

**MORBIDITY PATTERN IN 0-14 YEAR'S CHILDREN: A BRIEF STUDY IN TWO VILLAGES INHABITED BY THE RABHA TRIBE IN KAMRUP DISTRICT, ASSAM****Dr. Ripunjy Sonowal**

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ABSTRACT The present cross-sectional study attempts to investigate the morbidity pattern among children within the age of 0-14 years in two villages inhabited by the Rabha tribe viz. Jimiri gaon and Satter gaon located along Assam – Meghalaya border in Kamrup district, Assam. The study subjects consist of 67 children chosen through complete enumeration method. Data for one year (January-December' 2023) was collected through door-to-door survey; and personal interviews were carried out to generate the qualitative data. Statistical analysis was done with Microsoft Excel and SPSS software and chi-square test was used. 11 different disease conditions were recorded. Diarrhoea, viral fever and acute respiratory infection were the most common causes of child morbidity. Modern medicine, as compared to other systems, is preferred for majority of the morbidity episodes. Better socio-economic conditions, health awareness of parents, nutritional status, etc. are important determinants that have significantly influenced the child health.

KEYWORDS : Child morbidity, Diarrhoea, Rabha, Health awareness, Kamrup.**INTRODUCTION**

Child morbidity refers to any departure, subjective or objective, from a state of physiological or psychological well-being (i.e. sickness or illness) within a child (University of Manitoba, 2006). Morbidity in children could be due to lack or poor pre/postnatal care, infectious diseases such as acute diarrhea, acute respiratory infections, pneumonia, anaemia, skin, eye and teeth diseases, etc. along with other preventable ailments, or a congenital condition such as thalassemia, or an accident. Although India has made an appreciable progress in improving the overall health status of its population, it is far from satisfaction. Improving the health condition of children still remains a major challenge. Children, especially of the age group of under-05 face many ravages in the community and they suffer from diseases like diarrhoea, breathing infections, measles, and pneumonia (Das et al. 2012; Ganguly et al. 2015). Children are more vulnerable to infection as their immune system is not fully developed. Therefore, improvement in their health status is very much important as morbidities affect their health which in turn influences on the overall health status of the country. Studies by Santhanakrishnan et al. (1973), Gupta and Walia (1980), Anathakrishnan et al. (2001), Kurrey et al. (2017), Kallapurackal SJX et al. (2019), Devidas et al. (2021), etc. are some of the important researches on child morbidity in India. Studies pertaining to reporting of morbidity patterns in children reveal important facts which inform not only about their health status but also help in identifying the extent of deviation from the optimum growth as well as the factors responsible for this deviation. This provides vital feed back in setting priorities in health services reforms; there by interventions at appropriate levels can be made to combat and reduce the burden child morbidity. The magnitude of morbidity in children can be measured by: (i) the number of children affected, (ii) the number of episodes or spells of sickness, particularly for acute conditions, (iii) the duration of illness, and (iv) and severity of illness (Indrayan & Satyanarayana, 2000). In this backdrop, the present study is an attempt to investigate the morbidity pattern of children in 0-14 years in two Rabha tribal villages located along Assam – Meghalaya border in Kamrup district, Assam.

MATERIALS AND METHODS

The study area comprise of two villages viz. Jimiri gaon and Satter gaon located in a complete rural setting along the forest rich Assam-Meghalaya border under Rani Development Block of Kamrup district, Assam. The villages are inhabited by the Rabha tribe, one of the indigenous tribes of Assam. The study subjects consist of 67 Rabha children within the age group of 0-14 years chosen by complete enumeration method from the total population of 271 individuals. Data for one year (January–December' 2023) was collected through door-to-door survey; besides, in-depth personal interviews were carried out to generate the relevant qualitative data. Statistical analysis was done with Microsoft Excel and SPSS software and chi-square test was used. Morbidity conditions were coded according to the alphanumeric coding of the WHO 10th revision of International Classification of Diseases (WHO ICD-10).

