**Prevalence and Factors Associated with Rickets-like Bone Deformities in Rural Cameroon: A Cross-Sectional Study of Children in M’mockmbie Village in the southwest region**

**A****bstract**

**Background:** Rickets remains a significant public health concern in resource-limited settings, causing bone deformities through impaired mineralization. While traditionally linked to vitamin D deficiency, calcium deficiency appears predominant in Sub-Saharan Africa (SSA). Nevertheless, studies have not examined rickets-like bone deformities (RLBD) in rural Cameroon. This study assessed RLBD prevalence and associated factors in M'mockmbie village, in the southwest region of Cameroon.

**Methodology:** We conducted a community-based cross-sectional study from October 2021 to July 2022, employing a multi-step stratified random sampling technique across M'mockmbie's 12 quarters. The study population comprised children aged 6 months to 16 years (n=455). Data collection included sociodemographic, nutritional status, vaccination history, and clinical features of RLBD. Statistical analysis used Epi-Info version 7.2.5.0, with multivariate logistic regression to identify factors associated with RLBD (p≤0.05 significance).

**Results:** From the 455 children included, the study revealed a 12.31% RLBD prevalence, predominantly knock-knee deformities (60.71%). Most cases (76.79%) manifested by age 2. Significant associations emerged with incomplete vaccination (aOR=2.78, p=0.033), poor nutrition (aOR=0.57, p=0.025), parental loss (aOR=0.36, p=0.033), and family history of RLBD (aOR=0.31, p=0.017). Nutritional data revealed 58.9% of children experienced food insecurity, with 91.7% consuming carbohydrate-dominated diets and only 6.2% regularly consuming protein-rich foods. Healthcare-seeking behaviour showed 42.9% visited hospitals for deformities, while 25.0% used self-medication.

**Conclusion:** The high RLBD burden in M'mockmbie reflects intersecting nutritional and healthcare access challenges. Our findings highlight the critical need for integrated interventions addressing childhood malnutrition, incomplete vaccination coverage, and targeted screening for at-risk families. The predominance of early-onset cases suggests vulnerability during critical growth periods, warranting focused prevention strategies.

**Keywords:** Rickets, bone deformities, malnutrition, vaccination, M’mockmbie

**Introduction**

Rickets is a metabolic bone disease of deficient mineralization at the growth plate, usually caused by inadequate concentrations of extra-cellular calcium or phosphate, reported from at least 59 countries worldwide (1.2). The delay in or failure of endochondral ossification leads to deformation of the growth plate, the development of bone deformities and a reduction in linear growth (3). Children with bone deformities may be severely disabled, have increased morbidity and decreased quality of life. The burden is currently greatest and the public health impact most substantial in developing countries, where crippling deformities reduce physical capacity and drain economic prospects (4). Studies in high-income countries such as Canada, the United Kingdom, and the United States have reported prevalences of 2.9, 7.5, and 24 per 1000, respectively (5,6). A review in low- and Middle-income countries reported a prevalence of 9/100.000 in China and 30 % of under-five children affected in Tibet. In Nigeria, the prevalence is 6.4/1000 children aged 1 to 3 years (7). In Uganda, 9.5% of inpatient children are affected (8).

The global health community recognizes nutritional rickets and associated vitamin D/calcium deficiencies as entirely preventable public health problems (9). Concern has been expressed about the rising incidence of rickets with its associated long-term sequelae in children globally (10). Low dietary calcium intakes and poor vitamin D status are common findings in children living in developing countries. Despite many of the countries lying within the tropics and subtropics, overcrowding, atmospheric pollution, a lack of vitamin D-fortified foods, and social customs that limit skin exposure to sunlight are major factors in the development of vitamin D deficiency. Low dietary calcium intakes are typically observed as a consequence of a diet limited in dairy products and high in phytates and oxalates, which reduce calcium bioavailability (11).

Rickets is most commonly caused by vitamin D deficiency, although rickets in Sub-Saharan Africa (SSA), India and Bangladesh has been reported in children with a biochemical profile that does not suggest vitamin D deficiency but who may have calcium deficiency (12). A randomized controlled trial established that a daily amount of at least 1000 mg of oral calcium supplementation for 6 months or longer is required for radiographic bone healing of dietary calcium deficiency rickets in children (13). The therapeutic response is improved with additional vitamin D therapy (14). Nutritional rickets results from inadequate vitamin D and/or calcium nutrition resulting in bone weakness and bending because both nutrients are essential for bones to become mineralized. The bending of bones is most prominent in the legs, manifest as bowleg or knock-knee deformities. Global consensus recommendations for the treatment and prevention of nutritional rickets have been recently published (15).

