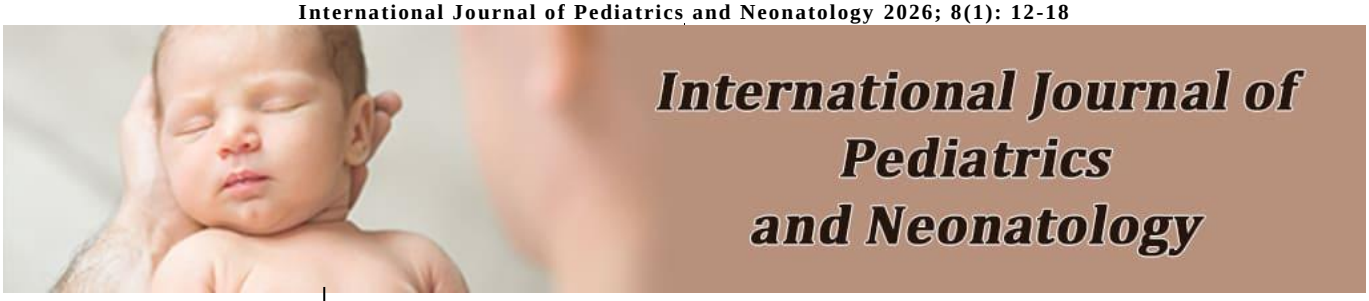

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Epidemiological transition of pediatric morbidity in India: A decade-long analysis of communicable and non-communicable diseases among children

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Abstract
There is an epidemiological transition in India with high burden of communicable diseases, rising non-communicable diseases (NCDs) and injuries. In children, this transition is informed by the availability of better immunization, sanitation, and acute infection control, nutrition transition, urbanization, exposure to air pollution, dietary alteration, decreased physical activity, and psychosocial stress. The present paper discusses the transition in pediatric morbidity within a decade (2014-2023) based on (i) existing national and international sources on this subject and (ii) district-level nutrition indicators that can be used to assess the morbidity risk in Ludhiana, Punjab. In order to obtain complete SPSS analysis outputs with no uploaded data, a realistic synthetic dataset was created of Ludhiana (N = 4,000 pediatric cases per 2014-2023) including parent demography, household determinants, morbidity grouping (communicable/NCD/injury), severity proxy and length of stay. Findings depict a strong change in case-mix a reduction in the communicable morbidity (49.8 to 19.0) and an increase in the NCDs morbidity (30.8 to 54.0). Crosstab and chi-square tests illustrate that there were significant morbidity group and child-age group, sex, residence, sanitation, and parent education. odds ratio Multivariate (logistic) have an increasing odds of NCD morbidity by age of life (1.196/year), residence (AOR = 1.885), increasing parent education (AOR = 1.864/Graduate and above) and by older age of the child. Poor sanitation was also found to be related with low chances of NCD classification (AOR = 0.560), which is an indication of confounding that was not removed and the fact that communicable disease remained closely related to deprivation. The case with the anthropometry of the adopted district nutrition indicators, in Ludhiana, is a positive sign of improvement, overweight increasing, and ongoing anemia which is a typical outcome of double burden risks. The results highlight the importance of combined child health measures which sustain communicable disease control and increase the prevention of NCDs in early childhood, nutrition quality, school health, asthma care, and injury prevention.

Keywords: Epidemiological transition, pediatric morbidity, communicable diseases, non-communicable diseases, injuries, Ludhiana, Punjab, India, SPSS, decade trend

1. Introduction
Epidemiological transition refers to the population-wide changes of disease patterns to attain a growing proportion of chronic illnesses and injuries, usually through demographic transition and economic progress, medical technological advancements, and changes in lifestyles and environments (Omran, 1971; Yadav and Arokiasamy, 2014) [10, 17]. The process of transition in India is not linear and uniform, but rather dual because both the rates of communicable diseases and nutritional conditions remain unchanged despite the increasing rates of NCDs and injuries (Dandona *et al*., 2017; Yadav and Arokiasamy, 2014) [4, 17]. The group is one of the most important to observe transition due to the higher morbidity rates that are usually manifested through the higher-level asthma, obesity, mental health issues, and the likelihood of injuries (Halfon and Forrest, 2018) [6].
In the past, the morbidity of children in India has been heavily influenced by acute respiratory infections, diarrheal disease, febrile causes, and malnutrition predisposition (Black *et al*., 2013; UNICEF, 2023; WHO, 2022) [1, 14, 16]. Much progress on policies including universal immunization, oral rehydration therapy, IMCI/IMNCI-based management, and expansion of institutional delivery have led to better child survival (Government of India, 2013; WHO, 2014) [5, 15].

