communities to be involved. Second, there was the actual field work activities, that started with introductory training so as to familiarize the students with the module’s content, which took two days. Pretesting the data collection instruments and the actual data collection were also done in this stage. Third, the post-field activities entailed of data cleaning and entry, analysis, writing the report, and feedback dissemination.

During the dissemination, barazas were organized by the sub-county community strategist, where all relevant stakeholders participated. There was representation of SCHMT, CHC, CHEWs, CHVs, Chiefs and Sub-Chiefs from all the wards. All the health indicators captured in the data collecting tools were discussed in-depth, as a basis of making the needed changes. Consequently, a clinical outreach (medical camp) was conducted by the students under supervision of their lecturers and in partnership with Mogotio sub-county Hospital. This was done in a slum in Mogotio town referred to as Kokoto. This slum is overpopulated, with many under-five children, lactating and pregnant women living in abject poverty. Activities of the outreach included anthropometric screening, documentation, deworming, Vitamin A supplementation and referrals. All severely and moderately malnourished children were referred for IMAM services in the nearest hospitals. This also applied to the pregnant and lactating women on basis of MUAC.

The nutrition and dietetics students from KMTTC, Kabarnet Campus were involved in the CDX as a crucial component for the fulfilment of their course. They resided in the community for effective teaching and learning, and to enable them examine and participate in addressing health problems by proposing effective interventions. Moreover, this enabled them to better visualize the communities’ health care difficulties. The communities were unfamiliar to the students, marginalized, and reaching households was a challenge. Through this exercise, the students also learnt varying communication skills, dissemination skills, data analysis, and its collection.

2.2 Study Design

The CDX used the cross-sectional descriptive design, which permitted an overview of the community at a point in time.

2.3 Study Area

The community setting of choice was Mogotio Sub-County, Baringo County, where the students were involved with the community between 22nd September and 6th October 2019. This area was selected based on the high malnutrition levels, healthcare challenges, and semi-arid nature. Therefore, it would offer a rich learning experience to the students. Two community units in every ward were visited as follows;

- a) Kisanana ward- **Molo Sirwe** and **Mukurin**
- b) Mogotio ward- **Ngubereti** and **Sirwa**
- c) Emining ward- **Emining** and **Maji moto**

2.4 Study Population

The population of interest for this diagnosis was children between 0 to 59 months, and pregnant or lactating women of age 15-49 years.

2.5 Sampling Procedure

132 households took part in the CDX at Baringo County, Mogotio Sub-County, which was selected purposively based on the health indicators. The diagnosis also applied a two-stage cluster sampling. probability proportional to population size was used for selecting the clusters, after which simple random sampling was used in selecting the households that responded to the questionnaire.

2.6 Data Collection Instruments and Tools

Various techniques and methods were used in conducting the CDX. Moreover, different actors were involved. The data collection methods used varied, and encompassed of observation, structured questionnaires, and key informants. The CDX examined varying primary health care domains, including community’s history, vital community institutions, communication means, power structure, leadership, and culture, as indicted by Sousa et al. (2017).

2.7 Pretesting of Instruments and Calibration of Tools

The data collection questionnaires were pretested in clusters that were not part of the larger diagnosis, for accuracy and reliability of all tools and instruments. The pretest was done in Kipsogon community unit. The pretesting involved practicing knowledge acquired on how to take anthropometric measurements, questionnaires’ completeness and sampling methodology.

2.8 Data Collection Procedure

A structured questionnaire aided in data collection. Data that was collected on anthropometry, vaccination information, morbidity rate within the previous three months, food security, water hygiene and sanitation. Data collection tools that the nutrition survey guidelines recommends were adopted in the CDX, with minor modifications so as to meet the intended objectives. A market survey was done on Friday 25th September, 2019 in Mogotio market to determine the affordability, accessibility and availability of foods in this sub-county, which would be a reflection of the food security status in the Sub-County.

2.9 Data Management and Analysis

The data cleaning, entry and analysis was done using SPSS version 22.

2.10 Logistical and Ethical Considerations

The local authorities received adequate information regarding the CDX. Verbal consent was obtained prior to data collection. The decision of caregiver to participate or withdrawal was respected. Participation was also voluntary. Confidentiality was maintained for all the data. Moreover, the findings of the CDX were shared with the key stakeholders, which enabled the students to practice use of adult learning skills and effective communication skills.