Cameroon's rural communities, including M'mockmbie village in the Southwest Region, face heightened vulnerability due to ongoing socioeconomic crises that exacerbate malnutrition and limit healthcare access. This study was designed to determine the prevalence of rickets-like bone deformities and identify factors associated with rickets-like bone deformities (RLBD) in the M’mockmbie village in children aged between 6 months and 16 years.

**M****ethodology**

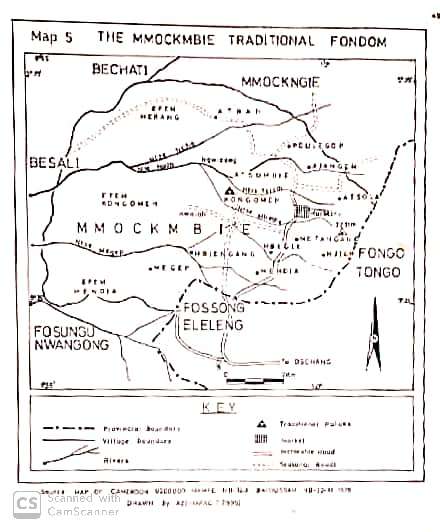
**Study design, period and setting**

We conducted a community-based cross-sectional study in M'mockmbie village, located in the Alou subdivision of Cameroon's Southwest region. The study was implemented from October 2021 to July 2022. The village was selected due to anecdotal reports of high bone deformity prevalence, and exacerbated malnutrition from ongoing regional crises. M'mockmbie comprises 12 quarters with an estimated population of 3,080 (2021), predominantly engaged in subsistence farming.

**Study population and sampling procedure**

The study population was made up of children aged 6 months to 16 years in M’mockmbie village. Children with trauma-related deformities and cases where parents/guardians declined consent were excluded from our study.

Using Epi-Info version 7.2.5.0, we calculated a minimum sample size of 180 based on the prevalence of rickets-like bone deformities of 5.7% from a study done in a rural region of West Africa in 2007 (1), 95% confidence level, 5% margin of error and design effect of 2 for cluster sampling. We employed multi-stage stratified random sampling by 1) dividing the village into 12 quarter-based clusters, 2) mapping households using Google Earth's "My Position" function, 3) randomly selected 8 households per cluster and 4) enrolling all eligible children per household.

**Figure 1**: Map of M’mockmbie village

**Data collection procedures**

The data collection tools were pretested in a sample of 5 children aged 6 months to 16 years in Bangou village. A total of thirty (30) surveyors were recruited, trained and then divided into ten (10) teams, each made up of three (3) members headed by a supervisor. In each quarter, the administrative authority (quarter head) was sought for authorization to have access to households. The questionnaire was administered to the children after obtaining consent from their parents/legal guardians. The form covered: section A: Sociodemographic (age, parental education, occupation), section B: RLBD prevalence and characteristics, section C: Nutritional status (breastfeeding history, dietary patterns) and section D: Risk factors (vaccination status, sunlight exposure, family history) (supplementary material 01: Study questionnaire).

**Data analysis**

Data were cleaned and analyzed in Epi-Info version 7.2.5.0. Descriptive statistics, including frequencies and proportions, were used to summarize participant characteristics and outcome measures. With a statistically significant threshold set at p-value≤0.05, Multivariate logistic regression was used to identify factors associated with RLBD and selected covariates.

**Results**

Among the 480 children aged 06 months to 16 years reached, 455 completed the interview (response rate of 94.8%) with 25 excluded (figure 01).

480 children aged 06 months to 16 years were contacted

22

10 denied to participate, non-response rate of 2.08%

470 participants

Excluded 15 participants due to questionnaires either wrongly or incompletely filled

455 participants included in the study

**Figure 2**: Flowchart of inclusion

**Socio-demographic characteristics of the participants**

The study included 455 children aged 6 months to 16 years, with a median age of 10 years. Most children (78.84%) had both parents alive. Parental education levels were predominantly primary (39.02%), with only 4.88% attaining higher education. Most parents (93.83%) worked had unskilled occupations, and nearly all participants (93.35%) identified as Christian (Table 01).