RESULTS AND DISCUSSION

Among the 67 children, 33 were male (49.25%) and 34 were female

(50.74%). 11 different disease conditions were recorded. During the study period viral fever (57; 85.07%) was found to be the most common illness among the study population. Severe cough and cold (55; 82.08%) accounts for the second most prevalent morbidity condition. Diarrhoea (24; 35.82%) was the third most common morbidity among the children. Measles (21; 31.34%), skin disease (15; 22.38%), followed by jaundice and dental problem (11; 16.41% each) were the other prevailing morbidities found in the present study. A number of other morbidities (26; 38.80%) that include eye and ear disorders, injuries, worm infestation, menstrual disorder, etc. were found to be occurring in lesser frequencies (Table 1).

Table 1: Distribution Of Morbidity Conditions Among The Study Childrens

Sl. No.	Name of the disease/ailment	ICD –10 Code	Sex		Total (n = 67)
			Male (%)	Female (%)	
1	Cough and Cold	J00	31 (46.28)	24 (35.82)	55 (82.08)
2	Skin Disease	L00	6 (8.95)	9 (13.43)	15 (22.38)
3	Diarrhoea	A09	15 (22.38)	9 (13.43)	24 (35.82)
4	Measles	B05	7 (10.44)	14 (20.89)	21 (31.34)
5	Abdominal Pain	R10	4 (5.97)	6 (8.95)	10 (14.92)
6	Tongue Disease	K14	2 (2.98)	1 (1.49)	3 (4.47)
7	Dental Problem	K02.61, K03	7 (10.44)	4 (5.97)	11 (16.41)
8	Bronchitis	J20	2 (2.98)	0 (0.00)	2 (2.98)
9	Jaundice	R17	5 (7.46)	6 (8.95)	11 (16.41)
10	Viral Fever	R50	27 (40.29)	30 (44.77)	57 (85.07)
11	Others	---	8 (11.94)	18 (26.86)	26 (38.80)

Table 2 provides a chi-square analysis for attitude of parents of the study population towards the use of modern and traditional medicare systems for different types of morbidities. It shows that the attitude of parents towards use of medicare system is independent of sex (male/female) i.e. there is no association between attitude of parents towards medicare system and sex of the parents.

Table 2: Association For Attitude Of Parents Towards Use Of Modern And Traditional Medicare Systems For Different Types Of Morbidities

	Modern	Traditional
Male	20	8
Female	15	13

** Chi-square = 0.154, critical value at 5% level of significance = 3.841 for 1 d.f..

Majority of the morbidity episodes (27.84%) were treated with modern medicare system or allopathic medicine. Sometimes, modern and traditional medicines (6.59%) are found to be considered simultaneously. Viral fever was reported to be more prominent during winter and rainy season. Severe cough and cold usually begins as a viral infection in the nose with congestion, either in the nasal sinuses or lungs, runny nose, sore throat and high fever and chills. When the disease advances it is termed as acute respiratory infection (ARI). Studies conducted by Gupta and Walia (1980) and Venkatesh et al.

(1986) also found ARI and diarrhoea as the most common causes of morbidity among children. Behera et al. (2009), in their study conducted in tribal children of Orissa of age up to 15 years, found fever (24.4%), acute respiratory infection (35.4%), goiter (14.4%), and diarrhea (5%) as the common morbidities. Diarrhoea remains a major cause of morbidity in developing countries because rotavirus and other gastrointestinal infections and infestations have remained high despite the UNICEF and WHO campaigns (Ugwu, 2012). The present study reveals that the morbidity load in the children from the study area is not so serious. The main causes of morbidity are diseases that are preventable or easily treatable. ARI and diarrheal diseases can easily be prevented by promotion of nutrition, personal hygiene, early diagnosis and treatment (Nigudgi et al., 2013).

The improvements in diagnosis and therapeutics of many infectious diseases and increasing access to healthcare services have lead to the better health condition of the children. Besides, better transport facilities from the study area to the urban centre where advanced health care facilities are located, impact of modern education and relatively a more or less sound economic condition of the people are also important factors that contribute to the above situation. Another important observation from the present study is that the better hygienic conditions, especially in Jimiri gaon, and vaccination has resulted in very fewer cases of child morbidity. However, in Satter gaon, it was observed that, it is necessary to increase education and health awareness of the parents. Further, there is requirement of improvement in the housing, sanitation, and hygienic conditions in some select corners of the village. There is one Anganwadi Centre (AWC) in each of the study village that provides supplementary nutrition and immunization to children less than 6 years of age and immunization against tetanus for all expectant mothers; besides nutrition and health education to all women in the age group of 15 - 45 years, among a number of other services.