III. Findings

3.1 Demographic indicators

The total population of males and females in Mogotio Sub County was 41271 and 41463 respectively. A household in Mogotio Sub-County had an average of 5 persons. The children aged between 6-59 months screened were 252.

3.3.1 Marital status

Majority of the people in this subcounty were married; 118 women married followed by 18 single women.

Table 3.1: The Respondents’ Marital Status

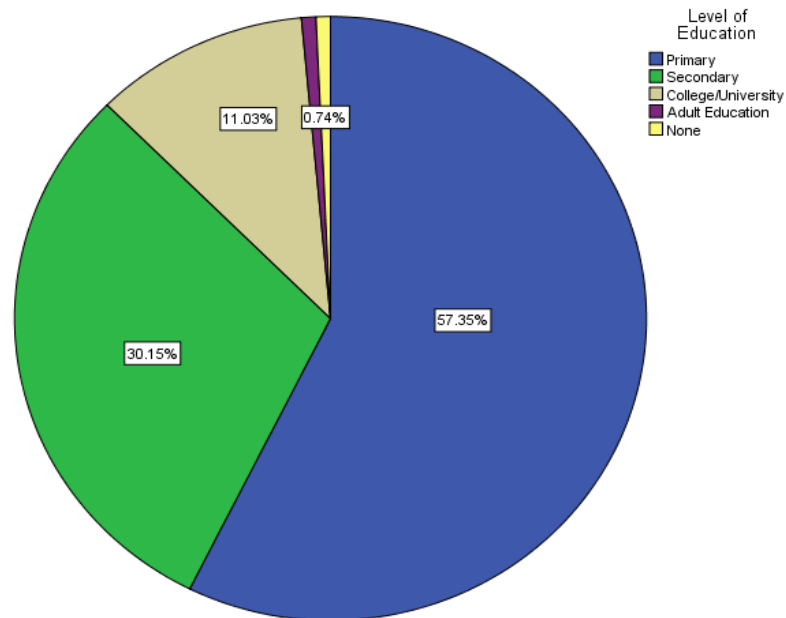
		community unit					
		Molo Sirwe Count	Ngubereti Count	Emmining Count	Sirwa Count	Mukurin Count	Maji Moto Count
Marital Status	Married	18	20	20	21	21	18
	Single	3	2	3	3	1	6

Divorced	0	0	0	0	0	0
Widowed	0	0	0	0	0	0

3.3.2 Education level

57.35% of the respondents had primary level education, 30.15% secondary-level, 11.03% college-level while 0.74 % attended the adult education level.

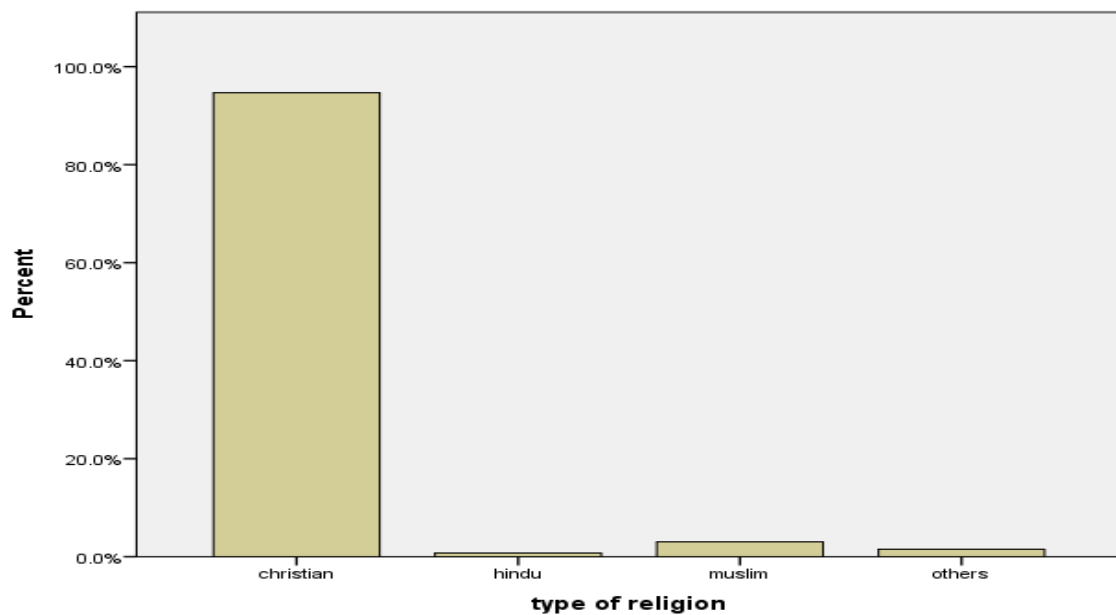
Table 3.2: *The Respondents' Education Level*