**Table 1:** Socio-demographic characteristics of participants

|  |  |  |
| --- | --- | --- |
| Variables | Frequency | Percentage (%) |
| Parents/Guardians (head of family) level of education |  |  |
| Never schooled | 90 | 19.96 |
| Primary | 176 | 39.02 |
| Secondary | 163 | 36.14 |
| Tertiary | 22 | 4.88 |
| Occupation of parents/guardians (head of family) |  |  |
| Skilled | 28 | 6.17 |
| Unskilled | 426 | 93.83 |
| Religion |  |  |
| Christian | 421 | 93.35 |
| Muslim | 28 | 6.21 |
| Atheist | 1 | 0.22 |
| Animist | 1 | 0.22 |
| State of parents |  |  |
| Both alive | 354 | 78.84 |
| One alive | 82 | 18.26 |
| Both dead | 13 | 2.90 |

**Prevalence of Rickets-Like Bone Deformities (RLBD)**

The prevalence of RLBD among the study population was 12.31% (56 out of 455 children). Knock-knee deformities were the most common (60.71%), followed by bowlegs (26.79%) and other deformities (12.5%). Most cases (76.79%) were first noticed by age 2. Regarding healthcare-seeking behaviour, 42.86% of parents took their children to a hospital upon noticing deformities, while 25% resorted to self-medication. Among those who sought treatment, 60.71% reported partial resolution of deformities, 30.36% saw no change, and 8.92% experienced worsening conditions (Table 02).

**Table 2:** Prevalence of RLBD in our study population

|  |  |  |
| --- | --- | --- |
| Variables | Frequency | Percentage (%) |
| Presence of RLBD | | |
| Yes | 56 | 12.31 |
| No | 399 | 87.69 |
| Age when the deformity was noticed (years) | | |
| 1 | 8 | 14.29 |
| 2 | 43 | 76.79 |
| 3 | 5 | 8.93 |
| Nature of deformity | | |
| Bow leg | 15 | 26.79 |
| Knocked knee | 34 | 60.71 |
| Others | 7 | 12.5 |
| Actions taken after noticing deformity | | |
| Auto medication | 14 | 25.0 |
| Went to the hospital | 24 | 42.86 |
| Went to a traditional doctor | 7 | 12.5 |
| Nothing | 11 | 19.64 |
| Evolution of the deformity after actions taken | | |
| Unchanged | 17 | 30.36 |
| Partially resolved | 34 | 60.71 |
| Became worse | 5 | 8.93 |

**Nutritional Status of Participants**

Most children (95.82%) were breastfed for at least one year (and still ongoing and exclusive for 06 months old children). However, dietary patterns revealed significant deficiencies: only 6.15% regularly consumed protein-rich foods, while 91.65% relied on carbohydrate-dominated diets. Food insecurity was prevalent, with 58.9% of children never eating to satisfaction, and 48.24% consuming fewer than two meals per day. Household income further highlighted economic challenges, with 47.67% of families earning less than 25,000 Francs CFA monthly (Table 03).

**Table 3:** Evaluation of nutritional status of our study population

|  |  |  |
| --- | --- | --- |
| Variables | Frequency (T=455) | Percentage (%) |
| Breastmilk received for at least a year |  |  |
| Yes | 436 | 95.82 |
| No | 19 | 4.18 |
| Diary product consumption |  |  |
| At least once a month | 163 | 35.90 |
| At least once a week | 86 | 18.94 |
| At least once in six months | 128 | 28.19 |
| Others | 78 | 16.96 |
| Eating till satisfaction |  |  |
| Never | 268 | 58.90 |
| Only at the beginning of the month | 78 | 17.14 |
| two times a week | 81 | 17.76 |
| Often | 28 | 6.15 |
| The number of times eating is done per day |  |  |
| Less than 2 | 219 | 48.24 |
| Between 2 to 3 | 178 | 39.26 |
| Greater than 3 | 58 | 12.58 |
| Types/classes of food consumed the most |  |  |
| Carbohydras | 417 | 91,65 |
| Lipids | 1 | 0.22 |
| Proteins | 28 | 6.15 |
| Vegetables | 9 | 1.98 |
| Average monthly revenue of the family |  |  |
| Less than 25000 Frs CFA | 215 | 47.67 |
| Between 25000 Frs CFA and 50000 Frs CFA | 133 | 29.49 |
| Above 50000 Frs CFA | 75 | 16.63 |
| Others (varying per months) | 28 | 6.21 |
| Number of children aged 06 months to 16 years in the house |  |  |
| Less than 5 | 140 | 30.84 |
| Between 5 and 10 | 306 | 67.40 |
| Between 10 and 15 | 7 | 1.54 |
| Greater than 15 | 1 | 0.22 |

**Factors associated with RLBD**

Following bivariate logistic regression (Table 04), the following factors were identified for the multivariate logistic regression: vaccination [3.68 [1.70- 7.99] P- value <0.001], state of parents [(0.55 [0.25- 1.20]), P -value 0.028], relative with a similar problem [0.31 [0.17- 0.54], P-value <0.001], parental level of education [0.50 [0.26-0.96] P-value 0.035], antenatal care (ANC) visits [0.31 [0.17- 0.59], P-value <0.001] and poor nutrition [0.58 [0.39-0.85], P-value 0.005].