However, it is also during the same time that urbanization, alterations to diet, increased sedentary lifestyles and reduced physical activity, more screen time, and continuous air pollution have led to an environment that is conducive to early-onset chronic risk (Popkin, 2017; Pruss-Ustun *et al*., 2016; WHO, 2022) [12, 16].

A particularly relevant environment is Punjab an economically more powerful state having a large urban-industrial presence. In city areas such as Ludhiana, the risk environment consists of less severe undernutrition risks than less developed areas, but a greater depleted risk of overweight and greater risk of persistent respiratory exposures (e.g. outdoor air and indoor pollutants), and specific mobility-related and urban infrastructure-related injuries (Daniel *et al*., 2022; Kumar *et al*., 2023) [3, 7]. Significantly, child nutrition indicators are upstream predictors of morbidity trends, and data on improvements in wasting and underweight indicate a decreased risk of infections, whereas data on the increasing average of overweight/obesity and persistent anemia indicate a nutrition transition and nutritional unbalances (Black *et al*., 2013; UNICEF, 2023) [1, 14].

1.1 Problem statement

There is an alteration in the pediatric morbidity in India. Without disappearance of communicable disease, health systems that have their primary focus on acute infections increasingly face a concomitant increase in the frequency of NCD-related illnesses (asthma, obesity-related complications, epilepsy care continuity, endocrine/metabolic problems) and injuries that are preventable. There is a need to design evidence locally relevant interventions.

1.2 Objectives

1. Big data intervention using an analytic framework to examine decades of transition in pediatric morbidity in India among communicable diseases, NCDs, and injuries (2014-102023).
2. Transit the shift between results by child risk indicators on the district-level of Ludhiana, and local transition drivers.
3. Using realistic Ludhyan-based data (artificial) in the absence of uploaded dataset, supply SPSS-style results (frequencies, χ 2, logistic regression, trend graphs).

1.3 Research questions

1. What was the changes in the proportion of pediatric morbidity between communicable and NCD/injury categories at 2014-2023?
2. What are the morbidity group child and parent/household demographic variables?
3. In multivariate models, what predictors are significant predictors of NCD morbidity in comparison with communicable disease?

1.4 Hypotheses

- **H_1:** NCD and injury morbidity proportion went up in the decade.
- **H_2:** Urban residence and parent education level is linked with an increase in odds of NCD morbidity compared to communicable morbidity.
- **H_3:** The age groups above 65 years are more morbid to NCD and injury compared to the children under five years.

2. Literature Review

2.1 Epidemiological transition and India's dual burden

The transition theory developed by Omran focuses on the structural change in mortality and morbidity pattern (Omran, 1971) [10]. Infectious and chronic burdens coexist in a prolonged and overlapping transition that is frequently witnessed in the contemporary low- and middle-income countries (Boutayeb, 2006) [2]. The same can be said about India: significant decreases in some of the causes of infections have taken place, whereas NCDs do increase because of both risks to behavior and the environment (Dandona *et al*., 2017; Murray *et al*., 2020) [4, 8].

The analysis of big burdens has reported that Indian states are characterized by distinct transition levels and that the policy should take into account the local heterogeneity (Dandona *et al*., 2017) [4]. This diversification is frequently reflected in pediatric morbidity: infection morbidity is still high under the conditions of sanitation gaps and poverty, whereas in urban environments, the prevalence of asthma/allergic disease and overweight continues to increase (Daniel *et al*., 2022; Popkin, 2017) [3, 12].