3.3.3 Religion

94.7 % residents were Christians, 3.03% Muslims and 1.52% did not have any religion.

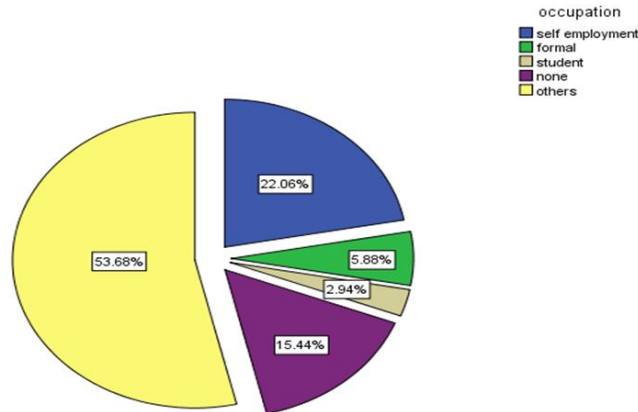
Table 3.3: *The Respondents' Religion*



3.3.4 Occupation

53.66% were farmers, 22.06% self-employed, 5.86% had formal employment, and 2.94% were still students. Most respondents were female, which indicated that a few have formal employment and majority do farming for a living.

Table 3.4: The Respondents' Occupation



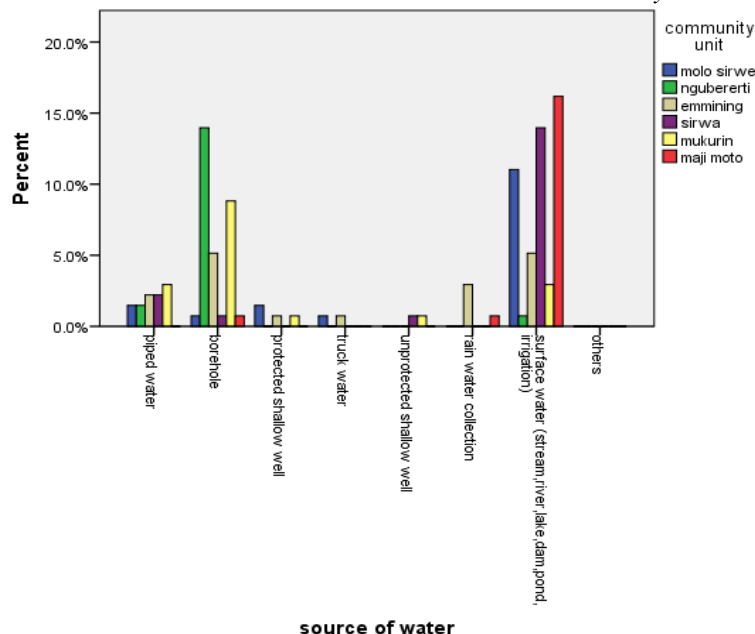
3.2 Environmental indicators

Based on the international human rights, water access and sanitation are basic human rights. Therefore, all people should be able to access essential safe drinking water amounts, as well as basic sanitation facilities. Moreover, the water ought to be affordable, acceptable, safe, physically accessible and sufficient for both domestic and personal use. There is a very close relationship between sanitation and water. Many human rights can be realized efficiently if the right to sanitation and water are achieved. High stunting levels and under-nutrition are some of the outcomes of poor WASH indicators, which also leads to diarrhoea, a major killer among children (Pruss-Ustun et al, 2014). In turn, a child's immunity is compromised, leading to a vicious circle. About 25% of stunting is linked to five and above diarrhea episodes before 24 months (Checkley et al, 2008).