**Table 4:** Bivariate analysis between covariates and RLBD

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Rickets-like bone deformities (RLBD) | | | |
| Variables | Yes (%) | No (%) | cOR [95%CI] | P-value |
| Received breastmilk (At least one year) |  |  |  |  |
| Yes | 54 (12.84) | 380(87.16) | 0.04 [0.02-1.78] | 0.095 |
| No | 2(3.00) | 17(97.00) |
| At least one parent alive |  |  |  |  |
| Yes | 8(7,92) | 93(92,08) | 0.55 [0.25- 1.20] | 0.028\* |
| No | 48(13.56) | 306(86.44) |
| Incomplete vaccines |  |  |  |  |
| Yes | 8(5.03) | 151(94.97) | 3.68 [1.70- 7.99] | <0.001\* |
| No | 48(16,33) | 246 (83.67) |
| Area exposed to sunlight |  |  |  |  |
| Yes | 22(11.76) | 165(88.24) | 0.90 [0.51- 1.60] | 0,723 |
| No | 34(12.88) | 230(87.12) |
| Caesarian section |  |  |  |  |
| Yes | 3(30.00) | 7(70.00) | 0.32 [0.08- 1.27] | 0,088 |
| No | 53(12.05) | 387(87.95) |
| First degree relative with a similar problem | |  |  |  |
| Yes | 25(24.04) | 79(75.96) | 0.31 [0.17- 0.54] | <0.001\* |
| No | 31(8.83) | 320(91.17) |
| ANC done during pregnancy |  |  |  |  |
| Yes | 14(6.36) | 206(93.64) | 0.31 [0.17- 0.59] | <0.001\* |
| No | 42(17.87) | 193(82.13) |
| Occupation of parents/guardians (head of family) | |  |  |  |
| Yes | 3(10.71) | 25(89.29) | 1.18 [0.35- 4.06] | 0.787 |
| No | 53(12.44) | 373(87.56) |
| Poor nutrition (carbohydrates only) |  |  |  |  |
| Yes | 52(12.47) | 365(87.53) | 0.58 [0.39-0.85] | 0.005\* |
| No | 4(10.81) | 33(89.19) |
| Members of household occupants (> 5) |  |  |  |  |
| Yes | 54(12.74) | 370(87.26) | 0.47 [0.11-2.03] | 0.303 |
| No | 2(6.45) | 29(93.55) |
| Average monthly revenue (Less than 25000 Frs CFA) | |  |  |  |
| Yes | 11(14.67) | 64(85.33) | 0.78 [0.35-1.73] | 0.538 |
| No | 19(11.80) | 142(88.22) |
| Educational level of parents (Did not schooled) | |  |  |  |
| Yes | 43(14.78) | 248(85.22) | 0.50 [0.26-0.96] | 0.035\* |
| No | 13(7.98) | 150(92.02) |
|  |  |  |  |  |

**cOR**=Crude Odd Ratio, **CI**=Confidence Interval, **\***= Factors that were statistically significant

To control confounders, the multivariate regression analysis included factors that were statistically significant from the bivariate logistic regression. Factors significantly associated with RLBD included: children with incomplete vaccinations were 2.78 times more likely to develop RLBD (aOR = 2.78, p = 0.033), children who had atleast one parent alive were less susceptible to RLBD (aOR = 0.36, p = 0.033). Furthermore, a first-degree relative with RLBD increased the likelihood of developing the condition (aOR = 0.31, p = 0.017), and children with inadequate nutrition were more prone to RLBD (aOR = 0.57, p = 0.025)