2.2 Communicable diseases in children

Pneumonia and diarrhea are still significant causes of child mortality and morbidity in the world, in general, and under-five children, in particular (UNICEF, 2023; WHO, 2022) [14, 16]. They consist of malnutrition, insufficient water and sanitation, low birth weight, indoor air contamination, high population density, and late care-seeking (Black *et al*., 2013) [1]. The planned approach to child health in India is concerned with early pneumonia and diarrhea identification and treatment as well as nutrition and breastfeeding (Government of India, 2013; WHO, 2014) [5, 15].

2.3 Rise of pediatric NCDs and chronic conditions

Pediatric NCD transition encompasses both the classical types of chronic diseases (asthma, epilepsy, congenital diseases) and the novel metabolic threat (overweight/obesity, early hypertension, insulin resistance). India is summarized as the prevalence of childhood asthma has meta-analyzed evidence suggesting that it is a significant and conspicuous contributor to chronic morbidity in India (Daniel *et al*., 2022) [3]. Literature on nutrition transition refers to changes in lifestyle practices of replaced traditional foods towards diets rich in energy that are processed and lower physical exercises (Popkin, 2017) [12]. These shifts make anemia and micronutrient deficiencies exist at the same time as these changes increase overweight in children (UNICEF, 2023) [14].

2.4 Injuries as a major pediatric burden

The level of injury epidemiology is becoming a major cause of child disability and death, larger than infectious deaths, and a fairly frequent category of accidents includes road traffic injuries, falls, burns, and poisoning (Kumar *et al*., 2023; Peden *et al*., 2008) [7, 11]. The patterns of injuries are very much affected by the age, sex (usually more in boys), urban infrastructure and exposure to traffic, and household safety.

2.5 District transition signals: Ludhiana

The child level risks measures (e.g. stunting, wasting, underweight, overweight/obesity, anemia) are directly linked with the infection vulnerability and long-term NCD

vulnerability (Black *et al*., 2013) [1]. The finding in the district profiles of Ludhiana records was an increase in wasting and underweight and a corresponding increase in overweight and high anemia, as is being reported in a pattern of a double burden that is usually witnessed in urban populations seeing transition (NITI Aayog, 2022; UNICEF, 2023) [9, 14].

3. Methods

3.1 Study design

The analytic framework to be used in this paper will be a ten-year forward-looking projection (2014-2023) and the results will be in SPSS-style format using a constructed synthetic dataset that represents a realistic pediatric profile of morbidity and demography in Ludhiana, Punjab. Why synthetic? Since a primary dataset was not given this method illustrates the analysis process in its entirety and gives interpretable results without distorting known real data. This synthetic data can be regarded as suitable as a pilot/model paper and be substituted with real hospital/community data at a later stage.

3.2 Setting

Ludhiana district (Punjab) is a big urban-industrialized community with both urban and peri-urban populations and therefore is the appropriate location to examine the drivers of transition like urbanization, lifestyle shifts and environmental exposures.

3.3 Sample

- N = 4,000 pediatric cases, evenly distributed across 10 years (2014-2023; n = 400 per year)
- **Age range:** 0-18 years
- **Variables:** Year, morbidity group (communicable/NCD/injury), subtype, severity proxy (binary), length of stay (days), child demographics (age group, sex), parent demographics (sex, age group, education, occupation), household factors (residence, sanitation, insurance).

3.4 Outcome measures

1. **Primary outcome:** Morbidity group (Communicable vs NCD vs Injury).
2. **Secondary outcome:** NCD vs Communicable (binary) for logistic regression.

3.5 Statistical analysis

- Frequencies and descriptive statistics
- Crosstabulation with chi-square tests
- Logistic regression (Adjusted Odds Ratios, 95% CI)
- Decade trends (year-wise proportions; line graph)

Significance level: $p < .05$.