3.2.1 Main sources of water

Improved water sources, if accessible, helps in reducing the faecal risk, in addition to associated diseases' frequency. It is also connected to socioeconomic characteristics, such as education and income. Drinking water coverage considers the use of both unimproved drinking water sources and improved drinking water sources (piped water). A majority of the water sources in this sub-county were surface water and borehole. Unprotected surface water was highly used in Maji Moto, Sirwa and Molo Sirwe. Therefore, there was a high risk of waterborne diseases.

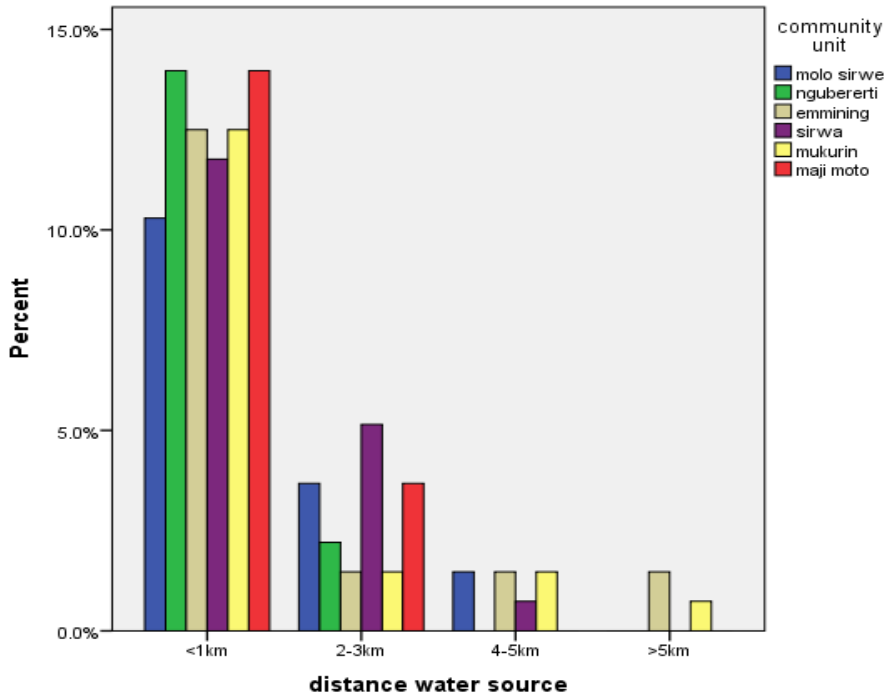
Table 3.5: Water Sources in the Sub-County



3.2.1.1 Distance to the Water Source and Queuing Time

Based on the minimum standards for WASH- SPHERE handbook, 500 meters is the maximum distance that any household should walk to reach the closest water point. Moreover, queuing for the water should not take over 15 minutes, while filling a 20-litre container should use less than three minutes. However, these parameters were yet to be achieved in Mogotio Sub-County.