CONCLUSION

Children are the future citizen of the country and hope of the world. They are the country's biggest human investment for development. The present study, despite its many inherent limitations such as by only including the health conditions of children, the study lacks insight of holistic approach, identifies certain morbidity causes that can hamper the educational process and the intellectual growth of children in rural areas. Hence, childhood health should be the utmost priority for us and all the health needs of children should be properly and timely addressed. Further extensive study is needed with larger samples and precise assessment criteria in order to study child morbidity pattern among the Rabha children.

REFERENCES

1. Anathakrishnan, S., Pani, S.P. & Nalini, P. (2001). A comprehensive study of morbidity in school age children. *Indian Journal of Pediatrics*, 38: 1009-1017.
2. Behera, T.R., Satapathy, D.M., Sahani, N.C. & Sahu, T. (2009). Nutritional deficiency status among tribal children in a hard to reach area of Malkangiri district in Orissa. *Indian Journal of Nutrition and Dietetics*, 46: 106-11.
3. Das, P., Basu, M., Dhar, G., Mallik, S. & Pal, R. (2012). Nutritional status and morbidity pattern of government primary school children in north Kolkata of West Bengal, India. *South East Asia Journal of Public Health*, 2(1):13-17.
4. Devidas, J., Mohapatra, J., Dehury, P. & Dehury, R.K. (2021). Socio-demographic and morbidity pattern among under-five children in rural areas of Adilabad district of Telangana, India. *Journal of Clinical and Diagnostic Research*, 15(10): 17-21.
5. Ganguly, E., Sharma, P.K. & Bunker, C.H. (2015). Prevalence and risk factors of diarrhea morbidity among under-five children in India: A systematic review and meta-analysis. *Indian Journal of Child Health*, 2(4):152-160.
6. Gupta, K.B. & Walia, B.N.S. (1980). A longitudinal study of morbidity in children in a rural area of Punjab. *Indian Journal of Pediatrics*, 47: 297-301.
7. Indrayan, A. & Satyanarayana, L. (2000). *Essentials of Biostatistics: 7. Measures of Mortality and Morbidity in Children*. *Indian Pediatrics*, 37: 515-521.
8. Kallapurackal, S.J.X., Hamsaveni, G., Rafeek, A., Mendez, A., Manu, K.K., Chitturi, L., Monika, G., Naveen, G.P., Nikitha, D.H. & Osuri, A.S. (2019). A cross sectional study to assess the morbidity pattern among under five year old children in urban Chitradurga, South India. *International Journal of Community Medicine and Public Health*, 6(6): 1-4.
9. Kurrey, V.K., Lokesh, S., Rakesh, N. & Sharja, P. (2017). Study of health status and morbidity pattern in 5-18 years Birhor children: A primitive tribe of Chhattisgarh. *Indian Journal of Child Health*, 4(2):180-183.
10. Nigudgi, S., Patil, V., Tenglikar, S., Shrinivasreddy, B. & Vijayanath, V. (2013). A study to assess the morbidity pattern among school going children of Gulbarga city. *Indian Journal of Public Health Research and Development*, 4(4):108.
11. Santhanakrishnan, B.R., Peter, A. & Raju, V.B. (1979). Morbidity and mortality pattern of children in Madras City. *Indian Journal of Pediatrics*, 40: 389-395.
12. Ugwu, G.I. & McGil (2012). Pattern and outcome of pediatric admissions in a tertiary hospital in the Niger Delta region of Nigeria: A two year prospective study. *International Journal of Medical and Applied Sciences*, 1(1): 15-29.
13. University of Manitoba (2006). Term: Child Morbidity. Glossary Definition. Available from: <http://mchp.appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=102414>
14. Venkatesh, S. & Bansal R.D. (1986). A longitudinal study of morbidity among under-five children in a semi-urban area. *Indian Journal of Community Medicine*, 11: 11-20.