**Table 5:** Multivariate analysis of factors associated with RLBD

|  |  |  |
| --- | --- | --- |
| Variables | Rickets-like bone deformities | |
|  | aOR [95%CI] | P-value |
| Incomplete vaccines (yes/no) | 2.78 [1.08 -7.15] | 0.033\* |
| State of parents (atleast one parent alive) (yes/no) | 0.36 [0.14- 0.91] | 0.033\* |
| Mode of delivery (caesarian section) (yes/no) | 0.75 [0.16-3.50] | 0.719 |
| First degree relative with similar problem (yes/no) | 0.31 [0.17- 0.54] | 0.017\* |
| Parents' level of education (never schooled /schooled) | 1.67 [0.31- 8.87] | 0.546 |
| ANC done during this pregnancy (Yes/No) | 0.80 [0.36-1.77] | 0.584 |
| Poor nutrition (carbohydrates only) (yes/no) | 0.57 [0.39-0.89] | 0.025\* |

aOR=Adjusted Odd Ratio, CI=Confidence Interval \*= Factors found to be statistically significant

**Discussion**

This study aimed to assess the prevalence and associated factors of rickets-like bone deformities (RLBD) among children aged 6 months to 16 years in M'mockmbie village, Cameroon. The findings revealed a high prevalence of RLBD (12.31%), with knock-knee deformities being the most common (60.71%). Most cases (76.79%) were identified by age 2, highlighting early childhood as a critical period for disease manifestation. Key risk factors included incomplete vaccination, parental loss, family history of RLBD, and poor nutrition. The observed prevalence of 12.31% aligns with findings from rural Northern China (13%) (16) but was notably higher than the 5.7% reported in rural Gambia (3). This increase may be because M’mockmbie is found in a region which has been under internal crisis since 2016. This crisis may have exacerbated malnutrition and limited healthcare access. We noted from this study that the majority (76.79%) RLBD was noticed at the age of 2 years. This finding was similar to that of *Mejı ́a-Guevar et al (*2019) in which 2years (71.26%) was the year in which rickets was noticed most (17).

The predominance of knock-knee deformities (60.71%) is consistent with a Gambian study (9), suggesting shared etiological factors such as calcium deficiency in Sub-Saharan Africa. Healthcare-seeking behaviour in M'mockmbie differed from other regions, with 42.86% of parents visiting hospitals for deformities, contrasting with studies in Kenya (51.3% self-medication) (18). This may reflect Cameroon’s relatively accessible healthcare infrastructure, including the presence of an integrated health centre in the village. However, the partial resolution of deformities in 60.71% of cases underscores the need for improved treatment protocols. The study revealed severe dietary deficiencies, with 91.65% of children consuming carbohydrate-dominated diets and only 6.15% regularly eating protein-rich foods. These findings mirror reports from the U.S. on immigrant populations (19) but contrast with Kenyan data showing higher protein consumption (20). The high prevalence of food insecurity (58.9%) and low household income (47.67% earning <25,000 CFA/month) highlight the economic constraints contributing to malnutrition.

Children with incomplete vaccinations were 2.78 times more likely to develop RLBD (p = 0.033), corroborating a study from Kuwait(21). This association may reflect increased susceptibility to infections and subsequent malnutrition in unvaccinated children (18).Orphaned children were also more vulnerable to RLBD. The loss of caregivers likely exacerbates food insecurity and reduces access to healthcare. A first-degree relative with RLBD significantly increased risk (aOR = 0.31, p = 0.017), supporting genetic or shared environmental influences, as suggested in Gambian studies (2) but differ with a study carried out in Yemen (22) who reported no association between parents or relatives having deformity and their children having it and with another study which states that the risk of vitamin D deficiency is higher in dark skinned populations, children who live at higher latitudes, exclusively breastfed infants and children, infants born to vitamin D– deficient mothers, and premature infants and may also be affected by cultural practices (23). This association is suggestive of the implication of genetic factors which may be further investigated. Inadequate dietary quality was strongly linked to RLBD (aOR = 0.57, p = 0.025), aligning with research from Kuwait (14). The reliance on carbohydrate-rich, nutrient-poor diets underscores the need for targeted nutritional interventions. Nevertheless, clinical features are easy to identify. Biochemical and radiographic exams are available to confirm the diagnosis. Vitamin D deficiency seems to be the main etiology. It is necessary to promote vitamin D supplementation and food fortification in children (24).

**Strengths and limitations of the study**

The study’s community-based design and stratified sampling enhance its representativeness, while multivariate analysis strengthens the validity of identified risk factors. Several limitations should be considered when interpreting these findings. The cross-sectional design precludes the establishment of causal relationships between identified risk factors and RLBD outcomes. Recall bias remains possible for historical variables like dietary patterns and vaccination history, particularly given the reliance on parental reporting. The study's focus on children aged 6 months to 16 years excludes potential late-onset cases that might manifest in early adulthood. The study did not assess genetic contributors to RLBD, which could interact with the identified nutritional and socioeconomic factors. Future research should employ longitudinal designs to establish causal pathways and evaluate intervention effectiveness, while incorporating biochemical and radiographic measures to refine case identification.