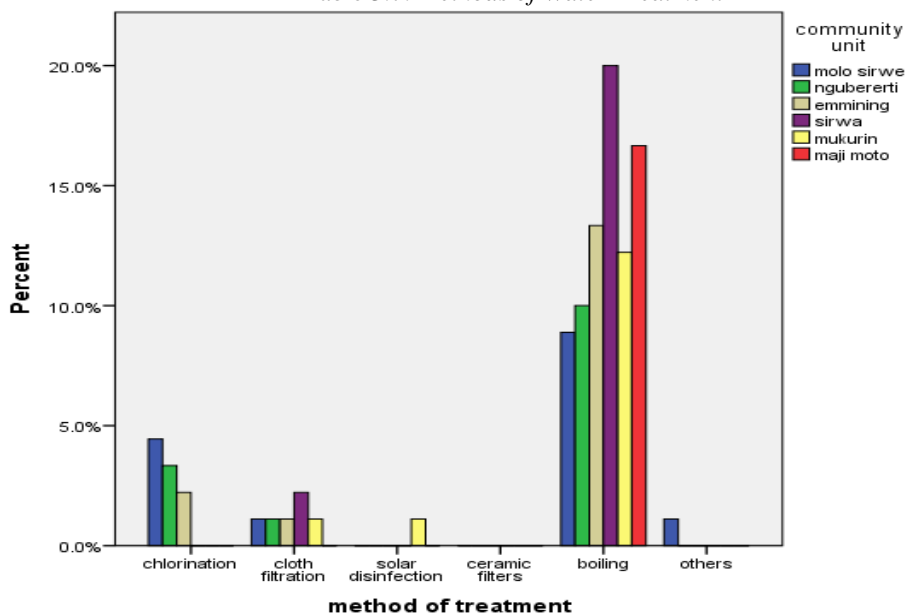
Table 3.6: Distance to Water Source



3.2.1.2 Methods of drinking water treatment

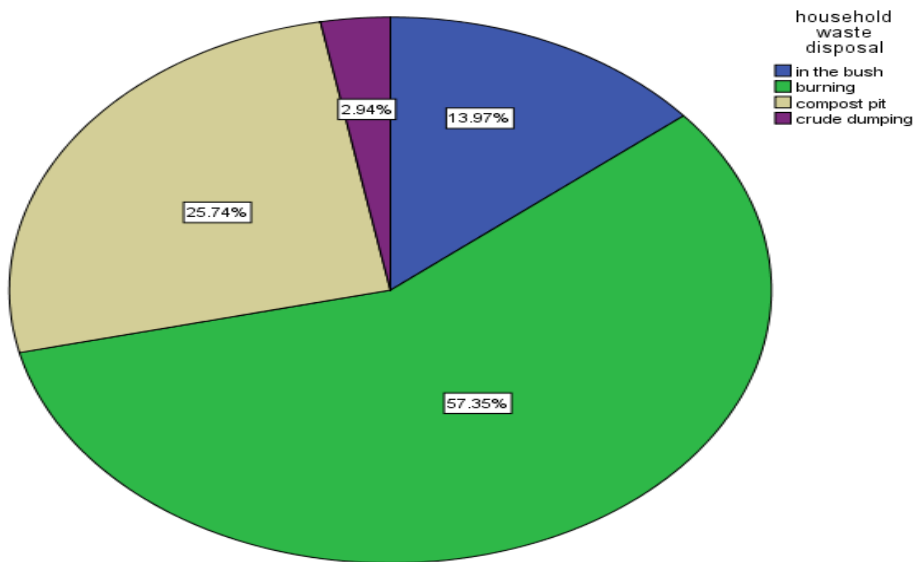
Water treatment is important to prevent waterborne disease. Households only treated drinking water. However, water used in food preparation was not treated. Boiling was the method majorly used in most community units since it was cheap and safe.

Table 3.7: Methods of Water Treatment



3.2.2 Sanitation

Table 3.8: Household Waste Disposal



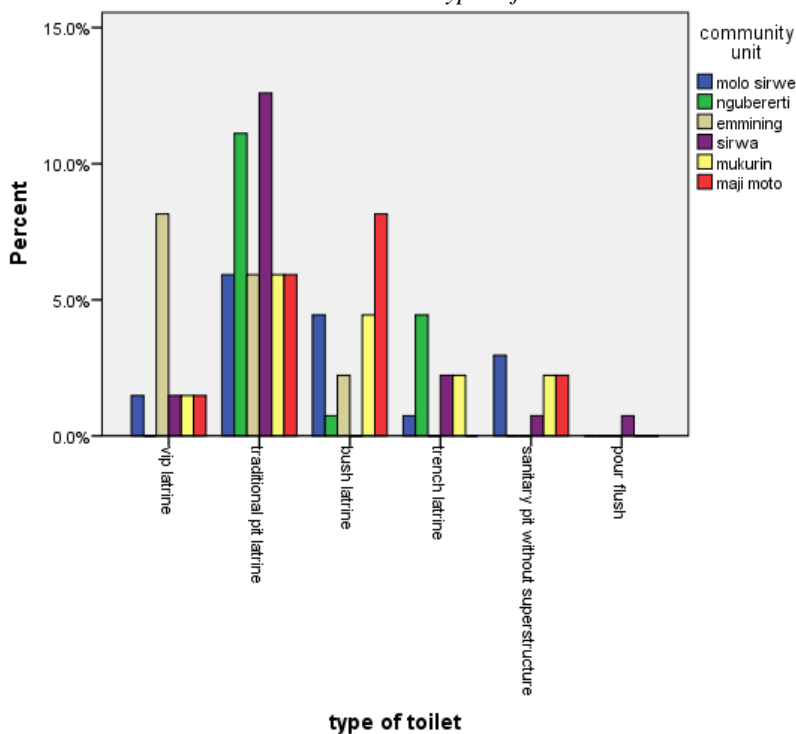
3.2.2.1 Waste disposal

Waste disposal is very crucial in health care since improper waste disposed ultimately contribute to various ailments. 57.35% of the respondents burnt their waste, 25.74% had dug a pit, while 13.97% disposed waste anyhow.

