MORBIDITY PATTERN SEEN IN THE URBAN PAEDIATRIC CENTRE PONDICHERRY*

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In the proper planning and implementation of health services in a most meaningful way, it becomes indispensable on the part of health administrators to have an insight into the morbidity pattern of the people concerned. This type of evaluation in relation to the prevalent disease conditions will be beneficial for more than one reason. They are:

(a) to assess the resources available and to make sure that they produce maximum benefit,

(b) to obtain sufficient knowledge about the patterns of morbidity in the community—which disease affects most in which age groups and its relative importance to environmental factors like living and working conditions—their incidence and mode of spread,

(c) to know the changing pattern of mortality and morbidity among the children and to modify the health services accordingly, and

(d) to use the data for teaching.

Extensive studies carried out among children by eminent persons in this field have concluded that mortality indices are more important than morbidity. Moreover, true morbidity data may be difficult to obtain because of the absence of proper registration. Also, there is a wide variation in morbidity patterns among children in several parts of India due to regional differences in social, economic and cultural conditions and also marked differences in dietary habits and child rearing practices that have a direct influence over the health of children.

Studies conducted by Silhar and Manu (1960), Chaudhuri and Chaudhuri (1962), Udani (1962), Vyas (1962), Mukherjee and Bose (1964), Malhotra and Prasad (1966) and Verma and Kumar (1968) revealed different major causes of morbidity in children. Vyas (1962) from Rajkot reported tuberculosis to be the commonest cause of morbidity among children, whereas Udani (1962) from Bombay listed tuberculosis as the 6th most frequent cause of morbidity. Gupta (1964) from South India observed that out of 23,661 children studied in the out-patient department of paediatrics, respiratory infections constituted 40.5% while Mukherjee and Bose (1964) found that avitaminosis and deficiency states were the leading causes of morbidity in primary school children.

Ghai et al. (1971) in their study in Haryana and Kumar and Mathur

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(1972) in a rural area of Delhi recorded diarrhoeal disease and respiratory infections respectively as the major causes of morbidity.

In the present study we report the causes of morbidity among the children of urban dwellers (mainly slum communities) as seen in the Urban Paediatric Centre of Jawaharlal Institute of Post-Graduate Medical Education and Research, Pondicherry-6.

**Material and Methods**

The area covered by the Centre is about 3.9 square kilometres. 2950 children, from newborn to 12 years, attending the Centre for about 4 years, 1968 to 1971, were studied and analysed.

Apart from the curative and preventive health services, specialist care for the treatment of ear, nose and throat ailments, eye, dental and skin diseases is also rendered through a referral system to the specialists at JIPMER, Pondicherry. Home visits by the social worker, public health nurse and medical officer to record the illnesses throughout the year is a special feature of this Centre. Our impression is that most of the children from the slum communities of the service area of this Centre availed themselves of these services, and also made use of preventive innoculations. The service area of this centre is clearly demarcated and each family is provided with a family folder where the health, social, economic and environmental conditions are recorded. Further more each family is visited regularly at monthly intervals by the field staff.

**Socio-economic conditions**

The majority (75%) of children attending the Centre belong to low economic groups. The main occupation of the parents is fishing, rickshaw driving and manual labour. Most of them live in ill ventilated houses with insanitary surroundings.

**Food habits and child rearing practices**

The majority of the families (80%) are nonvegetarians. The consumption of meat (beef or pork) by the adults is on alternate days. Most of the children are breastfed up to the age of 2½ to 3 years and are weaned off on coffee or tea. The introduction of proper supplementary feeds and solid foods is delayed considerably. Giving an egg bath up to the age of 6 to 12 months, the administration of til seed oil orally and through the nose and giving of gripe water and omam water as supplementary feeds are very common accepted practices.

**Observations**

Table 1 shows the morbidity pattern by age, for the year 1971. From this table it is seen that the major illnesses affecting the pre-school age group of 1-5 years are respiratory infections and gastrointestinal disorders. Table 2 shows the morbidity by month. Table 3 gives a bird's eye view of morbidity seen in the years 1968-1971.

**Discussion**

It is observed from Table 3 that the four leading causes of morbidity in the Pondicherry slum areas are respiratory disorders (42.8%), gastrointestinal disorders (30.1%), skin conditions (10.0%) and nutritional disorders (5.5%). The high incidence of respiratory infection may be due to the traditional