**Conclusion**

This study reveals a significant burden of rickets-like bone deformities (12.3%) among children in rural M'mockmbie, Cameroon, with most cases emerging by the age of two years. The findings highlight incomplete vaccination, parental loss, family history of RLBD, and poor nutrition as the factors associated with RLBD. The predominance of knock-knee deformities and early age of onset underscore the window for intervention during infancy and early childhood. These results call for integrated public health strategies combining nutritional supplementation (particularly calcium and vitamin D), complete immunization coverage, and targeted screening for high-risk families in rural Cameroonian communities. By addressing the intersecting nutritional and healthcare access challenges documented in this study, policymakers and health practitioners can substantially reduce the disability burden associated with RLBD in resource-limited settings like M'mockmbie.

**Ethical Approval and Consent:**

The study protocol was approved by the Faculty of Medicine and Pharmaceutical Sciences, University of Dschang and the South-west Regional Ethics Committee. Also, an administrative authorization was obtained from the chief medical officer of Alou. All participants provided written informed consent through parents/guardians. Data were anonymized using coded identifiers.

**Disclaimer (Artificial intelligence)**

Authors hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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**Appendix I: QUESTIONNAIRE**

**PREVALENCE OF RICKET-LIKE BONE DEFORMITIES AND FACTORS INFLUENCING RICKET-LIKE BONE DEFORMITIES IN RURAL CAMEROON (MMOCK MBIE VILLAGE)**

Date………………… Code of participant: …/…/…/…/…..

**SECTION A SOCIODEMOGRAPHIC DATA**

1. Age of Parents/Guardians (head of family): …………………………………………
2. Age of the child…………………………………………………………………………..
3. State of parents: both alive  one alive  both dead 
4. Parents/Guardians (head of family) level of education: never schooled  primary secondary  higher 
5. Number of household members………………
6. Number of children age 6months to 16year in the household? ……. Boys……Girls………
7. Occupation of parents/Guardians (head of family) : skilled (teacher, nurse, doctor, top administrator…)  unskilled(famer, hunters, construction work, retail sale person, taxi driver…) 
8. Religion: Christian Muslim Atheist Animist **others**
9. What is average monthly revenue of the family? Less than 25000f Between 25000f and 50000f above 50000f others

**SECTION B: NUTRITIONAL BEHAVIOUR**

1. Did the child take breastmilk? yes No
2. If yes for how long? Less than 6months between 6months still one year above one year
3. How often do you eat to your satisfaction? Never at the beginning of the month two times a week often others………………………………………………
4. What type/class of food do you consume most? carbohydrate (cocoyam, rice, cassava etc)

protein (meat, fish etc) vegetable lipids (fats)

1. How mang times do eat a day? 1 2 3 4 5
2. How often did you consummed a diary product(milk, ege, yoghurt)? Atleast once a week

Atleast once a month atleast once in six months others

**SECTION C: QUESTIONS ON PREVALENCE OF RICKET LIKE BONE DEFORMITIES**

1. Is there any lower limb born deformity in the household: yes No
2. If yes in how many children……………………….
3. Did you do any ANC during this pregnancy? yes No
4. If yes was there any problem?.................................. ......................................
5. ere any early neonatal hospitalization? Yes No
6. What was the mode of delivery of the child? Per vagina caesarean section
7. What is the position of the person in the family? First child middle child

last child other

**SECTION D: QUESTIONS ON RISK FACTORS OF RBD**

1. At what age did you notice the born deformity?.............
2. What is the nature of deformity: knock knee bow leg others…………….
3. What did you do when you notice it? Notting went to traditional doctor

went to hospital administered auto-treatment others………………….

1. How is the outcome? completely resolved partially resolved same became worst
2. Is there any first degree relative with the similar problem? Yes No
3. If yes, who? ………….
4. Which quarter are you living? Areas exposed to sunlight (Mbegle, Mendia, Njieh, Ajagem, Atsombi, Metagang) Area not exposed to sunlight( Attrah, Atogah, Mekong, Ntsengala, Kongameh Mbingang,)
5. Did you receive all you vacines? Yes  No 
6. Body weight……………………….height………………….BMI…………………………