3.2.2.2 Toilet coverage

Basic sanitation services entails of having excreta transported through sewers for treatment off-site. With poor excreta management, different diseases can be transmitted, leading to malnutrition. Every year, insufficient sanitation contributes to 280,000 diarrheal deaths. With proper sanitation facilities, which can either be improved or unimproved, health is promoted.

Table 3.2: Types of Toilet



The findings established that the traditional pit latrines, which is an unimproved sanitation facility, was the commonly used in the sub-county.

3.3 Anthropometric Indicators

For acute malnutrition prevalence using W-H z-score and MUAC, GAM (Global Acute Malnutrition) defines a z-score that is below -2 W-H or a MUAC less than 12.5 cm, with/without edema. GAM is further broken down into SAM (Severe Acute Malnutrition) when the z-score is below -3 W-H or a MUAC less than 11.5 cm, with/ without edema, and MAM (Moderate Acute Malnutrition) when the z-score is < -2 and > -3 W-H (WHO, 2006) or a MUAC of ≥ 11.5 cm – <12.5 cm. Based on the findings of the CDX, 12% and 22% of the children had SAM and MAM respectively, on the basis of MUAC.

3.4 Immunization Coverage

Kenya had the goal of achieving 90% by the close of the 2nd medium term plan (2013- 2017), under one immunization coverage. Based on the Kenyan guidelines, a child is considered to be fully immunized if they have received all prescribed antigens, and one dose of Vitamin A at least once prior to the first birthday, following the national immunization schedule. Research indicates that immunization goes along way in protecting children and the larger community from critical diseases, considering that spread is also minimized. Since vaccines trigger the immune system, vaccinated people's immune systems respond more effectively, and diseases are less severe. Many diseases are currently rare as a result of the high immunization rates.

This CDX assessed the coverage of three vaccines; BCG, OPV1, OPV3 at nine and eighteen months. The BCG vaccine is known to be successful in minimizing the chances and severity of both military TB and TB meningitis, particularly in infants and young children. This is more so in Kenya where there is a high prevalence of TB, and the chances of infant or young children' exposure to an infectious case are high. From the CDX results, 95.2% of the children had been immunized. Moreover, children under five years who had received OPV1 were 98.7% in Mogotio Sub County in 2019 while for 96% had received OPV3. This indicates a high immunization coverage in the sub-county, which is highly recommendable for disease prevention. However, the Sub-county ought to target for 100% immunization coverage.

3.5 Maternal Nutrition

During pregnancy, optimal maternal nutrition, is one of the key strategies for promoting child survival during the initial 1000 days. Through it, child mortality among those less than five years can be minimized upto 15%, if implemented on a 90% coverage (Bhutta et al., 2013). During pregnancy and lactation, there is high nutrient needs, whose absence leads to exhaustion of the reserves, and consequently malnutrition. Gestational malnutrition is often associated with low birth weights, and poor growth and development. Therefore, malnutrition in pregnant and lactating women should be treated as an emergency. Household food insecurity is linked to poor maternal nutrition, and consequently, fetus growth retardation, low birth weight and malnutrition among children under five years. WHO recommends daily intake of 60mg elemental iron and 0.4mg folic acid throughout the pregnancy to prevent anemia. These recommendations have since been adopted by Kenya government in its 2013 policy guidelines on supplementation of iron folic acid supplementation (IFAS) during pregnancy.

During the CDX, assessment of maternal nutrition was through MUAC measurements of all pregnant and lactating women (15 to 49 years) in all sampled households. The maternal malnutrition was defined as MUAC measurements < 21.0cm while risk of malnutrition was defined as MUAC measurements between 21.0- <23.0cm. The findings established that 72% of the pregnant and lactating women were at risk of being malnourished, while 46% were malnourished. This indicates the need of upscaling targeted interventions, which will help eliminate malnutrition in the vulnerable groups. Moreover, the need for folic acid and iron supplementation should not be ignored.