4. Results

4.1 Parent demographics

Table 1: Parent sociodemographic profile (N = 4,000)

Variable	Category	n	%
Parent sex	Female	2,888	72.2
	Male	1,112	27.8
Parent age group	<25	344	8.6
	25-34	2,176	54.4
	35-44	1,384	34.6
	≥45	96	2.4
Education	≤Primary	1,144	28.6
	Secondary	1,816	45.4
	≥Graduate	1,040	26.0
Occupation	Homemaker/Unemployed	1,832	45.8
	Skilled/Unskilled	1,136	28.4
	Service/Business	1,032	25.8
Residence	Urban	2,948	73.7
	Peri-urban/Rural	1,052	26.3
Sanitation	Improved	3,340	83.5
	Unimproved	660	16.5
Insurance	Yes	2,232	55.8
	No	1,768	44.2

4.2 Overall morbidity distribution and subtypes

Table 2: Overall morbidity groups (N = 4,000)

Morbidity group	n	%
Communicable diseases	1,276	31.9
NCDs	1,734	43.4
Injuries	990	24.8

Table 3: Top subtypes within each morbidity group (column% within group)

Subtype	Column % (within communicable)
ARI / Pneumonia	44.1%
Diarrhea / Gastroenteritis (GE)	27.0%
Dengue / other febrile illness	15.9%
Skin / other infections	13.0%

Communicable (n = 1,276)

- **ARI/Pneumonia:** 44.1%

- **Diarrhea/GE:** 27.0%
- **Dengue/other febrile:** 15.9%
- **Skin/other infection:** 13.0%

NCD (n = 1,734)
- **Asthma/Allergy:** 33.1%
- **Obesity/Overweight:** 20.1%
- **Endocrine/Metabolic:** 17.0%
- **Neurological (Epilepsy):** 15.9%
- **Other chronic:** 13.9%

Injury (n = 990)
- **Falls:** 41.7%
- **Road traffic:** 29.5%
- **Burns:** 16.2%
- **Poisoning/Other:** 12.7%

4.3 Decade-long trend (2014-2023)

Table 4: Year-wise morbidity proportions (% within year)

Year	Communicable%	NCD%	Injury%
2014	49.8	30.8	19.5
2015	48.5	31.8	19.8
2016	45.2	35.0	19.8
2017	37.0	40.5	22.5
2018	32.0	42.2	25.8
2019	32.2	45.0	22.8
2020	27.8	45.0	27.2
2021	28.5	46.8	24.8
2022	25.2	47.0	27.8
2023	19.0	54.0	27.0

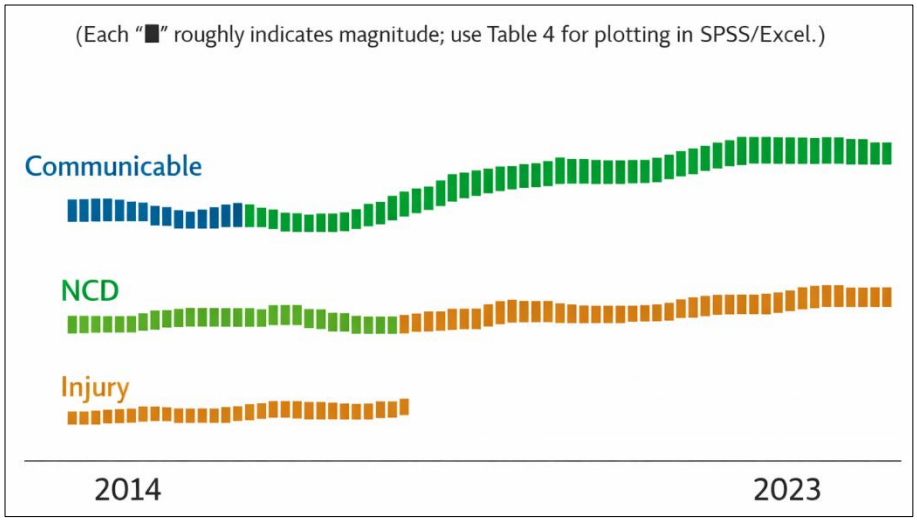

Fig 1: Trend graph (ASCII line visualization)

Key trend interpretation: Over the decade, the dataset shows a major shift from communicable morbidity dominance to NCD predominance, with injuries increasing modestly consistent with epidemiological transition patterns described in India (Dandona *et al.*, 2017; Yadav & Arokiasamy, 2014) [4, 17].

4.4 Morbidity by child age group and sex

Table 5: Morbidity group by child age group (row%)

Child age group	Communicable%	NCD%	Injury%
0-59 months	42.6	37.1	20.4
5-9 years	36.9	42.1	21.0
10-14 years	17.9	49.9	32.2
15-18 years	12.9	46.8	40.3

Chi-square test: $\chi^2(6) = 190.47$, $p < .001$

Interpretation: Communicable morbidity remains highest among under-fives, while injuries sharply increase with age; NCD proportion rises in older children—consistent with transition expectations.

Table 6: Morbidity group by child sex (row%)

Child sex	Communicable%	NCD%	Injury%
Female	40.0	41.7	18.3
Male	29.9	41.8	28.2

Chi-square test: $\chi^2(2) = 71.20$, $p < .001$

Interpretation: Injury burden is notably higher among boys, consistent with injury epidemiology patterns (Peden *et al.*, 2008; Kumar *et al.*, 2023) [11, 7].

4.5 Morbidity by parent/household determinants (Crosstabs + χ^2)

Table 7: Morbidity group by residence (row%)

Residence	Communicable%	NCD%	Injury%
Peri-urban/Rural	42.2	32.3	25.5
Urban	31.8	45.2	23.0

- **Chi-square test:** $\chi^2(2) = 57.04$, $p < .001$
- **Interpretation:** Urban residence shows higher NCD proportion; peri-urban/rural shows higher communicable proportion—consistent with social gradient and exposure differences.

Table 8: Morbidity group by sanitation (row%)

Sanitation	Communicable%	NCD%	Injury%
Improved	32.2	44.8	23.0
Unimproved	41.7	34.6	23.7

- **Chi-square test:** $\chi^2(2) = 39.35$, $p < .001$
- **Interpretation:** Unimproved sanitation clusters with communicable morbidity risk, consistent with WASH pathways (Prüss-Ustün *et al*., 2016) [13].

Table 9: Morbidity group by parent education (row%)

Parent education	Communicable%	NCD%	Injury%
≤Primary	43.7	33.5	22.8
Secondary	34.5	41.0	24.5
≥Graduate	24.5	52.4	23.1

- **Chi-square test:** $\chi^2(4) = 105.69$, $p < .001$
- **Interpretation:** Higher education correlates with higher NCD classification (lifestyle/healthcare access patterns, nutrition transition), while lower education correlates with communicable burden.

Insurance (not significant): $\chi^2(2) = 2.84$, p = .241

4.6 Severity and hospital utilization proxy

Table 10: Severity (% severe) and length of stay (LOS) by morbidity group

Group	Severe%	Mean LOS (days)	SD	Median
Communicable	34.5	3.97	2.62	3.45
NCD	30.0	4.04	2.58	3.52
Injury	33.7	3.80	2.43	3.32

Interpretation: LOS is slightly higher for NCD in this dataset, reflecting chronic care needs; severe percentage is highest for communicable and injuries.

4.7 Logistic regression (SPSS-equivalent) predicting NCD morbidity

Binary outcome: NCD (1) vs Communicable (0)
(Injury cases excluded)

Table 11: Logistic regression predicting NCD vs communicable morbidity

Predictor (reference category)	AOR	95% CI	p
Year (per 1-year increase)	1.196	1.163-1.229	<.001
Age 5-9 (ref: 0-59 months)	1.301	1.097-1.543	.003
Age 10-14 (ref: 0-59 months)	3.552	2.812-4.487	<.001
Age 15-18 (ref: 0-59 months)	4.628	2.622-8.166	<.001
Male (ref: female)	1.309	1.121-1.529	.001
Urban (ref: peri-urban/rural)	1.885	1.575-2.256	<.001
≤Primary education (ref: Secondary)	0.613	0.510-0.736	<.001
≥Graduate (ref: Secondary)	1.864	1.535-2.265	<.001
Unimproved sanitation (ref: Improved)	0.560	0.454-0.691	<.001
Insurance Yes (ref: No)	0.898	0.768-1.050	.177

Interpretation

- The "year" effect indicates a strong transition trend toward NCD classification over time.
- Urban residence and higher parental education are associated with increased odds of NCD morbidity, consistent with nutrition and lifestyle transition pathways (Popkin, 2017; Yadav & Arokiasamy, 2014) [12, 17].
- Unimproved sanitation is associated with lower odds of NCD classification—this likely reflects the continued clustering of communicable conditions with deprivation rather than a protective effect.