3.6 Vitamin A Supplementation

More than 140 million children face the risks of blindness, hearing loss, illness and death if no immediate action is taken to offer them the vitamin A supplements. Annually, two doses are recommended to save children's lives. Globally, vitamin A supplementation coverage has been dropping for the previous six years, thereby exposing over a third of the children to the detrimental vitamin A deficiency's effects. This indicates the need for more sustainable, cost-effective, safe, and evidence-based programs so as to end preventable deaths among children.

In its national nutrition action plan (2012- 2017), third priority objective, Kenya aims at minimizing micro-nutrient deficiencies, prevalence through supplementations, fortification, and awareness. Vitamin A is among the key micronutrients of concern. Vitamin A supplementation on a large scale can greatly help in reducing preventable child deaths annually (Jones et al, 2003). Moreover, it can enhance disease resistance and

minimize mortality from all causes by about 23% (UNICEF, 2007). According to WHO (2018), if children aged 6- 59 months are supplemented with two high-dose Vitamin A supplements annually, spaced 4-6 months apart, then their immune systems would be strengthened immensely, and there would be higher survival chances. Supplementations also protects against common infections, thereby reducing mortality and improving survival chances.

According to the diagnosis, 96.6% of the children aged 6- 11 months in MogotioSub County had received vitamin A supplements at least once, and 29.4% of children aged 12 to 59 months in the Sub County had been supplemented at least once. The reduction in % shows children are not taken to CWC after finishing the 9-month immunization hence there is hardly vitamin A supplementation above 9 months.

3.7 De-Worming

De-worming is a crucial intervention for the control of parasites, in addition to preventing anemia (Jones,Steketee&Black, 2003). According to WHO, children from the developing countries ought to be dewormed once in every six months, based on exposure to poor sanitation and inaccessibility to clean safe water. In the CDX, 72.9% of the children aged 12-59 months in Mogotio Sub County were dewormed. In particular school going children were dewormed, however, no documentation showed that; the caregiver only recalled from the report given by the children. Children above three years were hardly dewormed since the caregiver ceased to take the child to CWC as required up to five years.

IV. Conclusions And Recommendations

4.1 Conclusion

Health education and awareness was commendable amongst residents of Mogotio Sub-County. This was evident in the level of education where 98 percent of the population had attained basic primary education. There is a strong relationship between nutrition health outcomes and level of education.

There was good immunization coverage within Mogotio Sub-County. 98.7% of the children under five years in 2019 had received OPV1. while for OPV3, there were 96%. This positive statistic ensures a health future for children within the subcounty. The households reported reduced attendance of Child Welfare Clinic after 11 months. 96.6% of the children aged 6- 11 months in MogotioSub County had received vitamin A supplements at least once, and 29.4% of children between 12 to 59 months had been at least supplemented once. The reduction in % shows children are not taken to CWC after finishing the 9-month immunization hence there is hardly vitamin A supplementation above 9 months.

There was need to improve the levels of de-worming within Mogotio sub-county. The children 12-59 months dewormed was 72.9% in Mogotio Sub County. In particular, school going children were dewormed. However, no documentation showed that as the caregiver only recalled from the report children gave. Children less than 3 years were hardly dewormed since the caregiver ceased to take the child to CWC as required up to 5 years.

There was an urgent need to achieve 100 percent toilet coverage within Mogotio sub-county, based on the fact that poor excreta management linked to disease transmission and malnutrition. Inadequate sanitation also leads to deaths annually due to diarrhoea. Therefore, the need for proper sanitation facilities cannot be ignored, for better health.

4.2 Recommendations

1. Increased routine mass screening in hot spot areas where health nutrition and sanitation indicators are still low
2. Upscale health and nutrition outreaches, including activities related to pregnancy and lactation, supplementation with Vitamin A, and deworming in outreach sites, as well as ECDE.
3. Train CHEWs and CHVs comprehensively on nutrition and primary health care
4. Support training of mother-to-mother support groups on MIYCN and BFCI.
5. Conduct health education, in addition to implementing WASH in the community, in addition to schools
6. Support partnership and inter-sectoral collaborations on health and nutrition
7. Support Community Based Organizations (CBOs) and women groups on IGAs for resilience
8. Support post-harvest food handling in schools and households.
9. Enhance food security by using irrigation schemes and kitchen gardening in Mogotio Sub- County.

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