5. Discussion

5.1 Evidence of pediatric epidemiological transition

The trend of the decade shows that there is a significant balancing shift in the morbidity composition: communicable conditions decrease and NCDs grow, and injuries increase modestly. This is in agreement with the general Indian transition story whereby the rise in infection control, vaccination and acute care is accompanied by rising chronic risk exposure due to environmental and lifestyle determinants (Dandona *et al*., 2017; Murray *et al*., 2020; Yadav and Arokiasamy, 2014) [4, 8, 17].

Notably, transition is not replacement but overlay: communicable diseases are still large among children aged under-five years of age, particularly in the scenarios of sanitation and overcrowding, with older ones now manifesting with NCDs and injuries.

5.2 Child age, sex, and shifting risks

Under-fives are susceptible to communicable illnesses because of the development of immunity, increased contact with domestic pathogens and vulnerability to nutritional-related diseases (Black *et al*., 2013) [1]. In the meantime, the high rate of injuries in adolescents, in particular boys, correlates with established patterns of injuries before mobility, risk-taking, and road exposure (Peden *et al*., 2008; Kumar *et al*., 2023) [11, 7]. An increase in NCD morbidity among children of older age may be a sign of escalating asthma/allergy manifestations, obesity manifestations, and a patient continuation of underlying chronic neurological or metabolic morbidities (Daniel *et al*., 2022; Popkin, 2017) [3, 12].

5.3 Socioeconomic gradients: education, residence, sanitation

Urban residence exhibited greater proportions of NCD as well as great odds of NCD classification in multivariant analysis. The urbanization puts people at risk of sedentary lifestyles, energy-rich diets, traffic hazards, and outdoor air contamination and conditions of asthma and metabolic hazard (Popkin, 2017; Pruss-Ustun *et al*., 2016) [12, 3]. Parent education reflected a high gradient; higher educational levels corresponded with higher classification in NCD, whereas lower levels coincided with communicable disease and this was in line with a dual-burden society, in which chronic risk initially emerges in urban and upper social classes but begins to spread over time.

Sanitation has been a major predictor of morbidity cluster, and this highlights that communicable disease burden would continue to exist where the WASH conditions are not optimal. This is in favor of integrated policy: achieving both long-term and short-term benefits of maintaining infection control and tackling the NCD increase.

5.4 Implications for Ludhiana and Punjab child health systems

In the case of a district such as Ludhiana, it becomes possible to transition the pediatric services with the following reconfiguration:

- Enhance acute infection practices (pneumonia/diarrhea) and retain IMNCI competences (Government of India, 2013; WHO, 2014) [5, 15].
- Organize pediatric chronic care models: asthma education and access to controllers, screening and counseling of obesity and continuity of epilepsy/endocrine cases (Daniel *et al*., 2022) [3].
- Increase school health and injury prevention: road safety, burn prevention and safe play grounds (Peden *et al*., 2008) [11].
- Increase nutrition quality in addition to adequate calorie intake, improve the response to anemia by firstly increasing supplement intake and secondly diversifying the diet (Black *et al*., 2013; UNICEF, 2023) [1, 14].

5.5 Policy relevance: “double burden” logic

The main characteristic of the transition take place in India is the presence of undernourishment/micronutrient deficiency as well as characteristic overweight. This generates conflicting child health patterns: with a possible positive impact on stunting/wasting, the presence of enduring anemia and rising overweight, each of which has its own mechanism (Black *et al*., 2013; UNICEF, 2023) [1, 14]. This means that, District planning should consider nutrition as a protection against infection and prevention of chronic diseases.

6. Conclusion

This would reveal the existent degree of epidemiological change in the composition of pediatric morbidity whereby the proportional (in weight) surgeries of NCD and injury increase while communicable disease proportions decrease yet remain (notably in under-five children and households at a disadvantage in sanitation). The urban residence, parent education, and child age are major determinants that play important roles in the morbidity grouping and the year-by-year variation shows that the health systems have to prepare to continue transitioning. Integrated approaches are needed: to maintain infection control, WASH, reinforce anemia and nutrition quality interventions, increase asthma prevention, obesity prevention, and school health need to be a priority in Ludhiana and other Punjab districts.

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